Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Ms. XXXX's** laparoscopic cholecystectomy on 08/04/YYYY, subsequent small bowel perforation, its complications and its management*
- *Records from 08/04/YYYY to 08/30/YYYY have been presented in a detailed timeline manner*
- *Subsequent medical records from 09/02/YYYY to 11/28/YYYY have been reviewed and records related to abdominal complaints and management of sepsis have been presented in detail*
- *Records from 11/29/YYYY to 02/12/YYYY have been reviewed and presented in brief focusing on abdominal complaints and management of complication as a result of complication from 2014 surgery.*
- *Records related to other medical conditions have not been elaborated and repetitive information have been avoided.*

Flow of events

Multiple providers

10/20/YYYY-7/23/YYYY: Multiple visits for heme positive stool, diarrhea, constipation, anterior resection & mobilization of colon, abdominal pain – On 07/12/YYYY, she was diagnosed with cholelithiasis – On 01/17/YYYY, patient made ER visit for abdominal pain; CT abdomen revealed paraumbilical ventral hernia and no bowel obstruction – MRI abdomen on 01/23/YYYY revealed cholelithiasis with likely changes of chronic cholecystitis – On 02/05/YYYY, it was planned to proceed with a laparoscopic cholecystectomy and a diagnostic laparoscopy to evaluate for adhesions in her left upper quadrant for abdominal pain – On 07/23/YYYY, procedure risks were discussed again and patient elected to proceed

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AB Hospital:

08/04/YYYY-08/05/YYYY: Patient underwent laparoscopy with laparoscopic cholecystectomy, laparotomy with extensive lysis of adhesions and an open repair of ventral hernia without mesh under general anesthesia – She was admitted for postoperative pain management and was discharged on 08/05/YYYY

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AB Hospital:

08/06/YYYY-08/30/YYYY: Patient presented to ER on 08/06/YYYY for altered mental status, lethargy, having trouble speaking, unable to ambulate and abdominal pain – Diagnosed with septic shock and pleural effusion - Intubated for respiratory failure and admitted to ICU – Exploratory laparotomy performed and it revealed small bowel perforation; small bowel resection performed and primary anastomosis of small bowel perforation – Antibiotics started for sepsis – On 08/09, patient was off pressors; blood culture revealed Serratia marcescens – Extubated on 08/10 – Re-intubated on 08/11 for respiratory failure – On 08/11, thoracentasis performed for pleural effusion and removed 450 cc fluid – On 08/12, Infectious Disease consulted for fever and leukocytosis and antibiotics changed to Meropenem and Micafungin – On 08/15, CT guided intraabdominal abscess drainage was performed – Extubated on 08/16 – Assessed with C. diff and started on per oral Vancomycin on 08/18 - Transferred to floor on 08/19 – TPN discontinued on 08/20 and started on per oral – Discharged on 08/30 to Northeast Rehabilitation Center in stable condition

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AB Hospital

08/30/YYYY-09/06/YYYY: Re-admitted for intractable nausea and vomiting while at rehab to the point that she had essentially nonstop emesis - X-ray of abdomen performed for vomiting – It revealed normal bowel gas pattern without evidence of obstruction, extensive post-surgical changes in the abdomen and pelvis and moderate sized bilateral pleural effusions with compensatory bibasilar subsegmental atelectasis – Infectious Disease consulted on 09/02 and recommended to continue Meropenem and Micafungin through 09/12 and Metronidazole and oral Vancomycin through 09/26 and probiotics for 3 months – CT abdomen on 09/03 revealed probable abscess in the pelvic cul-de-sac, slightly decreased in size from previous study and minimal fluid in the bilateral paracolic gutters and surrounding the liver and spleen – Transferred to ABC Living on 09/06

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ABC Living – Gunwoody

09/06/YYYY-09/16/YYYY: Admitted from AB Hospital for rehab – Made follow up visit at AB Vascular Surgery on 09/11 with complaints of arm swelling and diagnosed with acute deep vein thrombosis in the right brachial vein and superficial vein thrombosis in the right basilic vein

which were related to the recent PICC lines and started on Xarelto – Discharged from nursing home per patient request on 09/16

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XYZ Home Care and Hospice

09/18/YYYY-01/15/YYYY: Home Health nursing visits made for nursing abdominal wound, physical therapy, occupation therapy and psychiatric counseling – Physical therapy was performed until 10/10/YYYY – Occupational therapy was performed until 10/16/YYYY – Nursing visits performed until 10/29/YYYY – Psychiatric visit performed until 01/15/YYYY

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Ruben, Luke & Garcha Surgical Associates, PC

09/24/YYYY-10/22/YYYY: Patient made follow up visit on 09/24/YYYY and complained of tightness just under her right breast – CT angiogram was negative for pulmonary embolism – It was suggested to stop packing wound and Home Health wound care was not required – On 10/22/YYYY, examination revealed small sinus tract approximately 4 cm with a narrowing opening that has been packed with Iodoform gauze and not closing

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AB Vascular Surgery

10/30/YYYY: Patient presented with right arm swelling – Ultrasound revealed resolution of previous thrombosis of the right brachial and basilic veins - Assessed with edema of upper extremity and recommended Compressive stockings, leg elevation and to complete 3 month course of Xarelto

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XXXX, R.N.

10/31/YYYY: Wound care visit for unhealed abdominal wound – Examination revealed small opening in midline incision which probes cephalad about 4 cm directly beneath the incisional scar

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XY Plastic Surgery, PC

11/07/YYYY: Plastic surgery consult for non-healing abdominal wound – Examination revealed 12cm indented, painful vertical laparotomy scar adhesed down to fascia with non-healing sinus tract – Recommended to finish her course of Xarelto and to undergo hypercoag work due to history of 2 DVTs

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XXXX, M.D.

11/21/YYYY-11/27/YYYY: Patient presented for hypercoag workup on 11/21/YYYY for recurrent thromboembolism – Workup on 11/27/YYYY revealed positive for two copies of C677T variant of MTHFR and remaining parameter were negative

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AB Vascular Surgery

12/04/YYYY: Patient reported resolution of right arm swelling and finished her Xarelto 4 days ago – Also noted that she was started on Aspirin for procoagulant condition – Advised to continue to wear the prescribed elastic compressive stockings all the time when she was on her feet

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XXXX, M.D.

12/08/YYYY-12/31/YYYY: Patient presented to discuss wound care surgery on 12/08/YYYY; assessed with anxiety, PTSD and recommended low dose Xanax; Also recommended physical therapy for physical deconditioning; Stool culture ordered for diarrhea; Assessed with Clostridium difficile diarrhea and started on Vancomycin 125 mg every 6 hours – On 12/23/YYYY, C. diff was improving – Diarrhea reported on 12/29/YYYY and stool culture ordered

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XY Plastic Surgery

01/05/YYYY: Underwent bilateral trunk fasciocutaneous flaps, abdominal wall debridement and complex closure anterior trunk 12 cm

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XY Clinical Care

01/12/YYYY: Patient complained of soft stool for 4-6 days - Taking oral Vancomycin and feeling better and recommended to continue probiotics for at least 6 months

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Multiple providers

01/26/YYYY-04/21/YYYY: Multiple visits for depression, PTSD, diarrhea – Cardiology visit for chest pain and shortness of breath on 02/27/YYYY; recommended cardiac workup for structural evaluation and monitor palpitation for now – On 03/05/YYYY, follow up made with vascular surgery; no pain reported in extremities and advised to continue compressive stocking and follow up in 6 months – Echocardiogram on 03/27/YYYY revealed left ventricular ejection fraction is 60% and mild mitral valve regurgitation; cardiac stress testing was normal – On 03/31/YYYY, patient complained of heartburn and constipation; CT abdomen was ordered – On 04/21/YYYY, incision was healing well

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XYZ's Hospital

05/12/YYYY: ER visit for constipation and vomiting – CT revealed no bowel obstruction – Discharged on same day

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Multiple providers

05/13/YYYY-11/23/YYYY: Multiple visit for PTSD, nausea, colitis, sensorineural hearing loss, cardiology follow up – CT abdomen on 05/27/YYYY revealed colitis – On 07/17/YYYY, surgical option was discussed for ventral hernia – CT abdomen on 07/23/YYYY revealed broad-based hernia involving the midline abdominal wall above the level of umbilicus without evidence for bowel incarceration – On 11/03/YYYY, patient was cleared for hernia surgery

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AB University Hospital

11/24/YYYY: Prophylactic IVC filter placement performed for planned ventral hernia repair

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AB University Hospital

12/01/YYYY-12/17/YYYY: Underwent exploratory laparotomy with extensive lysis of adhesions, proximal jejunal small bowel resection with antegrade side-to-side jejunal-to-jejunal anastomosis on 12/01/YYYY – Admitted for postop management of acute pain, acute blood loos anemia – Extubated on 12/02 - NG placed overnight for post-op nausea/vomiting on 12/02 – Discharged on 12/17/YYYY in stable condition

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Multiple providers

12/23/YYYY-01/07/YYYY: Multiple visit for anxiety, hernia repair follow up, vascular surgery follow up

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AB University Hospital

01/07/YYYY-01/08/YYYY: Presented with increase gastroesophageal reflux symptoms – EGD revealed small to moderate hiatal hernia and bile reflux into stomach – Symptoms improved on 01/08/YYYY and discharged

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Multiple providers

01/22/YYYY-03/03/YYYY: Multiple visits for diarrhea, GERD, atypical chest pain – On 03/03/YYYY, it was planned for removal of IVC filter

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AB University Hospital

03/08/YYYY: IVC filter was removed without incident

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Multiple providers

03/14/YYYY-08/30/YYYY: Multiple visits for MTHFR mutation, peptic ulcer disease, anxiety, depression, intractable migraine – CT abdomen on 05/25/YYYY revealed postsurgical changes from abdominal wall reconstruction with interval decrease in fluid associated with the mesh posterior to the anterior abdominal wall

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XXXX's Hospital

09/06/YYYY-09/07/YYYY: ER visit for abdominal pain – CT abdomen revealed no significant change in appearance of fluid collection associated with the anterior abdominal wall mesh - Labs revealed elevated WBC and Surgery recommended bowel regimen and discharged on 09/07/YYYY in stable condition

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AB University Hospital

09/13/YYYY: MRI abdomen revealed pancake shaped fluid collection anterior to the abdominal wall hernia mesh repair within the rim enhancement, multiple small bowel adjacent to the fluid collection/hernia mesh

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Multiple providers

10/17/YYYY-12/28/YYYY: Multiple visit for ventral hernia repair follow up, urinary incontinence, syncope, chest pain, immunology workup – ER visit for constipation on 11/12/YYYY; discharged with instruction for bowel regimen – Hospitalized from 11/18/YYYY to 11/22/YYYY for abdominal pain, leukocytosis – Hospitalization for evaluation of small bowel obstruction from 11/26/YYYY to 11/28/YYYY; assessed with sepsis and given single dose Levaquin and discharged with oral Vancomycin – On 11/30/YYYY, follow up made for loss of appetite; assessed with partial small bowel obstruction; Medications ordered – On 12/28/YYYY, continued to have chronic constipation and was on aggressive bowel regimen

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Multiple providers

02/27/YYYY-02/12/YYYY: Multiple visits for chest heaviness and palpitation, Clos. difficile, sepsis and immunology work up - ER visit for epigastric pain and generalized weakness on 11/14/YYYY; Medications given and discharged - ER visit for abdominal pain on 11/15/YYYY; diagnosed with acute chest pain, syncope, acute abdominal pain and small bowel obstruction; NG tube placed and recommended to get admitted; patient left against medical advice - ER visit for left arm pain on 02/04/YYYY; diagnosed with superficial phlebitis and advised to follow up with vascular lab - Ultrasound performed on 02/05/YYYY and it revealed acute superficial venous thrombosis – Prescription given and discharged – ER visit for abdominal pain on 02/10/YYYY; Lab revealed leucocytosis and small bowel obstruction; transferred to Emory - Hospitalization for small bowel obstruction from 02/10/YYYY to 02/15/YYYY; Initially admitted with NGT which was removed on day 2; tolerating regular diet on day 6 and ambulating well and discharged - MRI abdomen for small bowel obstruction on 03/28/YYYY; concern for fixed small bowel stricture; no bowel obstruction - Hospitalization for abdominal pain from 06/06/YYYY to 06/10/YYYY; she was given brief period of bowel rest and returned to normal bowel function - Still having issues with her bowels as on 11/15/YYYY and upper GI series negative 11/30/YYYY - Office visit for abdominal pain, nausea on 01/17/YYYY; Assessed with improving condition and suggested patient may have adhesions given number of surgeries - Hospitalization for abdominal issues, nausea from 01/28/YYYY to 02/05/YYYY; Workup revealed no evidence of GI tract inflammation, obstruction or inflammatory changes; discharged on 02/05/YYYY – Presented for EGD on 10/25/YYYY and noted with facial droop and weakness; Neurology consulted and MRI was negative – On 02/11/YYYY, patient presented for evaluation of transient ischemic attack – On 02/12/YYYY, patient presented for evaluation of fecal urgency and was referred to urogynecology

Patient History

Past Medical History: Asthma, ovarian cancer, gastroesophageal reflux disease, fibromyalgia. (PDF-Ref: 6382, 9071)

Surgical History: Appendectomy, hysterectomy, tonsillectomy and colon resection surgery in 07/YYYY along with an oophorectomy, ovarian surgery (PDF-Ref: 6382, 9071)

Family History: Heart disease, high blood pressure, stroke (PDF-Ref: 825-826)

Social History: Positive for occasional alcohol usage. No history of tobacco usage (PDF-Ref: 8769)

Allergy: Sulfa, Lortab, Percocet, Darvocet, Bactrim, Morphine, Latex (PDF-Ref: 8769, 9071)

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
10/20/YYYY	Hospital/ Provider Name	**Procedure Report:** **Procedure:** PillCam enteroscopy	8866-8867

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Preoperative diagnosis: Heme-positive stool Diarrhea **Indications:** The patient is a 48-year-old female who has had heme-positive stool. A former upper endoscopy revealed a normal esophagus. There were a few small non-bleeding erosions within the antrum, which were felt to be related to Aspirin and non-steroidal use. The duodenum was unremarkable. In addition, a colonoscopy was performed that was essentially unremarkable. The PillCam is being performed to further delineate the cause of her heme-positive stool. **Impression:** This is an essentially unremarkable PillCam enteroscopy expect for a tiny non-bleeding erosion within the proximal portion of the duodenum.	
07/13/YYYY	Hospital/ Provider Name	**History and Physical:** **Chief Complaint:** Constipation, stricture bowel **Present Illness:** The patient complains of abdominal pain, nausea, vomiting, constipation, and diarrhea, and has been taking Miralax, which is not helping. She is status post transit study, which showed all sitz markers remaining in the abdomen, sigmoid colon, and rectum, and Defogram, which showed a mild anterior rectocele. Exam revealed all sitz markers remaining, mild anterior rectocele, and distended abdomen. **Impression or preop diagnosis:** Constipation, stricture bowel	13427
07/13/YYYY	Hospital/ Provider Name	**Procedure Report:** **Preoperative diagnosis:** Left lower quadrant abdominal pain, colon stricture, constipation, history of ovarian cancer **Postoperative diagnosis:** Left lower quadrant abdominal pain, colon stricture, constipation, history of ovarian cancer, possible diverticulosis **Procedure:** 1. Anterior resection, mobilization of colon 2. Intraoperative colonoscopy **Indication:** Patient with severe abdominal pain and constipation. She is status post pelvic surgery for ovarian cancer. She has also had a positive transit study. **Findings:** Right colon, transverse colon and descending colon do appear normal. The sigmoid colon was severely strictured and scarred which was identified on the colonoscopy and does appear to be the site of partial colon obstruction.	13270-13271

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
07/20/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Admit date:** 07/13/YYYY The patient was admitted with constipation, stricture of the bowel and a history of ovarian cancer. She had a total colectomy, sigmoid resection and intraoperative colonoscopy. The patient tolerated procedure well. Postop course, the ileus is resolving. Patient wound is clean and dry with no signs of infection. Patient was started on clear liquids and the diet was advanced as tolerated. Foley out. Patient voiding without difficulty. Discharged in stable condition. Patient instructed in no heavy lifting or strenuous exercise, to resume home medications. Pain medication prescription was given to patient. Patient to follow up with Dr. Binderow in 1 week to remove clips.	13426
07/13/YYYY-07/20/YYYY	Hospital/ Provider Name	**Other records:** Anesthesia Record, Social Service Records, Progress notes, Physical Therapy Records, Pathology Report, PACU Record, Orders, Nursing Notes/Records, Medication Sheets, Medication Reconciliation Record, Labs, Input / Output Record, Flow sheet, EKG, Discharge Instructions, Checklist/Verification List, Assessment **PDF-Ref:** 13461-13477, 13272-13273, 13480-13508, 8870-8872, 13509-13592, 13436-13460, 13423-13425, 13428-13435	
01/24/YYYY	Hospital/ Provider Name	**Pathology Report:** **Surgery date:** 01/18/YYYY **Received date:** 01/21/YYYY **Final Pathologic Diagnosis:** A. Duodenum, Second Part (Biopsy): Small bowel mucosa with no significant histopathology. No histologic evidence of celiac sprue or infectious microorganisms. B. Stomach, Antrum (Biopsy): Gastric mucosa with no significant histopathology. No Helicobacter pylori microorganisms are identified with a special stain. C. Distal Esophagus, Lower Third (Biopsy): Squamous epithelium with no diagnostic abnormality. No glandular epithelium is present. An Alcian blue/PAS stain is negative for both intestinal metaplasia and fungal elements. D. Gastric Polyps (Polypectomy): Gastric mucosa with no significant histopathology. No Helicobacter pylori microorganisms are identified with a special stain. **Reviewer's comment: Corresponding operative/procedure report on 01/18/YYYY is not available for review.*	8788-8789
07/12/YYYY	Hospital/ Provider Name	**Ultrasound of abdomen:** **Clinical History:** Right upper quadrant abdominal pain	8793

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: Cholelithiasis. No common duct obstruction. Tail of pancreas not seen due to overlying bowel gas	
07/16/YYYY	Hospital/ Provider Name	**Consultation report:** **Reason for consultation:** Patient presents with abdominal pain. **History of present illness:** Patient has a history for ovarian cancer on April 1, 2003, and in July of 2011, she underwent a partial colectomy for I'm not really certain, but she says it was for scar tissue. She had a very difficult time with that surgery. She had a significant amount of pain and ended up having blood clots in her legs. Her present illness now is that she describes left upper quadrant abdominal pain, which is severe. It lasts most of the day. It is not really exacerbated by food. She does have difficulty with bowel movements, and she takes laxatives regularly. She denies nausea or vomiting, but she has this persistent pain. She also has a history of cholelithiasis, which was seen on an ultrasound recently. There was no gallbladder wall thickening or pericholecystic fluid. She has had a recent endoscopy, which was essentially normal. **Impression:** Complicated issue regarding left-sided abdominal pain associated with cholelithiasis and what was reported to have been hernia detected on a CT scan. I don't have those reports. **Plan:** I will plan on getting the reports of her previous surgeries, and we will go ahead and proceed with a CT scan of the abdomen and pelvis. I told her that the likelihood of this left-sided abdominal pain coming from her gallbladder was relatively remote, however certainly not impossible. We will review all of her records and discuss this with her and Dr. Pepper in the near future.	8768-8769
07/17/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with contrast:** **History:** Left upper quadrant pain. **Impression**: No acute abnormality within the abdomen or pelvis to account for the patient's left upper quadrant pain. Stable post-surgical changes from hysterectomy and oophorectomy with numerous clips scattered throughout the peritoneal cavity. A small left common iliac node is stable dating back to 2009. No evidence for metastatic disease.	8795-8796, 8790
07/23/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Patient was recently seen with a history of gallstones and history of abdominal pain, history of hysterectomy and oophorectomy remotely for ovarian cancer. She also had a history of laparotomy for lysis of adhesions and a laparotomy and colectomy. Subsequent to colectomy, she had some significant problems, and she	8770-8771

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		again is here with this persistent abdominal pain, mainly left-sided, but she also states that she has acid burning and it is very difficult for her to eat. We repeated a CT scan, which showed again a gallstone. There was no evidence of hernia and no evidence of bowel obstruction. I am still waiting to review op reports and the CT scan that was done back in Kentucky. We are still discussing the possibility of her undergoing a laparoscopic cholecystectomy.	
01/17/YYYY	Hospital/ Provider Name	**ER Record:** **Chief complaint:** Left upper quadrant abdominal pain. **History of present illness:** Patient with a past medical history significant for ovarian cancer with resultant adhesions and partial colectomy secondary to that, who presents to the emergency department complaining of left upper quadrant pain. She described the pain as sharp in nature, radiating to her left chest. States her symptoms came on at approximately 0100 she complains of nausea but denies any vomiting. She states she is not passing anything from below. **Discussion:** Given the patient's signs and symptoms, laboratories were performed and a CT of the abdomen and pelvis was ordered with IV and per oral contrast. Laboratories were remarkable for normal white count of 9. 9, hemoglobin of 13.7, hematocrit of 39. 2 with 208 platelets. Chemistries were unremarkable, although urinalysis may have some signs of infection. The patient complained of chest pain on arrival, an EKG was performed per protocol. EKG demonstrated normal sinus rhythm, rate of 74, normal axis, no acute ST changes per my interpretation. The patient's case will be turned over to the oncoming physician and her CT will be done at that time. **Diagnoses:** 1. Abdominal pain. 2. History of previous bowel obstruction. 3. Urinary tract infection.	13279-13281, 410-414
01/17/YYYY	Hospital/ Provider Name	**ER Record:** The patient was here with left upper quadrant abdominal pain. She had a history of prior resection, and a prior history of ovarian cancer with surgery. She was seen by Dr. Welch. A CT scan of the abdomen and pelvis with oral and IV contrast was ordered. This was read by Radiology showing gallstones with some questionable gallbladder wall thickening, but otherwise no secondary signs of cholecystitis. There is a small periumbilical hernia. ___ small bowel but no signs of obstruction. No definite etiology for left upper quadrant pain identified on CT scan. No obstruction. The patient does have a urinary tract infection with leuko esterase positive. We sent this for culture. Gave her a dose of Rocephin. I discussed case with Dr. Pepper. I also discussed the case with Dr. Ruben from General Surgery, and the patient will be discharged home. **Diagnostic impression:** Abdominal pain, gallstones, urinary tract infection.	13281-13282

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: Keflex, Ultram, Zofran. Follow up with Dr. Ruben. Follow up with Dr. Pepper. Return as needed.	
01/17/YYYY	Hospital/ Provider Name	**CT abdomen and pelvis with contrast:** **Reason for exam:** Bowel obstruction **Indication:** Abdominal pain and vomiting. History of ovarian cancer and scar tissue. By report, the patient's pain is left-sided. **Impression:** 1. Negative for bowel obstruction as queried. 2. Very small wide-mouthed paraumbilical ventral hernia just to the left of midline containing a single loop of non obstructed small bowel. This hernia has a wide mouth with fascial defect measuring approximately 2.5 cm. No evidence of complication. 3. Cholelithiasis. Nonspecific very mild gallbladder wall thickening but no pericholecystic inflammatory change. In the absence of right upper quadrant pain, findings would seem unlikely to represent acute cholecystitis. Discussed with the ER physician by Dr. Moreno at time of dictation.	13377-13378
01/17/YYYY	Hospital/ Provider Name	**Other records:** Assessment, EKG, Patient Education, Discharge Instructions, Medication Sheets, Vaccination/Immunization **PDF-Ref:** 13283-13287, 13289-13290, 13304-13376, 13379-13405	
01/22/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Subjective:** Patient comes in to the office today for a follow-up appointment regarding her left upper quadrant abdominal pain. It has been about six months since we saw her last. Over the last several weeks, her left upper quadrant pain has worsened. She reports that she continues to have episodes of alternating constipation and diarrhea and for the last week and a half, has had vomiting. She was seen at the Saint Joseph's Emergency Room last week due to these symptoms and, at that time, a CT scan was done which showed cholelithiasis and a periumbilical hernia which contained a loop of bowel but there was no evidence of obstruction at the site of the hernia. There was not any evidence of bowel obstruction in her small intestine or any sort of colonic obstruction. She has been seen by GI and is scheduled to undergo an MR enterography tomorrow. She feels that her pain is due to scar tissue and would like to have exploratory surgery done by Dr. Ruben because she can no longer live with this pain. She did have a sigmoid colon resection by Dr. Binderow in July of 2011 for these same symptoms and she did not at all improve after that surgery. She has not had a colonoscopy since July of 2011.	8772-8774

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment and plan: Patient with a five-year history of left upper quadrant pain which has been worsening and she has had vomiting over the last week. Recent CT showed no evidence of obstruction. Both Dr. Ruben and I explained to her that prior to proceeding with any sort of surgical intervention, she needs to complete her full GI workup to make sure there is no other etiology of her symptoms and definitely needs a colonoscopy before doing any exploratory surgery. We also discussed the fact that she does have gallstones, so if we do plan to do surgery, we should plan on doing a cholecystectomy at the time of surgery. She is hesitant because she does not feel like her gallstones are at all contributing to her pain. I explained to her that I agree the gallbladder is unlikely the source of her left upper quadrant pain but she does have definite stones which can cause complications down the road and if we do plan to do surgery, we would recommend doing a cholecystectomy at the time of the exploratory surgery. We did explain to patient that typically with adhesions, those can cause pain; however, they do not cause these functional issues of alternating between diarrhea and constipation and vomiting when there is no evidence of any sort of a bowel obstruction. We also discussed that if we did proceed with surgery, her symptoms still may not resolve. We also explained that the surgery may not be able to be done laparoscopically since she does have this low midline scar. We have asked her to get us copies of the MR enterography and the colonoscopy report, and once she has both of those complete, we can plan to talk on the phone. If the ultimate decision is to proceed with surgery, we will plan to do a laparoscopic cholecystectomy, open incisional hernia repair, and diagnostic laparoscopy versus laparotomy for lysis of adhesions. Patient was seen and examined in the office by Dr. Ruben today as well. He was present for the discussion regarding possible complications and the fact that she may not improve after we do surgery.	
01/23/YYYY	Hospital/ Provider Name	**MRI abdomen with and without contrast:** **Indication:** Patient with a past medical history significant for ovarian cancer with resultant adhesions and partial colectomy secondary to that, who presents with left upper quadrant pain. Gallstones on CT. **Impression:** 1. Cholelithiasis with likely changes of chronic cholecystitis. 2. Postsurgical changes of hysterectomy and bilateral oophorectomy for ovarian cancer without MRI findings of metastatic disease within the abdomen or pelvis. 3. Uncomplicated bowel containing periumbilical hernia.	736-738
01/31/YYYY	Hospital/ Provider Name	**Procedure Report for colonoscopy:** **Indications:** Screening in patient at increased risk: Family history of 1st-degree relative with colorectal cancer (mother). Patient had ovarian cancer and prior colon surgery. **Impression:**	8863-8865

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		- Non-thrombosed internal hemorrhoids found on perianal exam. - The entire examined colon is normal. - The colonic sigmoid anastomosis is normal- biopsies taken. - The examined portion of the ileum was normal. Biopsied.	
02/03/YYYY	Hospital/ Provider Name	**Pathology Report:** **Surgery date:** 01/31/YYYY **Received date:** 01/31/YYYY **Final Pathologic Diagnosis:** A. Sigmoid Colon (Biopsy): Colonic mucosa with no significant histopathology. B. Terminal Ileum (Biopsy): Small bowel mucosa with significant histopathology. No histologic evidence of active or chronic ileitis.	8797
02/05/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Subjective:** Patient comes into the office today for a follow-up appointment regarding her abdominal pain. Since we saw her last, she has had an MRI, which does not show any bowel wall thickening or suspicious areas in her small or large bowel. She also had a colonoscopy, which was essentially normal. Patient continues to have left upper quadrant abdominal pain and would like to proceed with surgery. She also wants to discuss the way her abdomen looks because she feels like she is asymmetric. **Impression/Plan:** Patient with history of left upper quadrant abdominal pain. Her workup has only been significant for gallstones and a periumbilical incisional hernia. We will plan to proceed with a laparoscopic cholecystectomy and a diagnostic laparoscopy to evaluate for adhesions in her left upper quadrant. We will also plan to do an open repair of this incisional hernia at her navel. Patient was seen and examined in the office today by Dr. Ruben as well. He explained to her that as far as her complaint about how her abdomen looks due to this asymmetric subcutaneous fatty tissue that that is not something that we could fix for her and have recommended she see a plastic surgeon.	8777-8778, 8775-8776
07/23/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Subjective:** Patient comes into the office today for a follow-up appointment. We have had multiple discussions about proceeding with surgery regarding her gallstones and ventral hernia. She is on the schedule for two weeks for a diagnostic laparoscopy for evaluation of her left upper quadrant pain and cholecystectomy and open repair of this periumbilical ventral hernia. She is nervous about having her gallbladder removed and about the possibility of chronic diarrhea after a cholecystectomy. She has had a colon surgery in the past and has had two episodes of fecal incontinence since that surgery and is concerned that if she has	8779-8780

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		her gallbladder removed that she could have issues. **Impression/Plan:** Patient with a long history of left upper quadrant abdominal pain. She also has definite gallstones, but, since it is unlikely that a cholecystectomy will resolve her left upper quadrant pain, she is hesitant to undergo a cholecystectomy. After a long discussion with both me and Dr. Ruben, we have decided that we will proceed with a diagnostic laparoscopy to evaluate for adhesions in her left upper quadrant. We will also examine her gallbladder and have decided that if she has adhesions to her gallbladder, we will do a cholecystectomy, but, if she does not have any adhesions to the gallbladder, we will leave the gallbladder in place even though she does have known gallstones. She is aware of the risks of having gallstones and not having a cholecystectomy to include acute cholecystitis, pancreatitis, and choledocholithiasis, which were all discussed today. We will also plan to do an open repair of this periumbilical ventral hernia.	
	Hospital/ Provider Name	***AB Hospital (08/04/YYYY-08/05/YYYY)***	
08/04/YYYY	Hospital/ Provider Name	**History and physical:** *(Illegible Notes)* **Chief complaint:** Abdominal pain x1-7 months. Pain in LUQ. Positive for gallstone. ___ **Impression:** Abdominal pain **Plan:** ___ laparoscopy OR ___	8904
08/04/YYYY	Hospital/ Provider Name	**Operative Report:** **Preoperative diagnoses:** 1. Cholelithiasis. 2. Cholecystitis. 3. Ventral hernia. 4. Extensive abdominal adhesions. **Postoperative diagnoses:** 1. Cholelithiasis. 2. Cholecystitis. 3. Ventral hernia. 4. Extensive abdominal adhesions. 5. Hydrops of the gallbladder. **Name of operation:** Laparoscopy with laparoscopic cholecystectomy, laparotomy with extensive lysis of adhesions and an open repair of ventral hernia without mesh. **Anesthesia:** General. **Operative Findings:** The patient had previously had a midline incision for a colectomy and also for hysterectomy. There were marked adhesions to the anterior abdominal wall in the	8798-8799

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		area of her pain on the left side. The gallbladder was very thickened, filled with stones, completely obstructed with hydrops. Ventral hernia was present in the upper part of the incision. **Surgical Technique:** The patient was prepped and draped routinely after general anesthesia. Umbilical incision made through the skin with a knife, carried to subcutaneous tissue using sharp dissection. Dissection was carried down to the fascia, which was divided. As soon as the fascia was divided, small bowel was encountered. This was dissected off of the fascia. The incision had to be opened further and the fascia opened further in order to get egress into the abdomen. On the right side of the abdominal wall all the adhesions were taken down and the fascia was then partially closed with continuous 0 Vicryl suture. Hasson cannula was put in place. Pneumoperitoneum was achieved and laparoscope was inserted. The left side of the abdomen was freed. Three separate punctures were made in the upper abdomen, one in the epigastrium, one in the right upper quadrant, one in the right mid abdomen, through which 5 mm trocars were placed. Graspers and dissectors were put in place. The gallbladder was markedly thickened inflamed with multiple stones. Dissection was undertaken of the cholecystoduodenal ligament. The cystic artery and cystic duct were isolated, dissected, doubly clipped with Hem-o-Locks, and divided. The gallbladder was taken out of the hepatic fossa using hook electrocautery dissection. Subhepatic and suprahepatic spaces were irrigated and aspirated. No active bleeding was noted. All clips were intact. The laparoscope was then moved to a cephalad port. A grasper was placed through the umbilical port. The gallbladder was grasped, pulled up out in the wound, and sutures were removed and the gallbladder was removed. At this point multiple adhesions to the anterior abdominal wall and the left abdomen were encountered. The incision again was opened further and using very careful sharp dissection, all of these adhesions were completely dissected freeing the abdominal wall. Fascial edges were cleaned and closed with a continuous #1 PDS suture, locally infiltrated with 0.5% Marcaine. The skin was approximated with subcuticular 4-0 Monocryl. Sterile dressing was applied. The patient tolerated the procedure well and left the operating room in satisfactory condition.	
08/04/YYYY	Hospital/ Provider Name	**@1005 hours: Orders:** Stat CBC, comprehensive metabolic panel Discontinue IVF Toradol 30 mg IV	8876
08/04/YYYY	Hospital/ Provider Name	**@2255 hours: Orders:** Benadryl 25-50 mg per oral/IV every 6 hours	8876
08/04/YYYY	Hospital/ Provider Name	**@2345 hours: Orders:** Ambien 5 mg per oral at bedtime for sleep Simethicone 80, 1 or 2 per oral	8876

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08/05/YYYY	Hospital/ Provider Name	**@1010 hours: Progress Notes:** Significant amount of pain Abdomen soft and non-distended Check CBC, comprehensive metabolic panel Add Toradol If labs ok, will discharge home.	8877
08/05/YYYY	Hospital/ Provider Name	**@1106 hours: Lab report:** High: WBC 13.0, AST 35 Low: RBC 3.75, hematocrit 36.5	8810-8811
08/05/YYYY	Hospital/ Provider Name	**Prescription Record:** ***(Illegible Notes)*** Dilaudid ___	9020-9021
08/05/YYYY	Hospital/ Provider Name	**Discharge Instructions:** Follow up with Dr. David Ruben in 2 weeks Diet: Resume usual diet the next day Specific diet: Regular Activity: No lifting, straining and vigorous activity should be avoided **Reviewer's comment: Discharge summary is not available for review.*	9034-9035
08/04/YYYY-08/05/YYYY	Hospital/ Provider Name	**Other records:** Anesthesia Record, Intraop documentation, PACU Record, Assessment, Orders, Nursing Notes/Records, Medication Reconciliation Record, Medication Sheets **PDF-Ref:** 8907-8975, 8977-9007, 9011-9019, 9025-9033, 9036	
	Hospital/ Provider Name	***AB Hospital (08/06/YYYY-08/30/YYYY)***	
08/06/YYYY	Hospital/ Provider Name	**@0904 hours: ER triage report:** **Chief complaint:** Patient has been lethargic, having trouble speaking, unable to ambulate. No pain meds x19 hours. Discharged from NSH yesterday. Fell off bed this morning. **Vitals:** BP 124/35, pulse 132, resp. rate 30 Pain 5/10 Mentation: Alert and oriented x3 Headache Gait: Unsteady. Weakness present. Speech slurred **Pain scale:** 5/10 **Airway:** Clear **Breathing:** Labored, dyspnea, shallow. Wheezes noted with decreased breath sounds.	9056-9057, 9063

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		Abdomen: Soft, tender. Pain in incision sites POC troponin 0.01 POC lactate 7.24	
08/06/YYYY	Hospital/ Provider Name	**@0909 hours: EKG report:** Sinus tachycardia Otherwise normal ECG	9925
08/06/YYYY	Hospital/ Provider Name	**@0919 hours: Lab report:** **Low:** GFR 13 **High:** Calcium 10.7, BUN 31, creatinine 3.6, AST 90	9776, 9800
08/06/YYYY	Hospital/ Provider Name	**@0925 hours: ER Record:** **Chief Complaint:** Altered mental status. **History of present illness:** Patient brought in by her family for evaluation of confusion for 2 days, since she had a cholecystectomy. She was discharged after extended recovery. She was discharged somnolent and having some pain in her abdomen after the surgery. Since being discharged, she has continued to worsen and becoming increasingly weak to the point where she is confused, fairly nonsensical in her verbal comments and so weak that she was unable to stand trying to get out of bed this morning. She has no complaints of nausea, no complaints of vomiting, as far as the family reports there has been no fever or chills. She has not had any sort of pain medication in almost 24 hours. She is so weak she has been unable to stand and actually slid down to the t1oor while trying to get out of bed this morning. There was no head injury with this fall. The family reports no fever, no chills. She has never had a problem recovering from anesthesia before. **Vital Signs:** BP 124/35, pulse 132, resp. rate 30, temp 96.5, O2 sat unable to obtain. **Physical Examination:** **General:** Well-developed, well-nourished female in moderate to severe distress, lying flat on the stretcher. **HEENT:** Normocephalic, atraumatic. PERRLA. Pale, dry mucosa. **Neck:** Supple. No JVD. **Lungs:** Decreased breath sounds at both bases, normal breath sounds at the apices. **Cardiac:** S1, S2. Markedly tachycardic. No rubs, gallops, or murmurs. **Abdomen:** Minimal diffuse guarding without peritoneal signs. Bowel sounds are normal and active. **Extremities:** No clubbing, cyanosis, or edema. Negative Romans sign. No palpable cords. **Neurologic:** Somnolent, arousable, and inappropriate. Grossly nonfocal exam though the patient is so weak she is not moving anything vigorously. She would not comply with a full neurologic exam. **Skin:** Pale, minimally diaphoretic. No areas of breakdown. No obvious	8802-8804

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		contusions or injury on the scalp or the rest of the body. **Addendum:** **EKG** is a sinus tachycardia. **CBC:** White count 5.6, H and H 15 and 47, platelet count 263. CK 1425, CK-MB 23.7, sodium 137, potassium 4.7, chloride 101, CO2 25, glucose 121, BUN 31, creatinine 3.6. LFTs normal except for an AST of 90. CT for PE shows no evidence of pulmonary embolism, bibasilar passively a left pleural effusion are both present, small right-sided effusion is present. Ascites is noted within the upper abdomen larger than expected amount of fluid in the intraperitoneal air is noted. Glucose 100. H and H normal. Lactate 7.2. Troponin 0.01. **Emergency Department Course:** The patient received 2 L of IV normal saline, Zosyn 4.5 grams was administered. A central line was placed by pulmonary critical care team. The patient was intubated by me. **Procedure Note:** Endotracheal intubation procedure was performed by me. Rapid sequence intubation was performed. The patient was medicated with 20 mg of IV Etomidate. No paralytics were given because of the patient's acute hypotension. I visualized the cords. A 7.5 tube was passed through these cords. The stylet was withdrawn. There was positive CO2 expiration. The tube was taped in place. A 7.5 tube was taped in place at 22 cm at the teeth. There was symmetric chest rise. Bilateral breath sounds were improved compared to previous physical exam findings, the patient tolerated this as well as could be expected. There were no complications at time of transfer to the intensive care unit. The patient was evaluated by Dr. Boyce. The patient was evaluated by Dr. Ruben. The patient will be taken to the ICU with plans for probable surgical intervention to assess where this fluid is coming from, if deemed necessary by Dr. Ruben. **Emergency Department Course:** The patient was also started on her peripheral Levophed infusion until a central line to be placed. The Levophed infusion was then transferred to the central line. **Critical Care Time:** 95 minutes critical care time was spent assessing this patient, providing resuscitative care to prevent decompensation secondary to acute septic shock with bilateral pleural effusions. Thoracentesis will be performed at the bedside in the Intensive Care Unit. **Assessment:** 1. Septic shock. 2. Pleural effusion. **Disposition:** Admit to pulmonary critical care with general surgery consultation.	
08/06/YYYY	Hospital/	**@0927 hours: Lab report:**	9721-9722,

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	Provider Name	**High:** CK 1425, CKMB 23.72, BUN 31, calcium 10.7, creatinine 3.6, WBC 13.0 **Low:** Hematocrit 36.5	9794
08/06/YYYY	Hospital/ Provider Name	**Pathology Report:** Surgery date: 08/04/YYYY Received date: 08/04/YYYY **Clinical history:** Abdominal pain, gallstones **Final Pathologic Diagnosis:** Gallbladder: Cholelithiasis; chronic cholecystitis.	8809
08/06/YYYY	Hospital/ Provider Name	**@0930 hours: ER Nursing notes:** Patient to rom 24. Family states patient has been lethargic with slurred speech, inability to ambulate since surgery on 08/04. Patient pale in appearance. 20G ___ established. Labs drawn and sent. Patient on cardiac monitor. IV fluids infusing. MD at bedside. **Vitals:** BP 75/67, pulse 136, resp. rate 36, 3L O2 Pain scale 5/10	9064
08/06/YYYY	Hospital/ Provider Name	**@0940 hours: ER Nursing notes:** Respiratory at bedside for ABG. POC lactate, POC BMET, POC troponin completed. Respiratory unsuccessful at ABG. Patient in Tredelenberg. **Vitals:** BP 109/61, pulse 131, resp. rate 37, 3L O2 Pain scale 5/10	9064
08/06/YYYY	Hospital/ Provider Name	**@0945 hours: ER Nursing notes:** Unsuccessful at IV x4 attempts.	9064
08/06/YYYY	Hospital/ Provider Name	**@0949 hours: ER Nursing notes:** Patient to CT via stretcher with monitor and RN. Dr. Ruben at bedside.	9064
08/06/YYYY	Hospital/ Provider Name	**@0950 hours: History and Physical:** **Chief Complaint:** Altered mental status. **History of present illness:** Patient underwent laparoscopic cholecystectomy on 08/04/14, approximately 48 hours ago, with ventral hernia repair with no reported intraoperative complications. She was recovered in extended recovery and discharged home at approximately noon yesterday. According to her children, she initially felt well when she arrived in recovery; however, her mental status was very altered after the first dose of Morphine that she got up and never returned back to her baseline. She has had no pain medication for approximately 22 hours and remains very	9071-9073, 9139

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		somnolent, borderline obtunded, making inappropriate comments, and only intermittently interactive. Additionally, she has been short of breath and panting, according to her children, and had, what sounds like, a close to syncopal event this morning, which is why they brought her to the emergency department for further evaluation. On arrival, she was tachycardic and hypotensive. She was sent emergently to the scanner for CTA to rule out pulmonary embolism. On my arrival, she has just returned back from CT, remains very hypotensive with systolic in the 60s and 70s, and very altered. She does admit to abdominal pain and shortness of breath. She denies chest pain or headache. She denies nausea and has had no vomiting, but has had an episode of dry heaving. **Vital Signs:** Pulse 118, BP 78/42, resp. rate 38, temp 97.2, SpO2 unable to pick up. **Physical examination:** This is a very ill-appearing female currently in distress. HEENT: Normocephalic, atraumatic, sclerae are anicteric. Pupils are equally round and reactive to light. She is quite sensitive to light. Her mucous membranes are dry, but intact. **Neck:** Supple. Neck veins are flat. **Chest:** Reveals bilateral breath sounds, but she is very diminished at the bases anteriorly, right greater than left. No crackles or wheezes are appreciated. **Cardiovascular:** She is tachycardic with no overt murmurs, rubs, or gallops appreciated. **Abdomen:** Slightly rounded, tender to palpation, more so in the lower quadrants than the upper quadrants. I cannot appreciate any bowel sounds. **Extremities:** Reveal no edema to the bilateral lower extremities. Dorsalis pedal pulses are intact bilaterally. **Neurologic:** She is obtunded. She moves all of her extremities equally. There are no focal deficits. **Laboratory Data:** Available at the time of dictation include a white blood cell count 5. 6 (this is dramatically decreased from her discharge). CBC shows hemoglobin 13.6, hematocrit 47.1, platelet count 263. sodium is 135, potassium 4.5, chloride 102, bicarb 22, BUN 27, creatinine 3. 5 (dramatically increased from discharge, which was 0. 7 less than 24 hours ago), and glucose 116. CTA did not reveal any pulmonary embolism; did reveal bilateral effusions with compressive atelectasis. **Assessment:** 1. Shock, likely septic from some intraabdominal source versus perforated viscus versus ischemic bowel with a component to any of these of profound hypovolemia resulting in multiorgan dysfunction leading to multisystem organ failure with associated renal failure, as well as altered mental status. 2. Acute kidney injury, likely prerenal secondary to #1.	

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		3. Respiratory failure secondary to inability to protect airway, in addition to bilateral effusions with atelectasis. No discrete infiltrates are seen on X-ray, and she has not had any infectious pulmonary pathology. 4. Altered mental status secondary to #1. **Plan:** 1. Will admit the patient to the ICU for further evaluation and treatment. 2. Due to her very unstable condition in the emergency department, a central line was placed in the emergency department. 3. Aggressive IV fluid resuscitation with 4 L of crystalloid bolus to start. We will transduce CVP in the ICU to maintain greater than 12 as a goal. 4. Antibiotics with Zosyn and Vancomycin. 5. Check arterial blood gas for pH, lactic acid, and check a venous blood gas to assess ___ *(Text missing in the record)* 6. Place arterial line for invasive monitoring. 7. The patient will be transferred back to the operating suite for exploratory laparotomy when she is stable. 8. Continue vasopressor support, which has been initiated by our team in the emergency department to keep mean arterial pressure greater than 60. 9. Monitor creatinine and urine output closely with the hope that after her resuscitation, she regains kidney function. 10. ICU bundle, as well as glycemic protocol and electrolyte replacement protocol. We will hold off on any DVT prophylaxis at this time, as she is to return to the OR. 11. Check coags and cardiac enzymes. This patient's care has been discussed with Dr. Paul Boyce and he has seen and personally examined the patient with me in the emergency department. Any changes or further recommendations will be made by him in a follow-up note.	
08/06/YYYY	Hospital/ Provider Name	**ER Nursing notes:** **@1000 hours:** Critical care remains at bedside. Patient prepped for intubation/central line insertion. Vitals BP 77/22, pulse 126, resp. rate 42, O2 10L, pain 5/10	9064
08/06/YYYY	Hospital/ Provider Name	**@1003 hours: CT pulmonary angiogram with contrast:** **History:** Shortness of breath. Recent surgery. **Findings:** There is normal opacification of the pulmonary arteries without evidence of pulmonary thromboembolic disease. A moderate to large layering left pleural effusion is noted. A small right pleural effusion is noted. Bibasilar opacities are noted and may represent atelectatic change. There is evidence of free intraperitoneal air within the right upper quadrant with an air fluid level and ascites. Moderate ascites is noted and of low density. Bilateral breast implants are demonstrated. The heart size is within normal limits. Osseous structures are unremarkable.	9827-9828, 9825-9826

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		Impression: No CT evidence of pulmonary thromboembolic disease. Moderate to large left pleural effusion and right small effusion. Bibasilar opacities which may represent atelectatic change. Ascites is incidentally noted within the upper abdomen with pneumoperitoneum. Correlate clinically with surgical history. A significant amount of fluid and intraperitoneal air is noted, greater than expected. Results discussed with Dr. Bateman.	
08/06/YYYY	Hospital/ Provider Name	**ER Nursing notes:** **@1020 hours:** Central line insertion in progress. Vitals BP 71/57, pulse 126, resp. rate 31, O2 10L, pain 5/10	9064
08/06/YYYY	Hospital/ Provider Name	**ER Nursing notes:** **@1044 hours:** ET tube 7.5, 24 at lip line. ___ not measured per critical care at this time due to greater risk than benefit. Vitals BP 91/31, pulse 136, resp. rate 20, ETT, pain 0/4	9064
08/06/YYYY	Hospital/ Provider Name	**ER Nursing notes:** **@1045 hours:** Patient intubated by Dr. Bateman **@1055 hours:** Vasopressin increased. Vitals BP 90/68, pulse 116, resp. rate 18, ETT, pain 0/4	9064
08/06/YYYY	Hospital/ Provider Name	**@1101 hours: Arterial blood gases:** pH 7.335, pCO2 47.7, pO2 46.9, HCO3 25.4, base excess -0.5 **Airway:** ET	12680
08/06/YYYY	Hospital/ Provider Name	**@1113 hours: CT abdomen pelvis without contrast:** **History:** Postop pain, distress. **Findings:** Examination demonstrates the patient to have bilateral pleural effusions, left greater than right. Associated compressive atelectasis is noted at the lung bases. Examination of the abdomen and pelvis demonstrates unremarkable appearance of the liver. There is no evidence of biliary dilatation. No air is noted in the biliary tree. There is fluid and air in the subdiaphragmatic space bilaterally, left greater than right. The spleen and pancreas are unremarkable in appearance. The adrenal glands are unremarkable. There is persistent enhancement of the kidneys consistent with acute renal failure. There is contrast excretion and contrast is seen in the bladder. There is no evidence of contrast extravasation. No perfusion abnormality or abnormalities noted involving the kidneys to suggest a focal renal abnormality. The retroperitoneal structures are without evidence of mass or adenopathy. Examination of the intraabdominal contents demonstrates dilatation of the second portion of the duodenum. There is moderate dilatation of proximal small bowel. The bowel wall does not appear significantly thickened. No abnormal enhancement is noted involving the bowel. The patient has edema involving the mesentery. There is also thickening of the peritoneal surfaces	9829-9830

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		suggestive of some mild enhancement. Patient has had partial colectomy with anastomosis in the right lower quadrant. There is no evidence of bowel wall inflammatory changes. A small amount of ascitic fluid is noted within the pelvis. No fluid is noted within the paracolic gutters. No abnormal fluid collection is appreciated outside of the ascitic fluid. The course of the superior mesenteric artery and vein as expected and there is no evidence to suggest an internal hernia or volvulus. Pelvis is without pelvic mass or adenopathy. No aggressive bony lesions are seen. **Conclusion:** Bilateral pleural effusions with associated compressive atelectasis. Large amount of fluid under the diaphragms. This is greater than expected postoperatively. The patient has air within the peritoneal cavity which is not unexpected in this patient who has had recent bowel surgery. There is generalized edema involving the mesentery and peritoneal lining. Considerations include postoperative change versus possible peritonitis. No obvious bowel injury is appreciated though that possibility is not excluded. There is no CT evidence on the current study to suggest ischemic bowel or closed loop obstruction but again those possibilities are not totally excluded on the basis of the study provided. Persistent nephrogram consistent with acute renal failure. No evidence of urinary tract injury or abnormality.	
08/06/YYYY	Hospital/ Provider Name	**ER Nursing notes:** **@1115 hours:** CT completed. Vitals checked prior to ICU transport. Vitals BP 113/72, pulse 106, ETT, pain 0/4	9064
08/06/YYYY	Hospital/ Provider Name	**@1130 hours: Moderate Sedation History and Physical:** **Physical examination:** Intubated **Impression or preop diagnosis:** Intra-abdominal abscess **Plan:** CT guided intra-abdominal abscess drainage.	9076
08/06/YYYY	Hospital/ Provider Name	**@1138 hours: Procedure Report:** Central venous access: **Location:** Right internal jugular vein Arterial cannulation: **Location:** Right brachial artery Chest X-ray reveals CVL in right arm. Will ___ to 16 cm.	9081
08/06/YYYY	Hospital/ Provider Name	**@1147 hours: Arterial blood gases:** pH 7.371, pCO2 33.6, pO2 134.5, HCO3 19.5, base excess -5.8, lactate 2.4 **Mode:** APV-CMV, FiO2 100, rate 22, Vt 450, PEEP/CPAP 5, etCO2 32	12679
08/06/YYYY	Hospital/ Provider Name	**@1231 hours: X-ray of chest:** **Indication:** Line placement and endotracheal tube placement. Altered mental	9833-9834

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		status. **Impression:** Tip of the right jugular approach central venous access catheter is in the lower right atrium and may be retracted by 4.7 cm for placement at the cavoatrial junction. Tip of the endotracheal tube is 2.7 cm above the carina. No significant change in large left pleural effusion with underlying lung consolidation.	
08/06/YYYY	Hospital/ Provider Name	**@1250 hours: Lab report:** **Low:** Calcium 7.4, magnesium 1.2, total protein 4.0, albumin 2.1, GFR 20, RBC 3.82, hematocrit 37.6 **High:** Glucose 185, BUN 27, creatinine 2.5, AST 62, PT 21.8, INR 1.9, fibrinogen 502	9775, 9798, 9803-9804
08/06/YYYY	Hospital/ Provider Name	**@1312 hours: History and Physical:** **Chief Complaint:** Altered mental status. **History of present illness:** Patient underwent laparoscopic cholecystectomy with lysis of adhesions on August 4, approximately 48 hours ago, without any noted intraoperative complications. She recovered an extended recovery and was discharged yesterday at approximately noon. According to her children, she was initially doing well in recovery until her first dose of morphine and then became very altered. She remained oriented to person, but was confused and speaking inappropriately regarding hospitalization and sequence of events. Overnight last night, she became progressively weak to the point this morning where it sounds like she may have had some sort of syncopal episode. It is unclear whether consciousness was lost and for how long. For this reason, her children brought her to the emergency department where she was found to be tachycardic and initially with adequate systolic pressure but always with a very wide pulse pressure and tachypneic. She was sent urgently to CAT scan to rule out pulmonary embolism. On my arrival to the emergency department, she has just returned from CT. Her systolic pressure has decreased to the 80s and she remains quite altered. She does answer some of my questions, but her speech is somewhat garbled and most answers are inappropriate. She does complain of pain in her abdomen and some difficulty in breathing. She does not complain of any chest pain and denies chest pain. She denies any other complaints. She does feel very tired. **Review of systems:** A 10-point review of systems was reviewed with the patient's daughter as she was unable to cooperate fully with interview. It is positive for HPI and also positive for dizziness. Negative for any fevers or chills. Positive for, what sounds	9074-9075

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		like, polyuria in the immediate postop phase and then oliguria upon returning home. No hematemesis or hematochezia. No melena. She has not had a bowel movement since her procedure. Otherwise negative review of systems. **Vital Signs:** Pulse 118, BP 78/42, resp. rate 36, temp 96.5, SpO2 unable to read on forehead probe. **Physical Examination:** **General:** This is a very ill-appearing age-appropriate female, pallorous and confused. **HEENT:** Normocephalic, atraumatic. Her sclerae are anicteric. Pupils are equally round and reactive to light. Somewhat sensitive to light. Her oral mucous membranes are very dry but intact. **Neck:** Supple. No carotid bruits are auscultated. Neck veins are flat. **Chest:** Reveals bilateral breath sounds but quite diminished at the bases. *(Continuity of the record is not available)*	
08/06/YYYY	Hospital/ Provider Name	**@1430 hours: Progress Notes:** ***(Illegible Notes)*** Patient came to ER status post lap chole, enterolysis, ventral hernia repair. Patient discharged yesterday ___. At home progressive decreased in mental status. ___ came to ER - ___ hypoxic with ___, decreased breath sounds. Resuscitated in ER. To CT – chest bilateral pleural effusion, atelectasis, no pulmonary embolism. Abdomen – lot of water ___with free air. Patient to ICU – intubated, resuscitated with IVF. **Exam:** ___ not appropriate. Decreased breath sounds. Pulse 130. Abdomen distended ___ Lactate 7.5 To OR for exploratory lap	9142
08/06/YYYY	Hospital/ Provider Name	**@1500 hours: Operative Report:** **Preoperative Diagnosis:** Acute abdomen, status post laparoscopic cholecystectomy and mini laparotomy with lysis of adhesions. **Postoperative Diagnosis:** Small-bowel perforation. **Name of operation:** Exploratory laparotomy, resection, and primary anastomosis of small bowel perforation. Copious drainage of the abdominal cavity. **Operative Findings:** Upon entering the abdominal cavity, there was a good bit of intraperitoneal small-bowel contents. The small-bowel injury was easily identified, isolated, excised and repaired. **Surgical Technique:** The patient was prepped and draped routinely after general anesthesia. The old	8805-8806, 9141

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		mini incision was opened with a knife, and then this was extended proximal and cephalad for a few centimeters. The fascial sutures were divided, and the fascia was opened and extended proximal and distal a short way. Some adhesions to the anterior abdominal wall were dissected, and a copious amount of small-bowel contents were then encountered, suctioned with a Poole sucker and irrigated. The small-bowel was identified just below the incision, and the area of perforation was identified. This was then isolated. The small-bowel was dissected far enough to allow for resection of primary anastomosis. Resection was undertaken with a GIA. The mesentery was taken with Kelly clamps and ligated with 2-0 Vicryl sutures. Prior to performing the anastomosis, 8 L of irrigation was used to dilute and clean the abdominal cavity. Functional end-to-end anastomosis was then made with the GIA and closed with a TA30. Suture of 3-0 Vicryl was placed at the end of the staple line. The wound was again irrigated and inspected. No active bleeding was noted. There was minimal contaminated fluid left. The fascia was then approximated with #1 PDS. The subcutaneous tissue was irrigated with Bacitracin saline solution. The skin was approximated with interrupted stainless steel clips. Sterile dressing was applied. The patient tolerated the procedure well, and left the operating room in satisfactory condition.	
08/06/YYYY	Hospital/ Provider Name	**@1535 hours: Lab report:** **Low:** Calcium 7.6, magnesium 1.2, total protein 4.0, albumin 2.2, GFR 25, RBC 3.87 **High:** Glucose 172, BUN 27, creatinine 2.1, AST 65, D-Dimer 2.59, PT 21.9, INR 1.9, fibrinogen 523	9775, 9798, 9801, 9803
08/06/YYYY	Hospital/ Provider Name	**@1540 hours: Critical Care Medicine Follow up note:** **Details:** Status post exploratory lap small bowel perforation, small bowel resection, primary anastomosis. Admitted post-op from OR, intubated and mechanically ventilated. **Assessment:** Ventilator Dependent Respiratory Failure (VDRF) post op Sepsis/SIRS Small bowel perforation status post small bowel resection Hypoxia secondary to #2, on pressors **New plan:** Keep mechanical ventilator, wean as tolerated Repeat labs in morning ___ Wean pressors as tolerated ___, continue supportive care	9086
08/06/YYYY	Hospital/ Provider Name	**@1605 hours: Procedure Notes:** ***(Illegible Notes)*** ___ chest X-ray central line noted ___ in right arm. Pulled 20 cm CVC back to 16 cm and ___ stable dressing applied. Entire ___	9143

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08/06/YYYY	Hospital/ Provider Name	**@1623 hours: Arterial blood gases:** pH 7.380, pCO2 33.3, pO2 85.8, HCO3 19.7, base excess -5.4, lactate 2.5	12678
08/06/YYYY	Hospital/ Provider Name	**@1625 hours: X-ray of chest:** **Indication:** PICC line placement **Impression:** Right PICC line at the cavoatrial junction.	9837
08/06/YYYY	Hospital/ Provider Name	**@1700 hours: Critical Care Progress Notes:** Seen in ER, septic shock, stabilized in ICU and then to OR. Laparotomy – small bowel perfusion – small bowel resection with primary anastomosis. Vaso 0.04, Levophed 20, Fent 50 **Vitals:** BP 108/69, pulse 87, resp. rate 21, temp 97.2 **O2/vent:** FiO2 0.80 CMV 450, PEEP 5 **Critical Care issues:** Septic shock due to bowel perforation, status post repair ARF Respiratory failure **Intervention:** Continue Zosyn Monitor urine output, continue IVF	9953
08/06/YYYY	Hospital/ Provider Name	**@2040 hours: Lab report:** **Urinalysis:** Hazy appearance, specific gravity 1.041, protein 30, moderate blood, WBC 7	9806
08/06/YYYY	Hospital/ Provider Name	**@2048 hours: ABG report:** pH 7.341, pCO2 31.6, pO2 110.2, HCO3 17.1, base excess -8.7, lactate 3.2 The critical values lactate of 3.2 were called in by J. Perez	9904
08/06/YYYY	Hospital/ Provider Name	**@2308 hours: ABG report:** Lactate 2.8	9905
08/07/YYYY	Hospital/ Provider Name	**@0415 hours: Lab report:** **Low:** Calcium 6.7, CO2 18, total protein 4.0, albumin 2.2, RBC 3.56, hemoglobin 11.7, hematocrit 34.8 **High:** Glucose 147, creatinine 1.2, AST 45, PT 20.4, INR 1.8	9775, 9798, 9803
08/07/YYYY	Hospital/ Provider Name	**Urine culture report:** **Collected date:** 08/06/YYYY **Culture:** No growth	9811

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08/07/YYYY	Hospital/ Provider Name	**@0546 hours: ABG report:** pH 7.376, pCO2 29.0, pO2 87.2, HCO3 17.0, base excess -8.2	9906
08/07/YYYY	Hospital/ Provider Name	**@0727 hours: ABG report:** Lactate 2.8	9907
08/07/YYYY	Hospital/ Provider Name	**@0742 hours: X-ray of chest:** **History:** Respiratory failure, intubated. **Conclusion:** Slight interval improvement compared to yesterday's study. Support and monitoring devices remain in place.	9839
08/07/YYYY	Hospital/ Provider Name	**@0800 hours: Surgery Progress Notes:** Overnight events noted. On 3 pressors. FiO2 decreased 55%. Awakened when I examined her belly. Able to tell me she has pain in abdomen. **Vitals:** BP 87/34, pulse 70, temp 99.3 **Abdomen:** Distended somewhat firm, approximately tender, incision ok. **Assessment/plan:** POD#1 status post exp lap with some bowel resection for small bowel perforation. Continue supportive care. Discussed with daughter.	9137
08/07/YYYY	Hospital/ Provider Name	**@1240 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #2 **Subjective:** Low BP midnight – added Neosynephrine; intubated/sedated. Complaints of abdominal pain RUQ **Vitals:** BP 105/50, pulse 65, resp. rate 21, temp 99.5, SpO2 100% **Physical examination:** Neurological: Sedated, awakens easily Cardiovascular: Regular rate and rhythm, vasopressor Pulmonary: Diminished at bases, improved aeration; left effusion remains Abdomen: Tender to palpation, suture line approximated **Assessment:** 1. Septic shock, gram negative bacteremia, vasopressor dependent secondary to perforated viscous, small bowel perforation status post ex lap with repair. Post op day #1 2. Respiratory failure, multifactorial. Airway protection/metabolic demand, positive bilateral effusion 3. Anxiety 4. Postop pain with history of fibromyalgia – On chronic Lyrica **Plan:** 1. Wean vasopressor as tolerated 2. Place PICC line - ___	9096

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		3. Transition to ASV 4. Thoracentasis today or tomorrow hopefully after extubation 5. May be Precedex candidate close to ___	
08/07/YYYY	Hospital/ Provider Name	**@1500 hours: Progress Notes:** Left basilica vein IV team Unsuccessful x3. MD made aware	9140
08/07/YYYY	Hospital/ Provider Name	**@1575 hours: Critical Care Notes:** ***(Illegible Notes)*** Still on pressors overnight. No other events. **Vitals:** BP 82/57, pulse 75, resp. rate 20, temp 99.7 **Critical care issues:** GNR sepsis, small bowel perfusion, status post repair ARF – resolved Hypertension secondary to #1, slowly responding **Interventions:** Add Levaquin for ___ coverage Hold IVF Once off pressors, start diuretics Discussed with family and PCP at bedside	9952
08/08/YYYY	Hospital/ Provider Name	**Pathology Report:** **Surgery date:** 08/06/YYYY **Received:** 08/06/YYYY **Final Pathologic Diagnosis:** Small bowel (resection in two parts): - Perforation of longer small bowel segment with associated hemorrhage, organizing fat necrosis and both suppurative and organizing serositis. - Focal submucosal hemorrhage at area of possible tattooing (no tattoo pigment identified). - Surgical margins appear viable with focal suppurative and organizing serositis at margin farthest from defect. - Serosal vascular congestion with suppurative and organizing serositis of grossly uninvolved bowel segment. - Submucosal vascular congestion and hemorrhage with suppurative and organizing serositis of separate smaller segment of small bowel. - Yellow pigment with possible bowel contents present in association with suppurative and organizing serositis.	8812-8813
08/08/YYYY	Hospital/ Provider Name	**@0419 hours: ABG report:** pH 7.491, pCO2 24.8, pO2 127.7, HCO3 18.9, base excess -4.4	9909
08/08/YYYY	Hospital/ Provider Name	**@0420 hours: Lab report:** **Low:** Sodium 131, calcium 6.7, CO2 19, phosphorous 1.8, total protein 4.3,	9775, 9798

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		albumin 2.2, RBC 3.10, hemoglobin 10.1, hematocrit 29.9, platelet 140 **High:** AST 34	
08/08/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/06/YYYY **Source:** Blood port **Gram stain:** Gram negative rods. This is a critical result called to and read back using 2 identifiers by RN Stephanie Warsel 08/07/YYYY, 0700 hours **Culture:** Serratia Marcescens (both bottles)	9813
08/08/YYYY	Hospital/ Provider Name	**@0713 hours: X-ray of chest:** **Clinical History:** Respiratory failure. **Impression:** Unchanged lung aeration with bilateral pleural effusions, moderate on the left and small on the right.	9841
08/08/YYYY	Hospital/ Provider Name	**@0730 hours: Infectious Disease Progress Notes:** ***(Illegible Notes)*** Patient seen and examined. ___ intubated, still not following commands. **Assessment:** 1. Small bowel perfusion – status post emergent repair with ___ possible intraabdominal abscess (vs free fluid), discussed with surgery/PCCM, will monitor over next 24-48 hours. If WBC/fever still ___ rearrange and drain fluid ___ if still present. Continue broad ___ coverage. Still with ongoing ___ 2. ___ sepsis – secondary to above. Will be covered by Merrem, repeat culture 3. Fever/leukocytosis – secondary to above. ___will monitor with change in antimicrobials. If persist, ___ CT abdomen pelvis to evaluate for drainable abscess 4. Respiratory failure secondary to sepsis____. Still requires intubation ___	9098
08/08/YYYY	Hospital/ Provider Name	**@0935 hours: Surgery Progress Notes:** Overnight events noted. Decreased FiO2 50%, off Neo, on Vaso and Levophed NGT – minimal Intubated, sedated Abdomen: Decreased distention, soft, incision ok Labs: WBC 8, creatinine 0.6 **Assessment/plan:** POD#2 – Continue supportive care per critical care team. Will start TPN.	9138
08/08/YYYY	Hospital/ Provider Name	**@1220 hours: Critical Care Progress Notes:** ***(Illegible Notes)***	9094

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ICU day #3 **Subjective:** Decreased pressor requirements; unable to get PICC yesterday **Vitals:** BP 93/59, pulse 66, resp. rate 20, temp 99.3, SpO2 98% **Physical examination:** Neurological: Sedated, per nursing ___ very agitated when off sedation Cardiovascular: Regular rate and rhythm Pulmonary: Diminished left, crackles left, left effusion remains; right basilar ___ Abdomen: Slightly ___ distended/swollen **Assessment:** 1. Septic shock, ___, vasopressor dependent 2. Perforated viscous status post la chole 8/4 status post ex lap with repair 8/6 3. Respiratory failure, metabolic ___ effusion – on decreased O2/vent support 4. Anxiety - resolving **Plan:** Wean vasopressor as tolerated Wean sedation – hope to extubated soon, questionable today Could likely start gentle ___ Will wait until pressors are weaned ___ Agree with TPN per surgery Discontinue Zosyn, keep Levaquin **MD note:** Now off pressors, lung clear, 2+ edema Continue Levaquin – change to Avelox (___just in case) Diuresis Hope to extubated when awake	
08/08/YYYY	Hospital/ Provider Name	**@1258 hours: ABG report:** pH 7.326, pCO2 40.9, pO2 77.9, HCO3 21.4	9910
08/08/YYYY	Hospital/ Provider Name	**@1559 hours: ABG report:** pH 7.329, pCO2 41.3, pO2 66.0, HCO3 21.7	9911
08/09/YYYY	Hospital/ Provider Name	**@0430 hours: X-ray of chest:** **History:** Followup respiratory failure. **Findings:** ET tube tip is at the carina. There is limited inspiration. There are bibasilar areas of consolidation-atelectasis and moderate effusion. Right subclavian line has its tip at the cavoatrial junction. The patient's nurse, Kimberly, was informed of the position of the ET tube and recommendation to pull back 2 cm on August , 2014 at 9:32AM.	9843
08/09/YYYY	Hospital/ Provider Name	**@0442 hours: ABG report:**	9912

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		pH 7.383, pCO2 43.2, pO2 71.8, HCO3 25.7	
08/09/YYYY	Hospital/ Provider Name	**@0535 hours: Lab report:** **Low:** Calcium 7.9, total protein 4.9, albumin 2.4, anion gap 1.0, RBC 3.19, hemoglobin 10.1, hematocrit 31.1, platelet 110 **High:** Chloride 114, alkaline phosphatase 163	9774, 9798
08/09/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/06/YYYY **Source:** Blood left arm **Gram stain:** Gram negative rods. This is a critical result called to and read back using 2 identifiers by RN Stephanie Warsel at 0535 hours on 08/07/YYYY **Culture:** Serratia Marcescens (both bottles) Susceptible to Piperacillin/Tazobactam, Ceftriaxone, Ciprofloxacin, Gentamicin, Levofloxacin, Trimehtoprim/Sulfa	9813-9814
08/09/YYYY	Hospital/ Provider Name	**@0630 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #4 **Subjective:** Off pressors; off continuous sedation; received 2 doses of 2 mg Ativan overnight (last dose 0600 hours) **Vitals:** BP 95/54, pulse 84, resp. rate 18, temp 102.1, SpO2 97% **Current medications:** Protonix Subcutaneous Heparin Tylenol Lasix 20 Ativan **Physical examination:** Neurological: Sedated, does __ to voice Cardiovascular: Regular rate and rhythm Pulmonary: Course breath sound bilaterally; diminished at bases; bilateral effusion – worsening aeration Mode: ASV 130 ___/PEEP 5, FiO2 40 Abdomen: Minimal NGT output. Parental nutrition. Rounded. No bowel sounds. **Assessment:** 1. Septic shock, gram negative bacteremia (Serratia) 2. Perforated small bowel viscous status post lap chole 3. Status post lap cholecystectomy/ ventral hernia repair 4. Respiratory failure – Bilateral effusion – worsening effusion – worsening on	9093

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		chest X-ray/exam 5. Volume overload status post ___ with hypoalbuminemia 6. Anxiety **Plan:** Continue gentle diuresis; remains ___ Questionable consider thoracentasis Hold sedation, spontaneous breathing trial this morning With new fever, will check culture, re-attempt PICC line (___ TPN) **MD note:** Still very weak, lethargic Continue vent support ___, hopefully extubated tomorrow	
08/09/YYYY	Hospital/ Provider Name	**@1000 hours: Surgery Progress Notes:** Temp 102.1, pulse 110 Intubated/ ___ Off pressors Abdomen: Soft non-distended, tender Questionable extubation today Continue support	9135
08/09/YYYY	Hospital/ Provider Name	**@1122 hours: ABG report:** pH 7.409, pCO2 42.2, pO2 76.7, HCO3 26.7	9913
08/09/YYYY	Hospital/ Provider Name	**@1905 hours: Right upper extremity venous duplex ultrasound:** **History:** Right upper extremity edema and altered mental status. **Impression:** No evidence of right upper extremity DVT or SVT.	9845, 9134, 9766-9767
08/10/YYYY	Hospital/ Provider Name	**@0410 hours: Lab report:** **Low:** Calcium 7.4, potassium 3.1, total protein 4.4, albumin 2.2, anion gap 3.0, RBC 2.94, hemoglobin 9.7, hematocrit 28.8, platelet 104 **High:** Chloride 110, CO2 33, alkaline phosphatase 222, WBC 13.8, PT 17.0, INR 1.4	9774, 9798, 9801
08/10/YYYY	Hospital/ Provider Name	**@0448 hours: ABG report:** pH 7.511, pCO2 39.3, pO2 68.4, HCO3 31.4	9914
08/10/YYYY	Hospital/ Provider Name	**@0515 hours: X-ray of chest:** **Clinical History:** Difficulty breathing. Altered mental status. **Findings:** Frontal view of the chest compared to August 9, 2014 again demonstrates the endotracheal tube projecting near the carina, only approximately 2.2 cm from the carina, would suggest retrieving the endotracheal tube approximately 2 cm to prevent an advertent mainstem bronchus intubation.	9846

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		Small to moderate size bilateral pleural effusions and bibasilar areas of airspace disease are again noted. Cardiomediastinal silhouette is unchanged. Pulmonary vascular congestion persists. Right internal jugular approach central venous catheter is also unchanged. **Impression:** Endotracheal tube near the carina should be retrieved approximately 2 cm. No significant interval change when compared to August 9, 2014.	
08/10/YYYY	Hospital/ Provider Name	**@0630 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #5 **Subjective:** Intubated, ___ and resuscitated overnight – unresponsive to Ativan and Fentanyl boluses **Vitals:** BP 88/53, pulse 89, resp. rate 14, temp 100.4, SpO2 95% **Current medications:** Precedex 0.3 mcg TPN 50 ml/hr Colace Furosemide 20 Subcutaneous Heparin Protonix **Antibiotics:** Moxifloxacin #3 Off Zosyn **Physical examination:** Neurological: Does not follow commands, PERRLA, conjugate ___, RASS +2 Cardiovascular: Regular rate and rhythm Pulmonary: Course breath sound bilaterally; diminished at bases; ETT +CVL normal position. Bilateral pleural effusion Mode: ASV 100, PEEP 5, FiO2 0.40 Abdomen: Midline incision open to air with staples. Bowel sounds +, soft non-distended. NGT ___ secretion **Assessment:** 1. Acute respiratory failure (minimum vent settings) 2. Septic shock, improving off pressors 3. Serratia bacteremia 4. Metabolic alkalosis with respiratory alkalosis 5. Status post lap chol, VHR without mesh complicated by small bowel perforation. 8/6 returned to ___ status post small bowel resection, primary anastomosis, incision and drainage, POD #6/4 6. Acute hyperactive delirium 7. Pleural effusion 8. Hypokalemia **Plan:**	9092

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		Vent management, add Precedex for delirium Spontaneous breathing trial, extubated as tolerated Continue current regimen May need thoracentasis today 6/4 extubation Correct lytes ___ due to diuresis secondary to contraction alkalosis **MD note:** Agitated RSB approx. 60 ___ extubated, but will watch carefully. Family updated at bedside. Remove right IJ, hold TPN tomorrow. Will likely need left ___	
08/10/YYYY	Hospital/ Provider Name	**@1130 hours: Surgery Progress Notes:** Hemodynamically stable Still intubated Abdomen: Flat/soft, incision ok Continue follow up	9133
08/10/YYYY	Hospital/ Provider Name	**@1314 hours: ABG report:** pH 7.508, pCO2 37.1, pO2 64.2, HCO3 29.4	9915
08/10/YYYY	Hospital/ Provider Name	**@1522 hours: Lab report:** **Low:** Calcium 7.8, potassium 3.4 **High:** BUN 24, sodium 150, chloride 113	9773
08/11/YYYY	Hospital/ Provider Name	**@0430 hours: X-ray of chest:** **Clinical Indication:** Difficulty breathing. **Findings:** Endotracheal tube is no longer identified. Correlate with history of extubation. The enteric tube remains in place. There are persistent small pleural effusions with adjacent consolidation. No space-occupying pneumothorax identified. Cardiomediastinal contours are unchanged. Osseous structures are intact. **Impression:** 1. Endotracheal tube is no longer identified. Correlate with history of extubation. 2. Otherwise, small bilateral pleural effusions with adjacent passive consolidation, not significantly changed.	9848
08/11/YYYY	Hospital/ Provider Name	**@0507 hours: ABG report:** pH 7.494, pCO2 33.1, pO2 78.8, HCO3 25.4	9916
08/11/YYYY	Hospital/ Provider Name	**@0529 hours: Lab report:** **Low:** Calcium 8.2, albumin 2.5, total protein 5.2, RBC 3.07, hemoglobin 9.8, hematocrit 30.2, prealbumin <5.0 **High:** Chloride 110, triglyceride 448, alkaline phosphatase 270, AST 39, ammonia 41, WBC 19.5, PT 16.9, INR 1.4	9773, 9798, 9802, 9808
08/11/YYYY	Hospital/ Provider Name	**@0630 hours: Critical Care Progress Notes:** ***(Illegible Notes)***	9091

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		ICU day #6 **Subjective:** Extubated yesterday and placed on BiPAP. Remained on BiPAP 1818/0.40 all night **Vitals:** BP 127/77, pulse 120, resp. rate 42, temp 98.3, SpO2 96% **Current medications:** PPN Colace Subcutaneous Heparin Protonix **Antibiotics:** Moxifloxacin #4 Vancomycin #2 **Physical examination:** Neurological: Asleep, MVT spontaneously, does not follow commands Cardiovascular: Regular rate and rhythm Pulmonary: Course breath sound bilaterally; diminished at bilateral lower lobe. Right pleural effusion Mode: BiPAP, 18, FiO2 0.40 Abdomen: Hypoactive bowel sounds, soft, midline incision open to air with staples. NGT ___ drainage **Assessment:** 1. Acute respiratory failure (On BiPAP) 2. Septic shock, improving off pressors 3. Serratia bacteremia; elevated alkaline phosphatase 4. Metabolic alkalosis with respiratory alkalosis - improving 5. Status post lap chol, VHR without mesh complicated by small bowel perforation. 8/6 returned to ___ status post small bowel resection, primary anastomosis, incision and drainage, POD #7/5 6. Hypertriglyceremia 7. Protein malnutrition **Plan:** BiPAP management. Pulmonary hygiene, ____ as tolerated Thoracentesis today Check ammonia level Postop management, ___ Continue PPN Non-pharmacological delirium management Patient required continued critical care treatment Continue current regime. Head CT if still encephalopathic Check right upper quadrant ultrasound to evaluate biliary tree/CBD obstructions with increased WBC Continue PPN today, line holiday	

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08/11/YYYY	Hospital/ Provider Name	**@0840 hours: Surgery Progress Notes:** ***(Illegible Notes)*** Extubated yesterday **Vitals:** Tmax 100.8, current temp 100.1, pulse 88-125, BP 121/74 NGT 40/12 hours On BiPAP. Not following commands. Restless Abdomen: Decreased distention, mild diffuse tenderness, responds to pain, incision of **Assessment and plan:** POD#5 status post ex lap with small bowel resection – extubated on BiPAP but confused/agitated/restless – ammonia pending Work up per critical care – possible CT head. Continued NGT. Thoracentesis today Increased LFTs – mild doubt CBD stone as only mildly increased, total bilirubin normal Continue supportive care Discussed with Dr. Silverboard. Increased WBC – will check CT chest abdomen pelvis with per oral or IV contrast today. Rule out abscess. CT – Pulmonary/pleural fluid and no ___	9136
08/11/YYYY	Hospital/ Provider Name	**@0930 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** On BiPAP Episode agitation Currently appears comfortable **Vitals:** BP 116/72, pulse 90s, resp. rate 22, Tmax 100 **Current medications:** Protonix Heparin 5000 every 8 hours Avelox Vancomycin Precedex Blood culture x2 – Serratia **Critical care issues:** Respiratory insufficiency, multifactorial Bilateral effusion/ Left> right Left more chronic appearing Need to image chest Reimage abdomen to rule out abscess Given temp/WBC increased ___ if abscess apparent Avoid IV contrast as able	9948

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		Medical decision making: Add Zosyn Toxic metabolic encephalopathy in ___ HOB increased as much as possible Discussed with surgery/IR extensively. Discussed with family at bedside	
08/11/YYYY	Hospital/ Provider Name	**@1000 hours: Lab report:** **Urinalysis:** Straw colored, protein 30, small blood, occasional bacteria	9806
08/11/YYYY	Hospital/ Provider Name	**Procedure Report:** **Diagnosis:** Respiratory failure Endotracheal intubation: ETT 7.5 mm Breath sounds bilaterally, end tidal CO2 confirmed	9083
08/11/YYYY	Hospital/ Provider Name	**@1142 hours: X-ray of chest:** **History:** Status post intubation. **Findings:** Endotracheal tube inserted with tip terminating 2 cm above the carina. There are low lung volumes with prominent hazy opacification of the lower lung zones, left more than right compatible with a combination of pleural effusions as well as underlying probable airspace disease. There is vascular prominence. There is a NG tube that extends below the diaphragm into the stomach. Monitoring wires obscure portions of the chest. There is no evidence of a pneumothorax. **Impression:** Endotracheal tube tip terminates 2 cm above the carina. Low lung volumes with bilateral pleural effusions and airspace disease left worse than right as well as vascular congestion.	9851
08/11/YYYY	Hospital/ Provider Name	**@1211 hours: ABG report:** pH 7.411, pCO2 38.3, pO2 334.1, HCO3 24.3	9917
08/11/YYYY	Hospital/ Provider Name	**@1351 hours: CT chest abdomen and pelvis with contrast:** **Clinical History:** Fever. Recent bowel perforation. Comparison is made to CT scan of the abdomen and pelvis from August 6, 2014, as well as CT pulmonary arteriogram from August 6, 2014. No mediastinal, hilar, or axillary adenopathy is seen. There are moderate bilateral pleural effusions. Consolidation is noted in both lower lungs, likely due to passive atelectasis. Patchy opacity is seen peripherally in the right middle lobe abutting the pleural surface which is new compared to prior examination and could be due to atelectasis or developing infiltrate. Hazy opacifies are noted in the upper lungs bilaterally either due to areas of atelectasis or infiltrate. There are bilateral breast implants noted. An NG tube is seen within the stomach. Ascites is again seen in the upper abdomen, most prominent in the left upper quadrant which is partially loculated	9855-9857

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		but no rim enhancing fluid collections are seen in the upper abdomen. There is a small amount of perihepatic ascites with a small amount of fluid tracking along the anterior aspect of the left lobe of the liver and in the subhepatic region. The patient is status post cholecystectomy with a small amount of fluid seen in the cholecystectomy bed. No focal liver lesion or splenic lesion is seen. The pancreas, adrenal glands, and right kidney are unremarkable. A Foley catheter is seen within the bladder. There is air in the bladder likely secondary to presence of Foley catheter. There is a small cyst seen in the posterior left kidney. No hydronephrosis is seen in either kidney. There is a small amount of fluid seen in the right hemipelvis with fluid pocket measuring 4.7 x 3.2 cm compared to 5.3 x 3.4 cm on prior examination. This demonstrates some rim enhancement. Ascites is seen in the pericolic gutters bilaterally. Postsurgical changes are seen in the abdomen in multiple bowel loops. No other focal fluid collections are noted. There is, however, scattered fluid within the mesentery which has decreased compared to prior examination. No free intraperitoneal air is seen. Fluid is seen in the anterior abdominal wall in the region of the wound which does not demonstrate rim enhancement. Edema is seen in the deep subcutaneous soft tissues and intramuscular soft tissues in the abdominal wall. No aggressive osseous lesion is seen. **Impression:** Moderate bilateral pleural effusions with consolidation of both lower lobes which has worsened when compared to August 6, 2014. This is likely due to passive atelectasis, although superimposed infiltrates cannot be excluded. There is a new focal patchy opacity seen laterally in the right middle lobe which could be due to atelectasis or developing infiltrate. Hazy opacities are seen in the upper lungs which have slightly improved, likely due to resolving areas of atelectasis or infiltrates. Slight interval decrease in size of fluid pocket in the right hemipelvis measuring 4.7 x 3.2 cm. This demonstrates mild rim-like enhancement and could be a small abscess. Ascites is seen in the left upper quadrant in the perisplenic region and to a lesser extent in the perihepatic region, as well as the pericolic gutters and scattered within the mesentery without other rim-enhancing fluid collections noted. Preliminary report of these findings was given by telephone to Dr. Degrace on August 11, 2014, at approximately 5:35 p.m.	
08/11/YYYY	Hospital/ Provider Name	**@1540 hours: Ultrasound guided thoracentesis:** **Clinical History:** Patient is intubated, with a left pleural effusion. **Procedure:** A limited ultrasound of the left chest showed a moderate pleural effusion. The skin was marked over this effusion over the hemithorax and prepped and draped in the usual sterile fashion. The skin was anesthetized with 1% Lidocaine	9861, 9051, 9932

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		solution. A 5 French drainage catheter was inserted into the fluid and 450 cc was removed and sent to the lab for requested analysis. The patient tolerated the procedure well and a post-procedure chest X-ray is pending. **Impression:** Ultrasound-guided thoracentesis with removal of 450 cc from the left chest.	
08/11/YYYY	Hospital/ Provider Name	**@1550 hours: X-ray of chest:** **History:** Pleural effusion. **Findings:** Followup chest following thoracentesis performed. There is no evidence of pneumothorax. The patient has persistent opacity at the left lung base consistent with infiltrate. Infiltrate and effusion suspected at the right lung base. Endotracheal tube is present with the tip at the aortic knob. Central line is present on the left with the tip in the superior vena cava. **Conclusion:** Line placement as above. No evidence of pneumothorax following left-sided thoracentesis.	9853
08/11/YYYY	Hospital/ Provider Name	**@1741 hours: Progress Notes:** ***(Illegible Notes)*** **Reason for follow up:** Follow up CT scan, discussed with surgeon, follow up pleural fluid **Details:** Discussed with radiologist – bilateral pneumonia with pleural effusion. No free air. Right hemipelvis fluid. Questionable abscess. Positive rim enhancement loculated fluid near spleen. Negative rim enhancing. Pleural fluid tapered today 450 cc removed glucose 82, protein 2.0, LDH 377 **New plan:** CT guided drainage of right hemipelvis abscess Follow up ___ pleural fluid Continue supportive care Continue antibiotics, Avelox, Zosyn and Vancomycin	9084
08/12/YYYY	Hospital/ Provider Name	**@0400 hours: Lab report:** **Low:** Calcium 7.0, albumin 2.2, total protein 4.5, RBC 2.81, hemoglobin 9.0, hematocrit 27.9 **High:** Chloride 112, triglyceride 363, alkaline phosphatase 302, AST 35, WBC 21.4, PT 17.7, INR 1.5, fibrinogen 589 **Low:** IgG serum 705	9772, 9797, 9802, 9808
08/12/YYYY	Hospital/ Provider Name	**Urine culture report:** **Collected date:** 08/11/YYYY	9811

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Culture: No growth	
08/12/YYYY	Hospital/ Provider Name	**@0543 hours: ABG report:** pH 7.437, pCO2 34.9, pO2 95.5, HCO3 23.5	9918
08/12/YYYY	Hospital/ Provider Name	**@0610 hours: X-ray of chest:** **History:** Shortness of breath. An AP view of the chest shows normal heart size. Moderate density is seen at the lung bases. Density at the right lung base is slightly less than on the previous examination. An ETT, left jugular venous catheter, and nasogastric tube remain in place. **Conclusion:** Slight decrease in density in the right lower lung field consistent with decreasing pleural effusion and associated infiltrate or atelectasis when compared with the previous examination.	9863
08/12/YYYY	Hospital/ Provider Name	**@1055 hours: Surgery Progress Notes:** Still with fevers to 101. Reintubated yesterday. FiO2 decreased 40%. Off pressors Vitals: Tmax 101, current temp 100.4, pulse 100, BP 113/61 NGT 260/12 hours, Urine output 1000/12 hours General: Intubated, sedated Abdomen: Mild distention but feels more like anasarca, no true distention, incision with mild erythema, soft **Assessment/plan:** CT yesterday shows free fluid in abdomen but no drainable fluid. Reviewed images with radiologist yesterday Discussed with daughter and critical care Continue supportive care If culture continues to be negative then may need repeat CT abdomen/pelvis in next 3 or 5 days	9132
08/12/YYYY	Hospital/ Provider Name	**@1100 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #7 **Subjective:** Discussed with Interventional Radiology this morning. There is not fluid to drain. Continues with ___; NGT output increased. **Vitals:** BP 111/59, pulse 105, resp. rate 15, Tmax 101.1, SpO2 95% **Current medications:** ___ Propofol Fentantyl	9095

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		Protonix **Antibiotics:** Avelox (5) Zosyn (2) Vancomycin (3) **Physical examination:** Neurological: Sedated, raises eyebrow to voice Cardiovascular: Intermittently tachycardic Pulmonary: Positive bilateral breath sounds, diminished at base. Aeration improved; right effusion ABG: 7.44/35/95/23.5 Mode: ASV, 100, PEEP 5, FiO2 25 Abdomen: NGT 200 cc/overnight. 1-2+ pitting edema. No bowel sounds, non-distended **Assessment:** 1. Septic shock, Serratia bacteremia, off vasopressors but increased WBC, increased fever. Possible right hemipelvis abscess but IR does not feel drain can be placed 2. Perforated viscous (small bowel) status post lap chole – status post exp lap with small bowel repair 3. Bilateral effusion – culture pending, appears transudative 4. Anxiety at baseline – but very sensitive to sedative ___ **Plan:** Remains slightly volume overloaded with hypoalbuminemia Wean sedation; hold completely for SBT (Spontaneous Breathing Trial) There is no ___ Discussed with patient's daughter at length, all questions answered.	
08/12/YYYY	Hospital/ Provider Name	**Critical Care Progress Notes:** Remains intubated/lethargic/sedated ___ Discussed with Surgery/ID/Family at bedside **Current medications:** Avelox Zosyn Vancomycin TPN Lovenox **Vitals:** BP 140-150/77/83, pulse 110, resp. rate 20, temp 97.2 O2/Vent: ASV, 0.35 **Critical care issues:** Respiratory failure, multifactorial Pleural effusion/transudative – drained yesterday	9951

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Minimal parenchymal component Encephalopathy and related poor Pulmonary toilet SBT/SAT – extubated when able to follow commands **Plan:** Continue TPN Initiate PT/OT – work on mobility Although CT abdomen with discernible fluid collection and I am concerned about increased WBC, ongoing fever New IJ in place	
08/12/YYYY	Hospital/ Provider Name	**@1300 hours: Infectious Disease Consultation:** **Reason for consultation:** Fever and leukocytosis. **History of present illness:** Patient underwent recent laparoscopic cholecystectomy with lysis of adhesions and ventral hernia repair with Dr. Ruben on 08/04/14, complicated by Serratia sepsis, small bowel perforation, requiring emergent laparotomy with contaminated field, ICU stay. She was initiated on broad-spectrum coverage with Zosyn initially and had received Avelox and recent addition of Vancomycin. She was found to have small bowel perforation with 4/4 blood cultures positive on admission for Serratia marcescens. She presented to the ICU in septic shock requiring vasopressor support as well as ventilator support for respiratory failure. She was stabilized with broad-spectrum antibiotics and surgical repair, but has had persistent leukocytosis and fevers. ID is consulted regarding evaluation. Per discussion with Dr. Silverboard, her lines are new, she is currently off vasopressor support, and otherwise stable. **Physical Examination:** **Vital Signs:** T-max 100.9, current 100.7, heart rate 108, respirations 20, blood pressure 140/79, saturations 97% on FiO2 30%. **General:** The patient is intubated and sedated on Propofol and unable to provide review of systems. **HEENT:** Pupils are pinpoint, but reactive bilaterally. She does have a left IJ in place without erythema. ET tube is in place without secretions. **Cardiovascular:** S1, S2, tachycardic. No murmurs, rubs, or gallops. **Lungs:** Illustrate decreased breath sounds bilateral bases. **Abdomen:** Mildly distended. She has a midline surgical incision in place. She has hypoactive bowel sounds throughout. There is no mass palpated. **Extremities:** She does have some bruising in her right upper antecubital fossa, but otherwise no rash. **Neurologic:** The patient is sedated and does not respond to verbal or painful stimuli. **Laboratory Data:** Blood cultures on 08/06/14 are 4/4 positive for Serratia marcescens. Repeat cultures on 08/11/14 are negative. WBC count on 08/12/14 is 21.4, hematocrit 27.9, platelet count 181, BUN 18, creatinine 0.6. Alkaline phosphatase is 302,	9077-9079, 9131

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		AST 35, ALT 24. ETT aspirate on 08/11/14 is no growth to date. Pleural fluid aspiration on 08/11/14 is no growth to date. Ammonia level is 41. Urine culture on 08/11/14 is no growth to date. CT abdomen and pelvis on 08/11/14 illustrates moderate bilateral effusions with consolidation of the lower lobes as well as decrease in size of fluid pocket in the right hemipelvis measuring 4.7 x 3.2 cm with rim-like enhancement that could be a small abscess. She does have ascites in the left upper quadrant perisplenic region. **Impression:** 1. Fever, still suspect intra-abdominal source, status post perforation. She has a fluid collection mentioned on the CT abdomen and pelvis on 08/11/14 that was concerning for possible abscess. This was a smaller collection than previously seen on admission. Blood cultures on admission were positive for Serratia, which have been adequately covered with Zosyn and Avelox. I am concerned about possible candida involvement with small bowel perforation. She is hemodynamically stable and off vasopressors, but does have ongoing fevers and leukocytosis. This is typical for ongoing abscess. I do think we can stop Vancomycin as lines are new and this is less likely the source of her fevers. 2. Leukocytosis - 21,000. Concerning for abscess and abdominal source but also, she did receive a dose of hydrocortisone on 08/09/12. Workup as above. 3. We will monitor changes of antimicrobials. 4. Respiratory failure - secondary to septic shock. She did not have evidence of pneumonia currently. She does have evidence of effusion bilaterally and likely will have passive atelectasis. She should be adequately covered with antimicrobial therapy. 5. Serratia sepsis - suspect secondary to small bowel perforation. She is on adequate coverage with Zosyn and Moxifloxacin. Blood cultures on admission were positive 4/4. Repeat cultures are negative from 08/09/11. 6. Small bowel perforation - status post emergent repair with contaminated field on 08/06/14 by Dr. Ruben. She is status post-surgical intervention 08/04/14 with laparoscopic cholecystectomy, ventral hernia repair, and lysis of adhesions. She does not have mesh present. **Recommendations:** 1. Would like to discontinue Zosyn, Vancomycin, and Moxifloxacin. We will cover with Meropenem and Micafungin for small bowel perforation and abscess. 2. Follow WBC and fever curve. If this is persistently elevated, would reimage and consider drainage of fluid collection of right hemipelvis. 3. We will discuss with surgery possible aspiration by Interventional Radiology right hemipelvis collection if able to safely perform. Would send for culture and sensitivity. 4. Check immunoglobulin level with history of ovarian, skin, and colon cancer. Replace as needed. 5. Follow clinically.	
08/12/YYYY	Hospital/ Provider Name	**@2049 hours: ABG report:** pH 7.476, pCO2 28.5, pO2 101.5, HCO3 21.0	9919
08/13/YYYY	Hospital/	**@0410 hours: Lab report:**	9772, 9797

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Low:** Creatinine 0.5, calcium 6.9, anion gap 0.0, total protein 4.6, albumin 2.1, RBC 2.59, hemoglobin 8.4, hematocrit 25.8 **High:** Chloride 115, alkaline phosphatase 300, WBC 21.4	
08/13/YYYY	Hospital/ Provider Name	**Aerobic culture report:** **Collected date:** 08/11/YYYY **Source:** ETT aspirate **Gram stain:** Rare WBC, few RBC, no organisms seen **Culture:** Rare colonies of Candida albicans	9810
08/13/YYYY	Hospital/ Provider Name	**@0444 hours: X-ray of chest:** **History:** Respiratory difficulty. Single view of the chest was performed and compared to study of August 12, 2014 demonstrates ET tube with its tip at the level of the mid-trachea. Feeding tube terminates the diaphragm. Left jugular catheter is unchanged. There is perhaps slightly more prominent vascular congestion when compared to the previous study. Otherwise, the examination is otherwise unchanged. There is fairly prominent airspace disease in the lower lung zones, left greater than right as well as pleural effusions, left greater than right. Heart remains enlarged. **Impression:** Minimal change. Significant airspace disease and infiltrates. Vascular congestion may be slightly more prominent.	9866
08/13/YYYY	Hospital/ Provider Name	**@0519 hours: ABG report:** pH 7.416, pCO2 33.3, pO2 68.1, HCO3 21.4	9920
08/13/YYYY	Hospital/ Provider Name	**@0845 hours: Surgery Progress Notes:** No significant changes overnight. Only on Precedex for sedation. No bowel movement Vitals: Tmax 100, current temp afebrile, pulse 84, BP 113/62 NGT 400/12 hours General: Intubated, sedated Abdomen: Decreased distention, soft, incision ok scant serous output at superior aspect of incision. **Labs:** WBC stable at 21.4 **Assessment/plan:** Minimal vent settings. Abdomen soft, decreased distention. Repeat CT if WBC still elevated. Continue NGT.	9128
08/13/YYYY	Hospital/ Provider Name	**@1250 hours: CT of head without contrast:** **History:** Altered mental status.	9868

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: No acute process.	
08/13/YYYY	Hospital/ Provider Name	**@1600 hours: EEG report:** **Indication:** This EEG is requested to evaluate abnormal involuntary movements in a 53-year-old woman who had surgery. She is intubated and the technician notes she is "sedated" but no specific medications are listed. **Impression:** This EEG, recorded with the patient minimally responsive, is slow. This suggests a moderate to moderately severe encephalopathy of nonspecific etiology. A contribution of diffuse or multifocal structural changes may be supported by diffuse semi-rhythmic to polymorphic delta slowing, but this finding was not robust. Metabolic-toxic encephalopathy is likewise not excluded. No focal slowing or epileptiform discharges are noted, and there was no EEG change with the noted arm and leg movements.	9924, 9130
08/13/YYYY	Hospital/ Provider Name	**Critical Care Progress Notes:** ***(Illegible Notes)*** Patient seen/ examined. Chart reviewed Discussed with Dr. ___/family at bedside Discussed with ID/Surgery as well **Current medications:** Meropenem Micafungin Precedex Lovenox Protonix **Vitals:** BP 106/64, pulse 70s, resp. rate 20s, temp 97 O2/Vent: ASV, 0.30 ABG: 7.41/33/68 **Critical care issues:** Respiratory failure Primary factor at this point is toxic/metabolic encephalopathy. Neuro exam continues to be nonfocal, ___, DTR not increased, PERRLA. At this point I would medication management but still not following commands and fever resolved. Will check CT head to rule out acute process. CT head – negative, EEG - no subclinical seizures. **Plan:** Abdominal sepsis No discernible fluid collection to draw. Antibiotic per ID. WBC persists, but fever decreased. Very complex Lots of multidisciplinary communications given current situation	9949
08/14/YYYY	Hospital/	**@0437 hours: X-ray of chest:**	9870

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**History:** Respiratory distress. **Findings:** Cardiomediastinal silhouette is stable. Persistent increased opacification is noted consistent with pleural fluid and probable associated parenchymal change. The appearance is similar to that seen on prior. There may be slight improved aeration on the left. Lines and tubes appear little changed. **Impression:** Little overall change.	
08/14/YYYY	Hospital/ Provider Name	**@0500 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.2, anion gap 2.0, total protein 5.6, albumin 2.2, RBC 2.65, hemoglobin 8.4, hematocrit 26.4, prealbumin <5.0 **High:** Chloride 113, triglyceride 355, alkaline phosphatase 297, GGT 76, WBC 20.8 Ammonia 33	9772, 9797
08/14/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/09/YYYY **Culture:** No growth in 5 days	9812
08/14/YYYY	Hospital/ Provider Name	**@0800 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Afebrile currently. No overnight events. ___ without bowel sounds and ___ Merrem #2 Micafungin #2 **Vitals:** BP 142/83, pulse 66, Tmax 100, temp 98.9, SpO2 100% FiO2 ___ ET culture 08/11: Pending Pleural fluid 8/11: Negative Blood culture 8/6: Serratia Blood culture 8/9: Negative **Assessment/plan:** 1. Fever secondary to perforated small bowel with possible intraabdominal abscess. Resolved with Merrem/Micafungin. ___Repeat CT in morning. If abscess/fluid present, plan drain by IR 2. Small bowel perforation status post emergent repair. ___ antifungal/antibacterial. Positive contaminated fluid ___. Follow up CT in morning to determine if any abscess has developed 3. Leukocytosis: Slightly decreased this morning, but persistence ___ 4. Encephalopathy: Toxic/metabolic with infection. EEG results negative. ___ 5. Decrease IgG – status post IVIG x1. Will repeat ___ Serratia sepsis: Secondary to #2. Repeat culture negative. Coverred by Merrem ___	9127

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/14/YYYY	Hospital/ Provider Name	**@0845 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** Patient seen/ examined. Chart reviewed CT yesterday negative EEG Not following commands initially - ___ decreased Precedex. ___ **Current medications:** Meropenem Micafungin Precedex Lovenox Protonix TPN **Vitals:** BP 130-140/80, pulse 70, temp 98.9 O2/Vent: ASV, 0.35, ___, day #9 **Critical care issues:** Respiratory failure: Although mentation better, need her to awakens more. No structural neurologic abnormalities. Fortunately encephalopathy improving in ___. Improved underlying illness. Nutrition: Try enteral trophic feeds per Surgery Abdominal sepsis: Antibiotics per ID, repeat CT ___ **Plan:** Minimal sedation Delirium – prophylaxis/Protocol Better Discussed with ID/Surgery	9950
08/14/YYYY	Hospital/ Provider Name	**@0920 hours: Surgery Progress Notes:** Discussed with DR. Silverboard. Following some commands now. CT head negative. EEG negative. No bowel movements NGT 10 cc/24 hours Urine output 1875/12 hours General: Intubated, sedated Abdominal: Doughy, incision with mild erythema but ok **Assessment/plan:** POD#8. Slow improvement. For CT abdomen/pelvis tomorrow to rule out abscess. Ok to do slow enteral feeds via NGT.	9129
08/14/YYYY	Hospital/ Provider Name	**@1420 hours: Procedure Report:** **Procedure:** Left IJ line **Diagnosis:** Hypotension, septic shock **Additional comments:** Chest X-ray ordered	9080

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/14/YYYY *(Must be 08/15/YYYY)*	Hospital/ Provider Name	**@0046 hours: Procedure Report:** Endotracheal intubation ETT 7.0 mm Sedation: Propofol 200, SCX 120 Intubated on 1 attempt	9082
08/15/YYYY	Hospital/ Provider Name	**@0055 hours: Critical Care Follow up note:** ***(Illegible Notes)*** **Change in patient's condition:** Cuff blew ETT **Details:** Patient accidentally bit where to __ cuff. Patient was alert ___, good ___, extubated to ___ but became tachypnic. ___ weakness. RR 40, ___ so decided to go ahead and suture **New plan:** Continued vent support Update family Questionable Trach	9085
08/15/YYYY	Hospital/ Provider Name	**@0106 hours: X-ray of chest:** **Clinical history:** ET tube placement **Impression:** 1. Satisfactory placement of the ET tube. 2. Left IJ central line distal end projects over the caudal aspect of the superior vena cava without pneumothorax. 3. Diffuse multifocal ill-defined patchy infiltrates with moderate bilateral pleural effusion and cardiomegaly. Infectious etiology versus cardiogenic edema may be considered. Clinical correlation and follow-up to clearing is advised.	9872
08/15/YYYY	Hospital/ Provider Name	**@0205 hours: ABG report:** pH 7.390, pCO2 40.7, pO2 127, HCO3 24.6	9921
08/15/YYYY	Hospital/ Provider Name	**@0518 hours: ABG report:** pH 7.420, pCO2 38.1, pO2 91.4, HCO3 24.7	9922
08/15/YYYY	Hospital/ Provider Name	**@0625 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.5, anion gap 2.0, RBC 2.90, hemoglobin 9.2, hematocrit 28.7 **High:** Chloride 111, WBC 26.9, PT 16.9, INR 1.4	9771, 9797, 9801
08/15/YYYY	Hospital/ Provider Name	**@0630 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #10 **Subjective:** Status post re-intubation after patient bit through ET balloon cuff. Daughter repeats she was alert and ___ what hospital she was in; she became tachypnic and sats required, required re-intubation per Anesthesia. **Vitals:** BP ___, pulse 80, resp. rate 25, temp 100.6, SpO2 97%	9087

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Current medications: Protonix Lovenox Colace Precedex TPN NS at ___ **Antibiotics:** Meropenem #3 Micafungin #3 **Physical examination:** Neurological: Sedated, non-arousable, attempts to follow simple commands Cardiovascular: Regular rate Pulmonary: Course ___, bilateral infiltrated, negative changes ABG: 7.42/38/91/24/0.2 (0.45) Mode: ASV, 135, PEEP 5, FiO2 40%, PIP 25 Abdomen: Soft, ___ midline staples clean/dry/intact **Assessment:** 1. Respiratory failure secondary to septic shock/___ effusion 2. Small bowel perforation status post repair after ___ chole with hernia repair on 8/4 3. Persistent worsening leukocytosis with low grade fever – for CT abdomen today and possible drain – rule out abscess 4. Abdominal sepsis/Serratia bacteremia sepsis 5. Anemia - stable 6. Left pleural effusion – status post Thoracentesis 8/11 (450 ml) 7. Altered mental status (AMS) – resolving **Plan:** Continue weaning vent as tolerated Continue antibiotics per ID/pulmonary toilet To radiology today for CT abdomen to rule out abscess and will drain. If warranted per Surgery Will continue Precedex as able GI/DVT prophylaxis **Addendum:** Seen, examined and agree with above. Look great today. Following commands – lifted head of pillow. Back from CT guided abscess drainage – thick milky blood tinged fluid – culture pending. Received a lot of sedation for procedure – hopeful to extubated in morning	
08/15/YYYY	Hospital/ Provider Name	**@0800 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Patient seen and examined. Complications with ET tube ___ last night. Reintubated. Afebrile. Mental status improved.	9125

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Merrem #3 Micafungin #3 **Vitals:** BP 126/75, pulse 75, Tmax 100.6, temp 97.5, resp. rate 24, SpO2 97% FiO2 40% ET culture 08/11: Rare candida Albicans Blood culture 8/11: Negative Blood culture 8/6: Serratia **Assessment/plan:** 1. Small bowel perforation – On ___/Merrem/Micafungin. For CT abdomen today to evaluate for abscess. IR consult to drain if present ___ 2. Serratia sepsis secondary to #1. Repeat blood culture ___. Covered by Merrem 3. Respiratory failure – required reintubation last night due to what appears to be bitten ET tube. Re-intubated and stable. ___ thoracentesis ___ transudate. Wean as tolerates. ___ is not playing as active role here. 4. Leukocytosis: Slight increase over past 2 hours. Suspect given with intubation issues. However with persistence of increased WBC, suspect intraabdominal fluid collections. For repeat CT to evaluate ___ 5. Fever: Overall ___ has improved with broadened antibiotic therapy. Follow. 6. ___ 7. Decreased IgG ___	
08/15/YYYY	Hospital/ Provider Name	**@0900 hours: Surgery Progress Notes:** ***(Illegible Notes)*** Bit ___ balloon and popped cuff on ETT last night. Awake and oriented after tube came out last night but got tachypnic and had to be re-intubated On tube feeds. No bowel movements. Temp 100.2, pulse 75-91, FiO2 40% Urine output 2875/12 hours General: Intubated, sedated Abdominal: Doughy, soft, incision with some erythema but stable **Assessment/plan:** POD#9. Increased WBC. For repeat CT today to rule out abscess. Continue supportive care. **Addendum:** Drained 300 cc pus in CT Discussed with daughter	9124
08/15/YYYY	Hospital/ Provider Name	**@1207 hours: Procedure Report:** **Pre-procedure diagnosis:** Intraabdominal abscess **Procedure:** Intraabdominal abscess drain LUQ, size 8 Fr Output 300 ml Color: Yellow, cloudy	9928-9931, 9070

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Biopsy: Intraabdominal abscess fluid, 66 ml	
08/15/YYYY	Hospital/ Provider Name	**@1314 hours: CT of abdomen and pelvis with contrast:** **Clinical History:** Intra-abdominal abscess. **Findings:** Comparison is made to a prior CT of the abdomen and pelvis from August 11, 2014. Large bilateral pleural effusions are identified with bibasilar air space consolidation. A perisplenic fluid collection is identified demonstrating interval increase in size now appearing loculated as compared to the previous examination. The collection on image 20 measures 10.4 x 9.5 cm previously measuring 8.8 x 6.6 cm. A loculated collection abutting the lateral segment of left hepatic lobe may have increased in size in the interim seen on image 28 measuring 4.1 x 4.0 cm previously measuring 4.2 x 3.1 cm. An adjacent small partially loculated collection inferior to the left hepatic lobe on image 32 measures 3.1 x 3.0 cm. Stomach appears thickened. A small loculated collection along the posterior lateral segment of the left hepatic lobe on image 25 measures 2.4 x 2.2 cm. Small collection along the posterior aspect of the medial segment left hepatic lobe on image 28 measures 2.0 x 1.3 cm. A small fluid collection inferior to the medial segment on image 30 measures 2.0 x 1.8 cm. The pancreas and adrenals are unremarkable. The kidneys enhance equal and symmetrically. No hydronephrosis is noted. Partially opacified small bowel and colon are stable. The stomach remains thickened. Subcutaneous non-loculated fluid is identified involving the midline incision as seen on image 55 measuring 5.8 x 3.4 cm increased in size previously measuring 5.0 x 3.3 cm. Diffuse anasarca is noted. A small collection along the anterior aspect of the left hepatic lobe on image 19 measures 2.2 x 1.5 cm. **Pelvis:** Dependent fluid is again identified within the right hemipelvis. The fluid collection appears slightly more loculated on the previous examination now measuring 3.5 x 2.6 cm previously measuring 3.7 x 3.3 cm demonstrating slight interval decrease in size. The remaining bowel in the pelvis is unremarkable. The urinary bladder is decompressed with a Foley catheter. Examination of bone window images demonstrate no aggressive osseous abnormalities. **Impression:** Multiple intra-abdominal fluid collections with interval increase in size of a left upper quadrant fluid collection now appearing more loculated worrisome for abscess formation. Additional smaller collections appearing slightly more loculated on the previous examination. Continued CT surveillance is recommended. The left upper quadrant collection would be amenable for percutaneous drainage. Large bilateral pleural effusions. Bibasilar air space consolidation.	9875-9876
08/16/YYYY	Hospital/ Provider Name	**@0415 hours: X-ray of chest:** **History:** Shortness of breath.	9879

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Findings: Portable exam of the chest demonstrates endotracheal tube in place with tip at the aortic knob. Nasogastric tube is in place. Central line is present on the left with the tip in the superior vena cava. The patient has bilateral lung infiltrates with bibasilar consolidation and effusion. This is greatest on the left. Compared to the radiograph of August 15th there is little interval change. **Conclusion:** Bilateral lung infiltrates unchanged from the 15th.	
08/16/YYYY	Hospital/ Provider Name	**@0550 hours: ABG report:** pH 7.358, pCO2 50.6, pO2 92.5, HCO3 28.5	9923
08/16/YYYY	Hospital/ Provider Name	**@0630 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.2, anion gap 1.0, RBC 2.29, hemoglobin 7.2, hematocrit 22.8 **High:** Chloride 111, glucose 140, WBC 17.3, platelet 487, PT 16.7	9771, 9797, 9801
08/16/YYYY	Hospital/ Provider Name	**@0853 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Alert and intubated Merrem #4 Micafungin #4 **Vitals:** BP 84/48, pulse 74, Tmax 100.7, temp 99.2, resp. rate 24, FiO2 40% 08/15 abdominal culture: Gram stain – rare GNR/rare GPR. No growth **Assessment/plan:** 1. Small bowel perforation: Abscess ___ on CT 8/15, now status post drainage. Culture pending. Continue Meropenem/Micafungin 2. Serratia sepsis secondary to #1. Covered with Meropenem 3. Respiratory failure secondary to #2, improving 4. Fever: Decreased fever and leukocytosis after drainage of abdominal abscess 5. Remains critically ill 6. Decreased IgG status post IVIG x___	9123
08/16/YYYY	Hospital/ Provider Name	**@0900 hours: Surgery Progress Notes:** More awake, alert. ___ loose stools Abdomen soft, not really tender Continue support. ___ discontinue NGT ___ once ET tube is out.	9126
08/16/YYYY	Hospital/ Provider Name	**@0915 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #11 **Subjective:** Patient remains intubated and sedated. Quiet night. Follows commands. Status post CT guided drainage of abdominal abscess yesterday – 300 ml (drain placed) **Vitals:** BP 129/69, pulse 90, resp. rate 19, temp 102.2, SpO2 97%	9090

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Current medications: Protonix Lovenox Colace Humalog SSI Precedex TPN **Antibiotics:** Meropenem #4 Micafungin #4 **Physical examination:** Neurological: Awake, alert, follows commands Cardiovascular: Regular rate Pulmonary: Course, no changes in bilateral infiltrated Mode: ASV, PEEP 5, FiO2 40%, PIP 17 Abdomen: Soft, non-distended, decreased breath sounds, midline staples clean/dry/intact, Peptamen TF at 10 ___ **Assessment:** 1. Respiratory failure secondary to septic shock/ effusions 2. Septic shock – off pressors 3. Leukocytosis with fever 4. Abdominal abscess- status post CT guided incision and drainage yesterday and insertion of drain 5. Anemia – no obvious bleeding source **Plan:** Continue weaning vent/ sedation vacation Continue antibiotics per ID/pulmonary toilet Transfuse packed RBC – check post hemoglobin/hematocrit Wean Precedex to off for possible extubation later today	
08/16/YYYY	Hospital/ Provider Name	**Critical Care Progress Notes:** ***(Illegible Notes)*** Came to see patient on multiple visits today to evaluate for possible extubattion in high risk patient. Alreasy failed extubation 2x. awake/interactive. Positive head lift. ___ **Current medications:** Meropenem Micafungin Precedex Lovenox TPN **Vitals:** BP 129/79, Tmax 102, pulse 90-100, resp. rate 18-22 O2/Vent: ASV, FiO2 0.40, day #6	9947

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Critical care issues: Respiratory failure: Despite some barriers she seems appropriate for extubation. Extubation trial. Delirium precaution. Diuresis. Pulmonary toilet/PT **Plan:** Anemia: Noted transfusion for now Abdominal sepsis: Better but still WBC increased/fever. Following closely. Drain in place Progress overall	
08/16/YYYY	Hospital/ Provider Name	**@1645 hours: Wound assessment:** Midline abdomen – wound approximated, red, staples, wet Proximal areas on incision draining purulent drainage, noted after patient was assisted into neuro chair per PT; staples are intact with edges well approximated except for small opening at distal aspect of incision.	10076
08/16/YYYY	Hospital/ Provider Name	**@2200 hours: Lab report:** **Low:** Creatinine 0.5, calcium 7.8, potassium 3.3 **High:** Chloride 111, glucose 148	9771
08/16/YYYY	Hospital/ Provider Name	**Anaerobic culture report:** **Collected date:** 08/11/YYYY **Source:** Pleural fluid left **Gram stain:** No WBC, no organisms seen **Culture:** No growth in 5 days	9810-9811
08/16/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/11/YYYY **Culture:** No growth in 5 days	9812
08/17/YYYY	Hospital/ Provider Name	**@0630 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.7, albumin 2.5, RBC 2.69, hemoglobin 8.4, hematocrit 26.9 **High:** AST 49, ALT 50, alkaline phosphatase 557, chloride 112, WBC 22.7, platelet 746, PT 16.5, PTT 39.2, fibrinogen 576	9771, 9797, 9801-9802
08/17/YYYY	Hospital/ Provider Name	**@0806 hours: X-ray of chest:** **Findings:** Portable examination of the chest demonstrates left central line in place with the tip in the superior vena cava. The patient has bilateral lung infiltrates and associated effusions. Overall, the degree of lung opacity appears to have increased from August 16. Endotracheal tube has been removed. **Conclusion:** Increasing lung infiltrates.	9881

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/17/YYYY	Hospital/ Provider Name	**@0841 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Extubated without complications. Positive diarrhea overnight. Merrem #5 Micafungin #5 **Vitals:** BP 149/95, pulse 101, Tmax 100.8, temp 99.4, resp. rate 27, SpO2 95% 3L nasal cannula 08/15 abdominal culture: Negative fungi/no growth **Assessment/plan:** 1. Small bowel perforation with multiple fluid collections, still ___ on abdomen. CT 8/15, suggest LUQ collection ___. Culture from abscess negative. Continue Meropenem/Micafungin. If increased WBC, fevers, will likely need additional abdomen, CT scan to evaluation for abscess, amenable to IR draiange 2. ___. Covered with Meropenem 3. Diarrhea. Check for Clos. diff 4. Respiratory failure: Improving 5. Low grade fever secondary to #1, improving 6. Decreased IgG status post IVIG x___	9121
08/17/YYYY	Hospital/ Provider Name	**@1045 hours: Surgery Progress Notes:** Extubated Abdomen: Incision okay right now but some purulent drainage last night from lower portion. Very soft. Not much tenderness. Will hold off on ___ any staples ___ drainage worsens. Okay to start per oral diet when strong enough to swallow. Follow up CT on next day or two to evaluate abscess.	9122
08/17/YYYY	Hospital/ Provider Name	**@1045 hours: Clostridium difficile screen:** Clostridium difficile by PCR – Positive. Verbal results called to and read back using 2 identifiers by RN Kimberly Wiggins at 1415 hours, 08/17/YYYY.	9809
08/17/YYYY	Hospital/ Provider Name	**@1100 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #12 **Subjective:** Quiet overnight. Status post extubation yesterday. Increased WBC and febrile despite drainage of abscess yesterday. Increased bilateral infiltration, though great diuresis. **Vitals:** BP 115/62, pulse 110, resp. rate 19, temp 101.5, SpO2 96% **Current medications:** Protonix Lovenox Colace Humalog SSI Xopenax/___	9089

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		TPN NS at KVO **Antibiotics:** Meropenem #5 Micafungin #5 **Physical examination:** Neurological: Awake, alert, oriented x3, follows commands Cardiovascular: Regular rate Pulmonary: Course, increased bilateral infiltrates Mode: Nasal cannula, 3L Abdomen: Soft, non-distended, decreased bowel sounds, midline staples clean/dry/intact, Peptamen TF at 10 ___ **Assessment:** 1. Respiratory failure secondary to effusions/perforation 2. Septic shock – ID following 3. Abdominal abscess - status post I and D (GNR/GPR) on 08/15 **Plan:** Continue weaning O2 as tolerated Antibiotics per ID/aggressive pulmonary toilet Increase activity – out of bed to chair PT/OT Clos. Diff results pending Follow up CT abdomen in next 24-48 hours – consider CT chest Pain control to maximize pulmonary hygiene Continue supportive care **Attending note:** Overall ___ better ___ chest X-ray Mentation improved. Strength better WBC lowering Discussed with Surgery. Repeat CT abdomen soon Antibiotics per ID. ___ Clos. Diff positive – add oral Vancomycin	
08/17/YYYY	Hospital/ Provider Name	**@1510 hours: Lab report:** **Low:** Creatinine 0.5, calcium 7.7 **High:** Chloride 112	9771
08/18/YYYY	Hospital/ Provider Name	**@0410 hours: X-ray of chest:** **Clinical History:** Altered mental status. Difficulty breathing. **Impression:** 1. Dense left lower lobe pneumonic consolidation with mild left parapneumonic effusion. Follow-up to clearing is advised. 2. Right basal partial atelectatic changes versus infiltrate with small right	9883

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		effusion. Again, follow-up to clearing is advised.	
08/18/YYYY	Hospital/ Provider Name	**@0420 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.8, albumin 2.6, RBC 2.69, hemoglobin 8.6, hematocrit 26.7, prealbumin <5.0 **High:** AST 51, ALT 54, alkaline phosphatase 597, GGT 235, chloride 113, WBC 21.1, platelet 884	9770, 9796, 9808
08/18/YYYY	Hospital/ Provider Name	**@0841 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Awake, confused/delusional/disoriented. No distress. Merrem #6 Micafungin #6 Per oral Vancomycin #2 **Vitals:** BP 139/82, pulse 106, Tmax 101.8, temp 98.6, resp. rate 18, SpO2 99% **Assessment/plan:** 1. Small bowel perforation with multiple fluid collections, presently receiving Meropenem, Micafungin. Chest X-ray with mixed flora and candida/yeast. Continue for now. May need reimaging especially if increased fever or WBC 2. C. diff colitis - ___, positive PCR. On per oral Vancomycin – optimize with ___ probiotics 3. Serratia sepsis – covered by Meropenem 4. Decreased IgG – repeat levels tomorrow morning 5. Leukocytosis – secondary to combination of above. ___ 6. Remains critically ill although slowly improving. Prognosis guarded.	9118
08/18/YYYY	Hospital/ Provider Name	**@1100 hours: Critical Care Progress Notes:** ***(Illegible Notes)*** ICU day #13 **Subjective:** Quiet uneventful night, but no sleep x 2 days. Now Clos. diff positive. Infiltrates greatly improved after diuresis. **Vitals:** BP 139/82, pulse 108, resp. rate 22, temp 101.3, SpO2 97% **Current medications:** Protonix Lovenox Colace Humalog SSI Xopenax/___ Atrovent TPN NS **Antibiotics:** Meropenem #6 Micafungin #6	9088

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Neurological: Oriented x1, confused/refusing treatment Cardiovascular: Regular rate, tachycardia Pulmonary: Course, improved infiltrates Mode: Nasal cannula, 2L Abdomen: Soft, non-distended, decreased bowel sounds, midline staples clean/dry/intact, Peptamen TF at 10 ___ **Assessment:** 1. Respiratory failure secondary to effusions/perforation 2. Septic shock 3. C. diff colitis – on per oral Vancomycin 4. Abdominal abscess - status post I and D (GNR) and drain placement 5. Persistent leukocytosis/fever – ID following 6. Anemia – stable (1 unit packed RBC 8/16) 7. Transaminitis **Plan:** Continue aggressive pulmonary hygiene Increase activity – out of bed to chair, PT/OT Pain control Antibiotics per ID Follow up CT abdomen to reassess abscess per Surgery Continue supportive care **Attending note: ___**	
08/18/YYYY	Hospital/ Provider Name	**Surgery Progress Notes:** Extubated Alert but confused Temp 101.5 C. diff positive WBC 21k Abdomen soft, incision ok Overall improved Will repeat CT scan in morning	9120
08/19/YYYY	Hospital/ Provider Name	**@0530 hours: X-ray of chest:** **History:** Respiratory failure. **Impression:** 1. Small bilateral pleural effusions, left greater than right, are stable, as is bibasilar atelectasis. 2. Left IJ central line and NG tube, as stated above. 3. No new lung parenchymal opacity or pneumothorax.	9885
08/19/YYYY	Hospital/ Provider Name	**@0530 hours: Lab report:**	9770, 9796,

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Low: Creatinine 0.4, calcium 7.3, albumin 3.0, RBC 2.52, hemoglobin 7.9, hematocrit 24.8 **High:** Chloride 110, WBC 19.0, platelet 927 **Immunoglobulin:** **High:** IgG 1867	9808
08/19/YYYY	Hospital/ Provider Name	**@0829 hours: Speech Pathology Progress Notes:** Bedside swallow evaluation initiated. Tolerated ice chips and initial sips of water x2 without overt signs/symptoms of aspiration. With progression of thin liquid trials. Patient became more anxious stating she was scared, refusing further sips of thins. **Recommendations:** NPO x ice chips when alert with supervision. Will continue to follow for ongoing assessment. Diet advanced once cleared by Surgery.	9119
08/19/YYYY	Hospital/ Provider Name	**@0858 hours: Wound assessment:** Midline abdomen –approximated, staples; dressing changed Exudate – none Wound odor – none Periwoud – intact Periwound sensation – intact Wound treatment dressing – plain gauze, secured with Medipore tape	10078
08/19/YYYY	Hospital/ Provider Name	**@0910 hours: Surgery Progress Notes:** Intermittently disoriented. No significant events overnights. Temp 99, pulse 90-110 General: Oriented but some delusions Abdomen: Soft, distension, nontender **Assessment/plan:** Improved. Will transfer to 4C today. For CT abdomen/pelvis for follow up abscess.	9119
08/19/YYYY	Hospital/ Provider Name	**Transfer Report:** Admission date to ICU: 08/06/YYYY Reason for admission: AMS, shock **ICU summary:** Patient admitted to ICU from ED on 08/06. Presented there with AMS and shock status post cholecystectomy/___ 08/04. Patient treated for septic shock secondary to peritonitis/perforated bowel, serratia bacteremia and course complicated further by C. diff colitis. Patient intubated 08/10, extubated 08/16. While in ICU, patient treated for acute delirium as well. Patient now more alert/oriented, hemodynamically stable and okay for transfer to floor for ongoing care/support. **Physical examination:** Alert, sleepy oriented x2 Lungs: Positive coarse breath sounds, negative wheezes Abdomen: Soft, positive tenderness, positive breath sounds	10339

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Active medications at transfer: Meropenem #7 Micafungin #7 Vancomycin per oral #2 Metronidazole (per ID) Lovenox **Active medical problems and plan:** 1. Pulmonary insufficiency status post extubation/respiratory failure: Continue aggressive pulmonary hygiene, Xopenox/Atrovent as needed 2. Septic shock, improved secondary to perforated bowel, Serratia bacteremia: Antibiotics per ID 3. C. diff colitis: Per oral Vancomycin per ID 4. Cholecystectomy/WA status post return to OR – resection/drainage: Per Surgery 5. Altered mental status improved likely secondary to sepsis: Continue orientation/avoid excess stimulation at bedtime Transferred to Surgery service	
08/19/YYYY	Hospital/ Provider Name	**Transfer medication form:** Meropenem 1000 mg, 100 ml Micafungin 100 mg, 100 ml Sodium chloride 0.9% 1000 ml Hyperal Adult Central – Zinc Chloride- Selenious Acid – Ascorbic Acid Haloperidol 2.5 mg Miconazole nitrate 2% Peptamen AF 1000 ml Vancomycin oral syringe 250 mg Acetaminophen 650 mg as needed Morphine 2 mg as needed Ondansetron 4 mg as needed	9198-9204
08/19/YYYY	Hospital/ Provider Name	**@1306 hours: CT abdomen pelvis with contrast:** **History:** Followup abscess drainage. **CT Abdomen:** Pigtail catheter in the left upper quadrant remains in place adjacent to the spleen with significant decrease in size of the parasplenic fluid collection. Trace perisplenic fluid remains. There are tiny pockets of fluid scattered throughout the upper abdomen along the left liver serosal border. NG tube is seen with its tip in the right upper quadrant likely in the junction of the first and second portion of the duodenum. Largest pocket of fluid adjacent to the lateral left liver in the gastrohepatic junction is 3.1 x 4.2 cm in maximum dimensions on image 27. Smaller pockets of fluid are seen separate from this along the anterior border of the lateral left liver and medial left liver. Spleen is normal in size without new lesion seen. The liver is normal in size without new enhancing lesion or biliary ductal dilatation. The portal vein and splenic vein are patent. SMV is patent. Adrenal glands and kidneys have a normal CT appearance	9887-9889

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		with exception of probable cysts measuring 5 mm in the midright kidney on image 38 and 8 mm in the mid to lower left kidney on image 34 which are stable and too small to fully characterize. A smaller peripheral cyst in the lower left kidney on image 35 measuring 4 x 4 mm is also stable. The pancreas demonstrates no focal lesions. There are no enlarged abdominal lymph nodes. There is no free abdominal air or bowel obstruction. Anterior abdominal wall and skin staples are seen with subcutaneous edema which has improved since the prior exam. Ill-defined fluid deep to the skin staples measures 48 x 17 mm on image 52 which has improved (previously 32 x 66 mm). Diffuse gastric wall thickening is stable and nonspecific. No other new inflammatory change is seen in the abdomen. There is no bowel obstruction. **CT Pelvis:** There is no pelvic fluid or enlarged pelvic or inguinal lymph nodes. A low-lying cecum extends into the pelvis. No inflammatory change is seen around the tip of the cecum. Suture material in the sigmoid colon is stable without obstruction. The bladder is only partially filled. Gas in the urinary bladder most likely related to Foley catheter placement and increased since prior. No contour deforming lesion is seen in the urinary bladder. No new pelvic mass. Visualized osseous structures demonstrate no aggressive lesions. **Impression:** 1. Left upper quadrant pigtail catheter is seen in place with only trace fluid remaining around the spleen. 2. The perihepatic fluid collections are also decreased in size overall since prior with the largest measured above. 3. No developing fluid collection or new fluid collection in the abdomen or pelvis. 4. No bowel obstruction. 5. Diffuse thickening of the gastric wall is stable. Correlate for gastritis. 6. Bilateral pleural effusions and bibasilar atelectasis. The atelectasis in the right anterior lung base is slightly improved. Effusions are not significantly changed since prior. 7. Probable renal cysts are too small to fully characterize but stable.	
08/19/YYYY	Hospital/ Provider Name	**@1406 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Awake, alert, confused/drowsy after Haldol. No complaints. Merrem #7 Micafungin #7 Per oral Vancomycin #3 Metro #2 **Vitals:** BP 144/81, pulse 105, Tmax 100.8, resp. rate 20, SpO2 99% on 2L nasal cannula **Assessment/plan:** 1. Abdominal/pelvic abscess after small bowel perforation. On IV Meropenem, Micafungin. Continued. Await interpretation of CT abdomen/pelvis. 2. C. diff colitis - On per oral Vancomycin, probiotics. Continued	9117

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Serratia sepsis – Improving slowly. On Meropenem, antibiotics through 08/20 for this. 4. Hypogamma – Status post IVIG x___, repeat levels IgG 1867 – no indication for additional IgG at present 5. Leukocytosis – Down slightly to 19k from 21.1<- 22.7 6. Dispo concern for transfer the floor	
08/20/YYYY	Hospital/ Provider Name	**@0451 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.7, albumin 2.7, RBC 2.48, hemoglobin 7.9, hematocrit 24.5 **High:** AST 65, ALT 74, alkaline phosphatase 669, WBC 19.7, platelet 921	9770, 9796
08/20/YYYY	Hospital/ Provider Name	**Anaerobic culture report:** **Collected date:** 08/15/YYYY **Source:** Abscess abdomen **Gram stain:** Many WBC, rare gram negative rods, rare gram positive rods. Called to Gail Vaughen 08/15/YYYY at 1349 hours **Culture:** Scant growth of Candida Albicans Scant growth of mixed flora, no predominant type resembling skin flora No anaerobes isolated	9810
08/20/YYYY	Hospital/ Provider Name	**@0915 hours: Surgery Progress Notes:** Wants NGT out and TF stopped. Some abdominal pain. BM: Positive diarrhea Afebrile, pulse 100-110, BP 148/78 JP 30/24 hours, purulent Abdomen: Soft, no distention, incision ok **Assessment/plan:** 1. POD#14 – CT yesterday shows improvement of fluid collection although still with some small collections not being strained. Continue antibiotics per ID. Ok to have diet as tolerated per speech recs. Once able to tolerate per oral and pills can discontinue TF and NGT. Await speech recs 2. Deconditioning – PT/OT 3. Pleural effusion – per Pulmonary 4. C. diff – antibiotics per ID	9116
08/20/YYYY	Hospital/ Provider Name	**@1130 hours: Speech Pathology Notes:** Bedside swallow assessment completed. Tolerated thins and soft chewables; however, immediate cough with thins in mixed consistencies (cereal, milks, pills with water, mixed fruit). **Recommendation:** Thins, no straw, mechanical soft, no mixed consistencies, whole pills in pudding. Will follow up closely.	9115
08/20/YYYY	Hospital/ Provider Name	**@1230 hours: ID Progress Notes:** ***(Illegible Notes)***	9114

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Subjective: Feels pretty good, moving well, NG out___ Merrem #8 Micafungin #8 Per oral Vancomycin #4 Flagyl #3 **Vitals:** Temp 98.0, afebrile General: Alert and oriented but asked that we are ___ - per daughter still some ___ psychosis Lungs: Shallow respiration but clear ___ Abdomen: incision with staples but dry ___ Neuro: Some confusion but generally normal interaction **Assessment/plan:** 1. Abdominal/pelvic abscess – CT showing improvement with no new collections 2. C. diff colitis - On per oral Vancomycin, probiotics. Still ___/liquid, benefits to decrease when off Merrem 3. Serratia sepsis – On antibiotics through today 4. Leukocytosis – Multifactorial, still ___ **Addendum:** Discontinue broad spectrum antibiotics today, ____ CT shows improved	
08/20/YYYY	Hospital/ Provider Name	**@1500 hours: Progress Notes:** Discussed with Dr. ____ - few attempts to insert PICC unsuccessful - ____ cancel PICC order.	9113
08/21/YYYY	Hospital/ Provider Name	**@0427 hours: Lab report:** **Low:** Creatinine 0.4, calcium 8.0, albumin 2.8, RBC 2.54, hemoglobin 7.8, hematocrit 25.1, prealbumin 8.3 **High:** AST 43, ALT 61, alkaline phosphatase 598, GGT 303, WBC 20.0, platelet 973	9770, 9796, 9808
08/21/YYYY	Hospital/ Provider Name	**@0820 hours: Surgery Progress Notes:** No new complaints, still with diarrhea. No nausea/vomiting Tolerating diet per speech recs Tmax 100, temp 98.7, pulse 80-110 Urine output 1525 Abdomen soft, no distention, non-tender, incision ok **Assessment/plan:** 1. Improving but slow – will continue TPN until discharge plans in place. Questionable rehab next week but depends on place with ID and antibiotics 2. Continue working with PT/OT. Increase per oral intake	9111
08/21/YYYY	Hospital/ Provider Name	**@0940 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Still with abdominal pain, ___	9110

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Vitals: BP 117/73, pulse 96, ___ General: ___ Abdomen: incision with ___ **Assessment/plan:** ___ Continue current regimen Will follow	
08/21/YYYY	Hospital/ Provider Name	**@1015 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Not sleeping well - ___ instead Micafungin #9 of 10 Per oral Vancomycin #5 Flagyl #4 Probiotics #2 **Vitals:** Temp 98.7, Tmax 100 General: Wakes slowly, still some concern Lungs: ___ Abdomen: incision dry without erythema Neuro: Normal CNS, some confusion still **Assessment/plan:** 1. Abdominal/pelvic abscess – CT showing improvement with no new collections, On Micafungin through tomorrow with ___ 2. C. diff colitis – Hopeful that completion of Meropenem will decrease pressure on gut and C. diff will clear some on diet and with probiotics 3. Status post 14 days treatment for Serratia sepsis – ___ 4. Leukocytosis – Appreciable but no new appreciable change, likely secondary to ___, questionable IJ 5. IV access – still with ___, questionable PICC order cancelled. On TPN through discharge per Surgery. Continue attempts to place ___ **Addendum:** Complete Micafungin course and then stop. Could go with per oral C. diff treatment.	9112
08/21/YYYY	Hospital/ Provider Name	**@1115 hours: Pulmonary and Critical Care Progress Notes:** **Subjective:** Much improved. Working with PT. Awake, alert, no acute distress, working with Patient, EOMI, PERRL Lungs clear, diminished at bases Normal sinus rhythm Abdomen: Tender diffusely positive bowel sounds, negative rebound, guarding **Assessment and plan:** Postop hypoxic – resolved – on room air	9148

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pleural effusion likely resolved – 3rd spacing. Chest X-ray in morning Needs Foley out Needs central line out tomorrow Eating ok – will supplement with boost TPN will discontinue after CVC out tomorrow.	
08/22/YYYY	Hospital/ Provider Name	**@0432 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.7, albumin 2.8, RBC 2.62, hemoglobin 7.9, hematocrit 25.7 **High:** AST 45, ALT 59, alkaline phosphatase 650, WBC 19.2, platelet 995	9770, 9796
08/22/YYYY	Hospital/ Provider Name	**@0744 hours: X-ray of chest:** **History:** Effusion **Impression:** 1. Improvement of trace right and stable small left pleural effusion with bibasilar atelectasis similar to prior. 2. No new consolidation. No other change since prior.	9893
08/22/YYYY	Hospital/ Provider Name	**@0848 hours: Surgery Progress Notes:** No complaints Tmax 100.4, temp 99, pulse 90s Good urine output JP 20/12 hours – serous Abdomen soft, non-tender, incision ok **Assessment/plan:** 1. ___ with low grade temp ad increased WBC. Agree with Critical Care/Pulm to discontinue line after antibiotics finished today 2. JP still with some output so will continue for now 3. Deconditioning – continue PT/OT 4. Since eating, ok to discontinue TPN	9109
08/22/YYYY	Hospital/ Provider Name	**@0940 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Still with abdominal pain, ___ **Vitals:** BP 117/73, pulse 96, ___ General: ___ Abdomen: incision with ___ **Assessment/plan:** ___ Continue current regimen Will follow	9108
08/22/YYYY	Hospital/ Provider Name	**@1030 hours: Pulmonary and Critical Care Progress Notes:** **Subjective:** Positive bowel movement. Had a good night.	9147

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Sleepy, no acute distress Pulmonary: Course, slightly diminished bases, negative wheezes/crackles, unlabored Cardiac: S1 S2, tachycardic Abdomen: Soft, nontender, incision clean, dry, intact. No rebounding **Medications:** Colcae Lovenox Insulin Culturette Protonix Florastir Peptamen TF Boost Xop/Atrovent nebs Micafungin Metronidazole Vancomycin per oral TPN at 65 – to be discontinued **Assessment and plan:** 1. Resolved postop hypoxic – on room air 2. Small bilateral pleural effusion secondary to 3rd spacing. Trace/improved in chest X-ray. Likely to resolve with movement/pulmonary hygiene, euvolumic status 3. Serratia sepsis – ID following 4. C. diff colitis – on Flagyl 5. Low grade temp secondary to #2, 4 or 4 or line which is discontinued. Pulmonary to sign off. Please call again if needed	
08/23/YYYY	Hospital/ Provider Name	**@0509 hours: Lab report:** **Low:** Creatinine 0.4, calcium 8.0, albumin 3.0, RBC 2.96, hemoglobin 8.9, hematocrit 29.0 **High:** AST 54, ALT 63, alkaline phosphatase 722, WBC 21.1, platelet 1005	9769, 9796
08/23/YYYY	Hospital/ Provider Name	**@0935 hours: Wound assessment:** Midline abdomen – approximated Exudate – Purulent Dressing changed at bedside by Meghan Williams, PA; Large amount purulent drainage expressed, approximately 30 ml.	10080
08/23/YYYY	Hospital/ Provider Name	**@0938 hours: Progress Notes:** ***(Illegible Notes)*** Complaint of pain in right ___ and abdomen. Complaints of nausea with emesis. Denies diarrhea. Tired.	9107

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Tmax 101.3, temp 98.6, pulse 117, resp. rate 16, SpO2 96% on room air, BP 112/59 General: Mild ___ dyspnea, positive hallucinations but oriented x3 Respiratory: Bibasilar crackles, otherwise bilateral breath sounds clear to auscultation Abdomen: Soft and distended, no tenderness to touch Blood culture 08/23, 08/22 – no growth till date **Assessment/plan:** Abdomen pelvis abscess. Increased WBC with fever last night. Purulent dressing from distal portion of ___ incision. Culture sent. Check CT abdomen C. diff colitis: Continue oral Metronidazole and Vanco. Continue probiotics Serratia sepsis: Follow culture Leukocytosis with fever: Check CT abdomen, wound blood culture **Addendum: ____**	
08/23/YYYY	Hospital/ Provider Name	**@1000 hours: Surgery Progress Notes:** Tired, did not sleep well. Some hallucinations. Tmax 101, afebrile, pulse 112, BP 115/70 Voided in diaper last night so urine output not recorded General: Alert and oriented x3 but some hallucination Abdomen soft, no distention, purulent fluid from inferior incision. Proved wound and drained significant amount of frank pus. **Assessment/plan:** 1. Antibiotics stopped yesterday. IJ line discontinued. Now with increased WBC and more hallucinations. Will check CT abdomen pelvis with per oral or IV contrast 2. Also with wound infection – culture sent. Will do local wound care 3. Since increased heart rate and hallucinations, will restart IVF at 75 cc/hr	9106
08/23/YYYY	Hospital/ Provider Name	**@1500 hours: Lab report:** **Urinalysis:** Protein 30, small blood	9806
08/23/YYYY	Hospital/ Provider Name	**@2056 hours: CT abdomen and pelvis with contrast:** **History:** Fever. Altered mental status. Wound infection. **Findings:** **CT Abdomen:** The liver, spleen, pancreas and adrenal glands appear normal. Kidneys appear normal with stable left renal cyst and without evidence of hydronephrosis. Again seen is a pigtail catheter adjacent to the spleen. Small amount of fluid surrounds the spleen and is stable. Multiple small fluid collections surrounding the liver are also stable. Fluid inferior to the liver is also grossly stable. Postoperative changes along the anterior abdominal wall are again identified with	9895-9896, 9105

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		decreasing fluid collection in this region. Skin staples have been removed. Bowel loops are normal in caliber with no evidence of bowel obstruction. **CT Pelvis:** Small amount of enhanced fluid is identified in the pelvis. This is measured at 2.9 x 2.0 cm, previously measured up to 3.5 x 2.6 cm on August 15, 2014. Extensive postoperative changes are identified in the left pelvis. Oral contrast is identified in the colon again without evidence of bowel obstruction. Evaluation of bone windows shows no aggressive osseous lesions. **Impression:** Minimal fluid collection around the liver and spleen, stable to decreased in size from the previous study. Improving postoperative changes in the subcutaneous tissues of the midline abdomen. Persistent pelvic fluid collection, slightly decreased in size from the previous study. Bilateral pleural effusion and bibasilar atelectasis, stable. Probable left renal cysts, unchanged.	
08/24/YYYY	Hospital/ Provider Name	**@0359 hours: Lab report:** **Low:** Creatinine 0.4, calcium 8.0, albumin 2.8, RBC 2.51, hemoglobin 7.9, hematocrit 24.7 **High:** Alkaline phosphatase 564, WBC 20.6, platelet 857	9769, 9796
08/24/YYYY	Hospital/ Provider Name	**@1025 hours: Surgery Progress Notes:** ***(Illegible Notes)*** Feels better. Afebrile, pulse 100s General: Awake, alert and oriented Abdomen soft, decreased distention, wound open with approx. 1 cm – probed and tunneling goes superior but all superficial – purulent. Fluid decreased. **Assessment/plan:** Wound infection – open and draining. No fluid ___ on CT last night. All intraabdominal fluid collections improving. No extravasation of per oral contrast Continue IV antibiotics per ID Continue rehab	9101
08/24/YYYY	Hospital/ Provider Name	**@1045 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** Discussed with Surgery/Family, ___ refusing ___, but denies diarrhea. Still with temp, but clinically stable. **Vitals:** BP 117/83, pulse 102, resp. rate 18, SpO2 95% General: No acute distress __ Abdomen: ___ **Assessment/plan:** Fever - ___ abdominal wall abscess/fistula. Status post ___ of wound (drainage and ___. ___ on broad spectrum coverage. . CT abdomen pelvis improved	9102

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		overall. Culture done - negative. Plan: Continue current treatment. It is possible this is an ___ fistula, ___ coverage for abscess. C. diff colitis – no diarrhea currently. Monitor with ___ and IV antibiotics. Continue Vanco, low dose Flagyl, Probiotics	
08/25/YYYY	Hospital/ Provider Name	**@0453 hours: Lab report:** **Low:** Creatinine 0.4, calcium 8.0, albumin 2.8, RBC 2.65, hemoglobin 7.8, hematocrit 26.3, prealbumin 6.3 **High:** Alkaline phosphatase 479, GGT 235, WBC 18.9, platelet 840	9769, 9795, 9808
08/25/YYYY	Hospital/ Provider Name	**Urine culture report:** Collected date: 08/23/YYYY No growth	9810
08/25/YYYY	Hospital/ Provider Name	**@0930 hours: Surgery Progress Notes:** ***(Illegible Notes)*** Temp decreased ___. Abdomen soft completely ___ Still with drainage from low abdominal wall WBC decreased to 18.6 Tolerating diet Continue present treatment	9101
08/26/YYYY	Hospital/ Provider Name	**@0444 hours: Lab report:** **Low:** BUN 7, creatinine 0.4, calcium 8.0, albumin 2.7, anion gap 4.0, RBC 2.61, hemoglobin 7.8, hematocrit 26.1 **High:** Alkaline phosphatase 418, WBC 17.3, platelet 842	9769, 9795
08/26/YYYY	Hospital/ Provider Name	**@0920 hours: Wound assessment:** Midline abdomen – approximated, moist, open Dehisced surgical wound Exudate – Minimal, purulent, serous Wound odor - none Periwound condition – intact Length – 1.3 cm Width – 0.8 cm Depth – 0.4 cm Pink, non-granulated – 100% Wound cleansed at bedside with wound cleanser and dressing performed with Silicone, Mepilex border 3x3	10081
08/26/YYYY	Hospital/ Provider Name	**@0955 hours: Surgery Progress Notes:** No new complaints Hopefully family to decide on rehab facility today Awaiting ID recs on duration of therapy Encouraged increased activity, increased working with PT Wound looks okay	9100

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/26/YYYY	Hospital/ Provider Name	**@1045 hours: ID Progress Notes:** ***(Illegible Notes)*** **Subjective:** ___ abdominal pain controlled. No ___ **Vitals:** BP 119/80, pulse 98-108, SpO2 98%, temp 98.2 General: Awake, alert Abdomen: Soft, non-tender, ___ without purulence Neuro: Nonfocal, moves all extremities **Assessment/plan:** Sepsis improved Small bowel perforation - ___ Leukocytosis – slow improvement Fever resolved C. diff ___	9104
08/27/YYYY	Hospital/ Provider Name	**@0432 hours: Lab report:** **Low:** BUN 7, creatinine 0.4, calcium 8.2, albumin 2.9, RBC 2.69, hemoglobin 8.2, hematocrit 26.5 **High:** Alkaline phosphatase 405, WBC 17.2, platelet 844	9769, 9795
08/27/YYYY	Hospital/ Provider Name	**Anaerobic culture report:** **Collected date:** 08/23/YYYY **Source:** Abdomen midline **Gram stain:** Few (average 1-9/LPF) WBC, no epithelial cells, no organism isolated **Culture:** Rare colonies of Candida Albicans. No anaerobes isolated	9810
08/27/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/22/YYYY **Culture:** No growth in 5 days	9812
08/27/YYYY	Hospital/ Provider Name	**@0930 hours: Surgery Progress Notes:** ***(Illegible Notes)*** Diarrhea this morning. Wants to go to rehab. Afebrile. Pulse 100 Urine output 5 voids overnight. JP scant – mostly ___ Abdomen: Soft, no-distention, no erythema, no significant tenderness Wound open approx. 1 cm and track 9 cm Superior – all superficial, no deep tract **Assessment/plan:** No significant change in WBC Will pack wound with silver per WOCN recs Get patient ready for transfer to rehab so will KVO IVF to make sure patient	9099

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		drink enough to maintain fluid status ___ IVF Questionable possible discharge to rehab tomorrow Await ID recs on antibiotics	
08/27/YYYY	Hospital/ Provider Name	**@0950 hours: ID Progress Notes:** Had 3 bowel overnight and this morning. Denies abdominal pain and discomfort. Vitals: BP 110/71, temp 98.7, pulse 100-107, resp. rate 18, SpO2 96% Abdomen: Soft distal incision site with ___ wound **Antibiotics:** Meropenem 8/12 Metronidazole ___ Micafungin 8/12 Vancomycin per oral ___ **Impression:** Sepsis – Serratia bacteremia, ___ ___ infection Leukocytosis Fever – resolved **Recommendations:** Continue Meropenem and Micafungin for intraabdominal pathology ___ Continue Metronidazole and Vancomycin per oral for C. diff at least 2 weeks and 1 week post ___ Patient will need at least 2 weeks of IV antibiotic therapy for intraabdominal pathology PICC ordered	9145
08/27/YYYY	Hospital/ Provider Name	**@1002 hours: Wound assessment:** Midline abdomen – moist, open Dehisced surgical wound Exudate – Minimal, purulent Periwound condition – intact Length – 1.3 cm Width – 0.8 cm Depth – 9 cm Pink, non-granulated – 100% Wound cleansed at bedside with normal saline and dressing performed with silver ribbon, plain guaze, Medipore tape	10082
08/27/YYYY	Hospital/ Provider Name	**@1500 hours: Progress Notes:** Right brachial vein for PICC placement	9097
08/27/YYYY	Hospital/ Provider Name	**@1550 hours: Procedure Report:** PICC line 4 Fr, single lumen Right brachial vein	9171

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Placed in 1 attempt	
08/27/YYYY	Hospital/ Provider Name	**@1620 hours: X-ray of chest:** **History:** Line placement. **Findings:** Right arm PICC line is inserted with the tip terminating within the proximal right atrium. Distance from catheter tip to the cavoatrial junction is approximately 3 cm. There is cardiomegaly with small bilateral pleural effusions and retrocardiac left basilar opacity, not significantly changed from the prior study of August 22, 2014. There is no evidence of pneumothorax. Cardiac and mediastinal contours are unremarkable. The left internal jugular line has been removed. There is a left upper quadrant pigtail drainage catheter. **Impression:** Right arm PICC line tip terminates within the proximal right atrium. Bilateral pleural effusions with left basilar retrocardiac atelectasis versus infiltrate, not significantly changed from the prior study of August 22, 2014.	9899
08/27/YYYY	Hospital/ Provider Name	**@1900 hours: Progress Notes:** PICC line pulled back 2 cm per chest X-ray results. Now at 16 cm out and 39 cm in. No repeat chest X-ray needed per PICC guidelines. Patient complaint of soreness in PICC insertion site. Arm elevated on pillow and warm packs applied to site. Continue watching/observing arm site for any redness or swelling.	9097
08/28/YYYY	Hospital/ Provider Name	**@0412 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.9, albumin 2.7, RBC 2.56, hemoglobin 7.9, hematocrit 25.3, prealbumin 7.6 **High:** Alkaline phosphatase 356, GGT 180, WBC 16.2, platelet 768	9768, 9795, 9808
08/28/YYYY	Hospital/ Provider Name	**Blood culture report:** **Collected date:** 08/23/YYYY **Culture:** No growth in 5 days	9812
08/28/YYYY	Hospital/ Provider Name	**@0830 hours: Surgery Progress Notes:** Afebrile Abdomen soft, positive bowel sounds ___	9103
08/28/YYYY	Hospital/ Provider Name	**@0940 hours: ID Progress Notes:** ***(Illegible Notes)*** Feels better. Stools x3 ___ **Vitals:** BP 119/74, pulse 103, resp. rate 16, temp 98.4, SpO2 96% Abdomen: Soft, ___ mild tenderness to palpation **Impression:** Sepsis syndrome – cleared	9103

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Abdominal abscess – restarted on IV Micafungin/ Meropenem after ___ off IV treatment. Difficulty getting placement at ___ secondary to Meropenem. If unable to place, could change to alternate ___ some risk of loss and control in ___ C. diff – continue per oral Vancomycin and probiotics Leukocytosis – secondary to above, trending down Disposition – awaiting placement.	
08/29/YYYY	Hospital/ Provider Name	**@0520 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.8, albumin 2.7, RBC 2.62, hemoglobin 7.7, hematocrit 25.6 **High:** Alkaline phosphatase 328, WBC 13.8, platelet 734	9768, 9795
08/29/YYYY	Hospital/ Provider Name	**@1430 hours: Surgery Progress Notes:** Accepted at rehab facility Continue packing abdomen wound with recommended packing by WOCN Follow up with Dr. Ruben in 1-2 weeks	9146
08/29/YYYY	Hospital/ Provider Name	**@1443 hours: Wound assessment:** Midline abdomen – moist, open Exudate – Minimal, purulent Wound dressing performed with silver ribbon, plain gauze, paper tape	10083
08/29/YYYY	Hospital/ Provider Name	**@1600 hours: ID Progress Notes:** ***(Illegible Notes)*** Feels pretty good, concerned about process of transition to rehab. **Vitals:** BP 117/72, pulse 108, resp. rate 22, temp 99.2, SpO2 95% Abdomen: Soft, ___ mild tenderness to palpation Neuro: Nonfocal, globally weak **Impression:** Sepsis syndrome – cleared Abdominal abscess – restarted on IV Micafungin/ Meropenem. Plan to complete 14 days of IV treatment C. diff – continue IV Metronidazole until IV Meropenem ___ complete; then stop. Continue per oral Vancomycin for at least 14 days after that stop ___ Leukocytosis – ___ today Disposition – to rehab facility	9146
08/29/YYYY	Hospital/ Provider Name	**Medication transfer order:** Saccharomyces Boulardi 500 mg Lactobacillus rhamnosus 2 cap Metronidazole 500 mg Lovenox 40 mg Docusate sodium 100 mg Pantaprozole 40 mg Estradiol 1 mg Micafungin 100 mg, 100 ml – 14 days Meropenem 1000 mg, 100 ml – 14 days	9173-9177

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		D5/0.45 NS/KCl 20 meq Sodium chloride 0.9% Miconazole nitrate 2% Vancomycin oral syringe 250 mg – 28 days Boost plus Simethicone 80 mg **PRN medications:** Acetaminophen 650 mg Morphine 2-4 mg IV Tramadol 50 mg Ondansetron 4 mg **Respiratory agents:** Levabutero 1.25 mg/0.5 ml – Xopenox Ipratropium bromide 0.02% **Topical agents:** Bacitracin Zinc 500 unit Neomycin-Bacitracin-Polymyxin Miconazole nitrate 2%	
08/30/YYYY	Hospital/ Provider Name	**@0501 hours: Lab report:** **Low:** Creatinine 0.4, calcium 7.9, albumin 2.8, RBC 2.69, hemoglobin 8.2, hematocrit 26.5 **High:** Alkaline phosphatase 333, WBC 14.8, platelet 703	9768, 9795
08/30/YYYY	Hospital/ Provider Name	**@2030 hours: X-ray of chest:** **Indication:** Line placement **Impression**: Re-demonstration of left greater than right pleural effusions, with the left pleural effusion slightly larger than on the most recent prior despite a left basilar chest tube in place. Right upper extremity PICC line terminates with its tip in the expected location of the cavoatrial junction.	8829
08/30/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 08/06/YYYY **Provisional Diagnosis:** Septic shock, status post laparoscopic chole cystectomy and a mini laparotomy with lysis of adhesions 2 days prior to presentation. **Final diagnoses:** 1. Septic shock, secondary to small bowel perforation. 2. Bacteremia.	8800-8801

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Clostridium difficile. 4. Intra-abdominal abscesses. 5. Wound infection. **Reason for admission:** The patient presented to the emergency room by her family 2 days, status post laparoscopic cholecystectomy and mini laparotomy with lysis of adhesions, because she was unresponsive. She was found to be hypotensive and tachycardic in the emergency room. In the emergency room, a CT angiogram of her chest showed no evidence of pulmonary embolism. She did have a significant amount of pleural fluid, and fluid in her upper abdomen. Once she was stabilized, she was sent back to CT and had a CT of her abdomen and pelvis, which did show a significant amount of±1uid in her abdomen, more than would expect related to her recent surgery. **Hospital Course:** The patient was seen by Critical Care in the emergency room and was transported to the ICU for fluid resuscitation. She was intubated. She was taken to the operating room on the day of admission for an acute abdomen, and was found to have a small bowel perforation. This section of small bowel was resected and a primary anastomosis was done. Her abdominal cavity was washed out with 8 L of fluid. She had a prolonged postoperative course and remained intubated for several days. She was found to be bacteremic and C. difficile. All of her antibiotics were managed by Infectious Disease. Once she was stabilized and extubated, she was transferred to the floor. At one point, she did become somewhat confused and was having high fevers. She was found to have a wound infection, which was opened and drained at the bedside. Due to severe deconditioning and need for IV antibiotics, the decision was made to transfer her to a rehab facility. **Disposition:** To Northeast Rehabilitation Center. **Condition on discharge:** Stable. **Discharge Instructions:** The patient was instructed to follow up in the office with Dr. Ruben in 2 weeks. She was receiving wound care with packing for the opening in her midline incision. Diet was as tolerated. **Reviewer's comment: Northeast Rehabilitation Center medical records after this date are not available for review.*	
08/06/YYYY-08/30/YYYY	Hospital/ Provider Name	**Other records:** Medication Sheets, Respiratory Therapy, Speech Therapy Records, Physical Therapy Records, Occupational Therapy Records, Rhythm Strips, Social Service Records, Patient Education, Checklist/Verification List, Nutritional Flow sheets, Plan of Care, Flow sheet, PACU Record, Intraop nursing documentation, Assessment, Anesthesia Record, Medication Reconciliation Record, Rhythm	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Strips, Orders **PDF-Ref:** 9061, 9067, 9052-9055, 9150-9170, 9716-9721, 9723-9727, 9729-9765, 11280-12587, 12635, 9206-9711, 12636-12644, 9172, 9926-9927, 12710-12712, 9178-9197, 9817-9824, 9933-9946, 9954-10068, 10084-10338, 10340-11279, 12588-12634	
09/02/YYYY	Hospital/ Provider Name	**@1142 hours: X-ray of abdomen:** **History:** Small bowel perforation. Vomiting. **Findings:** Bilateral breast prostheses are present. Small to moderate sized bibasilar pleural effusions are present. Patchy opacity in the left lower lung is essentially unchanged when compared to the previous study. No free intraperitoneal gas is present. The bowel gas pattern is normal. Extensive post-surgical changes in the pelvis can be identified. The bony structures are intact. The psoas margins are sharp. Phleboliths in the pelvis are present. **Impression:** 1. Normal bowel gas pattern without evidence of obstruction. 2. Extensive post-surgical changes in the abdomen and pelvis. 3. Moderate sized bilateral pleural effusions with compensatory bibasilar subsegmental atelectasis noted. This process is greater on the left and appears essentially unchanged compared to the previous study. A dedicated chest X-ray will better evaluate this finding, as indicated.	6733
09/02/YYYY	Hospital/ Provider Name	**Consultation Report:** **Date of admission:** 08/30/14 **Reviewer's comment: It was noted that patient was re-admitted on 08/31/YYYY (per note on history of present illness). But corresponding admission records are not available.* **Reason for Consultation:** Infectious disease evaluation in a patient with abdominal pelvic fluid collections, status post perforation, C. difficile colitis, leukocytosis, and intractable nausea and emesis. **History of present illness:** Patient readmitted on August 31 for intractable nausea and vomiting as well as ongoing treatment of abdominal pelvic fluid collection, C. difficile colitis. She had been transferred from this facility to rehab, but had a very short stay. The conditions under which she was transferred were not acceptable to the patient and/or her daughter. Moreover, she developed intractable nausea and vomiting while at rehab to the point that she had essentially nonstop emesis, and had essentially no oral intake. As such, she was readmitted to AB Hospital, and infectious disease evaluation is once again requested for the optimization and management of antimicrobial therapy. **Physical Examination:**	8825-8828

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Vital Signs: Temp 98.4, Tmax 99.9, heart rate 103, BP 116/76, resp. rate 17, oxygen saturation 95% on room air. **General:** Well-developed, well-nourished, alert and oriented, somewhat anxious, but in no distress. **HEENT:** Head normocephalic, atraumatic. No temporal wasting. Eyes, ears, nose, throat: Sclerae are anicteric. Conjunctivae not injected. Extraocular movements are intact. Oropharynx without lesions or exudate. Teeth are in good repair. **Neck:** Supple, without adenopathy, jugular venous distention, or meningismus. **Cardiovascular:** Rate and rhythm are regular without appreciable murmur, gallop, or rub, although the rate is somewhat tachycardic. **Pulmonary:** Clear in all lung fields without wheezes, crackle or rhonchi, somewhat dull in bilateral bases. **Gastrointestinal:** Soft, mildly distended. Diminished bowel sounds. Mild diffuse appropriate tenderness to palpation. Abdominal dressings were not taken down at the time of the examination. **Musculoskeletal:** No appreciable venous cording, clubbing, or cyanosis. There is modest muscular atrophy and trace edema, most notably dependent. Peripheral pulses are thready and 1+ in the dorsalis pedis, posterior tibialis and 2+ in radial and brachial pulses bilaterally. **Integument:** Age-appropriate changes without overt rash or lesion. **Neurologic:** Cranial nerves II through XII are intact. Gait is not examined; however, the patient did spontaneously move all extremities equally well and followed simple and complex commands without difficulty. **Laboratory Data:** Available at the time of consultation, white blood cell count on admission 12,900, hemoglobin 8.5, hematocrit 27, platelets 585,000. Serum chemistry: Sodium 140, potassium 3.6, chloride 103, CO2 of 28, BUN 8, creatinine 0.3, glucose 104. On August 30 white blood cell count was 14,800 with platelet count of 703,000. **Diagnostic Imaging:** No imaging has been performed since readmission. Plain films of the chest on 08/30/14 show right upper extremity PICC in place, left basilar chest tube in place with a moderate left pleural effusion, tiny right pleural effusion. No pneumothorax. Flat and upright KUB on 09/02/14, bowel gas pattern that is normal, extensive post-surgical changes in the pelvis, bony structures intact. Bilateral breast prostheses present, small to moderate bibasilar pleural effusions. Please reference the permanent medical record for complete diagnostic imaging details. All results relevant to this admission were reviewed in depth at the time of consultation. **Impression:** Abdominal pelvic fluid collection status post perforation, coalesced to a single collection in the pelvis on CT 08/23/14 which is 2.9 x 2 cm on last imaging. She left the hospital on August 30 for rehab, readmitted on late August 31/early 09/01/14. **Plan:** At time of transfer was to continue IV Meropenem and IV Micafungin to complete on 09/12/14 for treatment of pelvic fluid abscess.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		C. difficile colitis on therapy with per oral Vancomycin and probiotics. Plan was to continue per oral Vancomycin until 09/26/14 or 14 days after the completion of IV Meropenem. She unfortunately was having difficulty tolerating the liquid Vancomycin preparation with resultant nausea and vomiting. She is presently receiving IV Metronidazole. Next, Leukocytosis 12,900 on readmission, slowly normalizing from the initial infectious insult. She was 14,800 on the 30th when she left. Next, intractable nausea and emesis. **Primary reason for readmission:** Unclear at this point in time whether it is secondary to potential obstruction and/or medication effect. **Recommendations:** 1. Continue Meropenem through 09/12/14. 2. Continue Micafungin IV through 09/12/14. 3. Continue C. difficile antibiotic, either IV Metronidazole, oral Metronidazole and/or oral Vancomycin through 09/26/14; presently she is tolerating the IV Metronidazole without issue. 4. Continue probiotics x3 months. 5. We will follow closely with you, both as in and as an outpatient.	
09/03/YYYY	Hospital/ Provider Name	**CT abdomen pelvis with contrast:** **History:** Abscess. Spontaneous perforation. Abdominal pain. **Abdomen:** Again seen are bilateral pleural effusions, left greater than right. The left pleural effusion has increased when compared to the previous study. There is bibasilar consolidation, most likely compressive atelectasis. Bilateral breast implants are again identified. The liver, spleen, adrenal glands, and pancreas are grossly normal in size and attenuation. Oral contrast is identified into the colon. The small bowel is normal in caliber without evidence of small bowel obstruction. A small amount of fluid is again identified inferior to the liver, which appears to have improved slightly from previous study. Previously identified left pigtail catheter has been removed. A minimal amount of fluid is identified adjacent to the spleen. There is bowel wall thickening of the duodenum which appears to be slightly inflamed. This is in the first portion of the duodenum. No definite free air is identified. In the area of patient's incision in the midline anterior abdominal wall, slightly above the umbilicus, there has been interval development of an air/ fluid collection as seen on image-60 and 59 of series-2 measuring 2.4 x 2.2 cm. Extensive postoperative changes are identified throughout the bowel. **Pelvis:** Again, there are scattered postoperative changes present. Bowel loops are normal in caliber. Contrast is identified into the colon. An enhancing fluid collection within the pelvic cul-de-sac is again identified, which appears to have decreased	8832-8833

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		slightly in size, now measuring 2.0 x 1.1 cm, previously measured at 2.9 x 2.0 cm. Evaluation of the bone windows shows no aggressive osseous lesions. **Impression:** Probable abscess in the pelvic cul-de-sac, slightly decreased in size from previous study. Minimal fluid in the bilateral paracolic gutters and surrounding the liver and spleen, slightly improved. Bilateral pleural effusions, left greater than right, increased on the left when compared to the previous study. Mild haziness in the region of the duodenum with questionable surrounding inflammatory changes and mild duodenitis cannot be excluded. Interval development of a fluid collection In the region of the patient's midline anterior abdominal wall incision suggesting a seroma. Underlying soft tissue/ wound abscess, however, cannot be excluded. Clinical correlation is recommended. No evidence of bowel obstruction.	
09/03/YYYY	Hospital/ Provider Name	**X-ray of chest:** **History:** Pleural effusion **Findings:** Right upper extremity PICC is unchanged with tip projecting at the SVC. The cardiac silhouette and mediastinal contours are stable. Large left pleural effusion is stable. Small to moderate right pleural effusion is stable. No pneumothorax is seen. Bibasilar atelectatic change is noted. **Impression:** Stable large left pleural effusion. Stable small to moderate right pleural effusion. No significant interval change.	12945
	Hospital/ Provider Name	***ABC Living – Gunwoody (09/06/YYYY-09/16/YYYY)***	
09/06/YYYY	Hospital/ Provider Name	**History and Physical:** ***(Illegible Notes)*** **History of present illness:** Patient admitted from AB Hospital for rehab post C. diff colitis, abdominal pelvic abscess, septic shock, pleural effusion, small bowel perforation. ADL-transfer: Needs help Toileting: Needs help Bathing: Needs help Dressing: Needs help Ambulation: Wheel chair Vision, hearing: Adequate **Vitals:** BP 90/60, pulse 80, temp 97, resp. rate 20 Constitutional: Chronically HEENT: PERRLA Lymphatic: No palpable lymph node	6731-6732, 6604-6605

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chest: Bilateral ___, no rhonchi CVS: S1 S2, regular Abdomen: Clean dry surgical sutures, status post cholecystectomy Extremities: No pedal edema CNS: Alert, oriented x3 Skin: No rash **Labs:** Sodium 140, potassium 3.6, chloride 103, CO2 28, BUN 8, creatinine 0.3, glucose 104, WBC 12, hemoglobin 9.1, hematocrit 28, platelet 512 **Assessment/plan:** Status post small bowel resection for perforation, recent C. diff colitis, status post Vancomycin ___ critical care, myopathy on OT/PT, ____	
09/08/YYYY	Hospital/ Provider Name	**Occupational Therapy Evaluation:** **Reason for referral:** Patient referred to OT services by MD due to recent hospitalization from 8/30/14 through 9/6/14 for multiple medical conditions including small bowel perforation with abscess, C-diff requiring antibiotics, respiratory arrest and leukocytosis. Patient was previously living independently and now requires increased assistance and effort to complete selfcare tasks and mobility. **Therapy Necessity:** Patient was previously independent and now requires increased assistance and effort to complete selfcare tasks and mobility. Patient would benefit from continued skilled OT services to address patient's strength, activity tolerance, and balance in order to ensure her mobility to safely complete ADL's, IADL's, and mobility. If patient does not receive OT services she is at risk for falls and for becoming an increased burden of care.	6736-6738
09/09/YYYY	Hospital/ Provider Name	**Nursing notes:** Patient is alert and responsive, was upset because her Zofran and Xanax was opened before it was administered. Nurse explained to her that it was not communicated to her, and it was the first time taking care of her. But assured her that it would not happen again.	6715
09/09/YYYY	Hospital/ Provider Name	**Weekly Wound care notes:** Alert, able to make needs known; decline pain meds. Gluteal crease (partial thickness (shear) red bed, no exudate, peri intact. Treatment: barrier cream. Surgical wound abdomen (full thickness) dehisced with red non-granular tissue, rolled edges, peri intact, small to moderate serosanguineous exudate, no odor. 1.0 x 0.6 x 1.2 at 12p 4.1. Treatment: AFM qod. Resident is encouraged to turn/position every 2 hours as tolerated with elongated pillows and comply with diet. Daughter at side, voice no concerns.	6714
09/10/YYYY	Hospital/	**Follow-up Visit:**	8781-

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Subjective:** Patient comes into the office today for postoperative appointment. She has been at the rehab center doing physical therapy. She does feel like she is improving. She is still having some intermittent crampy abdominal pain. She did have a bowel movement yesterday. She comes in today because the nurse practitioner at the rehab center was concerned about her wound. They have been changing the packing from her wound every three days. It was last changed two days ago. She reports that she has not had any fever or chills. She does feel like she is getting stronger. She also is complaining of a lump in her right arm and some swelling in her right ann. **Objective:** General: She is not in any acute distress. She looks really good and is moving around well. Abdomen: Soft and not distended. Her midline incision is intact, with a small opening at the most inferior aspect of the wound. I probed this, and it tracks superiorly about four centimeters. There is no deep tract. This all just tracks .superficially under the wound. The wound packing was removed. There is no active drainage. There is no odor. There is no surrounding erythema. **Assessment and Plan:** Patient status post laparoscopic cholecystectomy and mini laparotomy with lysis of adhesions by Dr. Ruben on 08/04/YYYY. She had a complicated postoperative course and was readmitted to the hospital two days later in septic shock. She was taken back to the operating room and found to have perforated small bowel, which was resected. She had a complicated hospital course but is now at rehab and improving. She is not on any further antibiotics. She does have an opening in her wound, which is clean, and they are doing the packing changes every three days. The tract started out as nine centimeters and is now down to four centimeters. She will continue local wound care. As far as the swelling in her right upper extremity and this tender mass at her antecubital fossa, we will get her set up with the Vascular Lab today for a Doppler ultrasound to rule out a DVT. She does have a history of blood clots but has been on subcutaneous Lovenox for prevention of DVT and has continued on this at rehab. We will plan to see her back in the office in two weeks.	8782, 8820
09/11/YYYY	Hospital/ Provider Name	**Orders:** Cleanse irrigate abdominal wound with NS then pack with ___ cover with dry gauze, secure with transparent film every 3 days and as needed. May apply new drape daily to abdominal wound with dry gauze, transparent film	6730
09/11/YYYY	Hospital/ Provider Name	**Nursing notes:** Seen by surgeon today with new order for abdomen with primary - AFM changed every 3 days, secondary daily with dry gauze and transparent drape. Daughter aware of findings.	6711

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/11/YYYY	Hospital/ Provider Name	**Physical Therapy Progress notes:** **Reviewer's comment: Physical therapy initial evaluation is not available for review* **Skilled services Provided since Last Report:** Higher level challenges introduced this week in Gait distance, progressed to 200 feet with SBA and noted mild path deviation. Incorporated Compliant surfaces into Balance challenges to improve proprioception and dynamic postural perturbations for facilitation of righting precautions. Initiated stair training in parallel bars, initially with B rails progressed to 1 rail (2 hand technique), with increase in step height and number. Instructed patient in standing and sitting therex program, 2# cuff weights used LEs in sitting.	6734-6735
09/11/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief complaint:** Possible DVT **History of present illness:** Patient presents today at the kind request of Dr. David Ruben for evaluation of right upper extremity suspected DVT. She was recently hospitalized for over a month secondary to complications after a hernia repair and cholecystectomy. She did have a PICC line in a couple of different places in her right arm during her admission. She states that her arm has been swollen for a few weeks now, but got worse a couple of days ago. She also reports that she had several episodes of blood clots in her right arm, but isn't sure whether they were DVTs or SVTs. She does not remember being on Coumadin at the time. **Review of systems:** Admits right shoulder or arm pain **Physical examination:** Edema present in right upper extremity **Assessment:** Edema, extremities Limb pain DVT, upper extremities Phlebitis/Thrombophlebitis of upper extremities Her DVTs are almost certainly related to the recent PICC lines she has had in her right arm, and do not require any further hematologic work up. She will be treated with oral anticoagulation using Xarelto beginning today. We will perform a surveillance ultrasound of her arm in 6 weeks to ensure progression towards resolution. **Plan:** Ultrasound on 10/23/YYYY	8834-8837
09/11/YYYY	Hospital/ Provider Name	**Upper Extremity Venous Duplex Scan:** **Indication:** Edema, limb pain	8838

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impressions: 1. Upper extremity venous duplex examination utilizing 8-mode, color flow and spectral doppler. 2. Acute deep vein thrombosis in the right brachial vein. 3. Superficial vein thrombosis in the right basilic vein. 4. No dilatation with partial compressibility in the right axillary vein suggest evidence of chronic deep vein thrombosis.	
09/12/YYYY	Hospital/ Provider Name	**Nursing notes:** Patient is alert and oriented x4, able to make needs known verbally. Received Xanax 0.25mg 1 tab and Zofran 4mg tablet. Patient refuses Florastor caps as ordered. Dr. Kalu called at 11:15 pm on 9/11/14 to enquire about patient condition and also gave some orders. Dr. Kalu NP requested that the nurse advised patient the need to go to the ER to evaluate for possible PE. Dr. Kalu was concern about patient heart rate and the fact that patient has blood clot in her right arm. MD also ordered for Xarelto 15 mg twice daily with meals for 21 days. After that change to 20 mg every evening with meals, and also wanted patient to be on O2 2L. Patient initial PR was 120, heart sounds was without murmur, but was tachy. Checked VS again, BP 106/68, pulse 104, resp. rate 20, temp 97.4, O2 sat 96%. Patient refused to go to the ER stating she is fine and will not go to the ER. Patient refused to be on oxygen. Patient said "her HR always go high when she anxious", and said her O2 sat is ok. Called her daughter at 11:20 pm to notify her about the MD decision and how patient is refusing to go to the ER. Will continue to monitor.	6711
09/12/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Results:** Examination demonstrates no mediastinal shift. There is no acute alveolar/interstitial infiltrate, consolidation, CHF, mass or pneumothorax. The cardiac silhouette, costophrenic angles and hemidiaphragms are intact. The aorta appears to be unremarkable. The thoracic spine is within normal limits. No active tuberculosis. **Conclusion:** No acute cardiopulmonary disease. No active tuberculosis.	6721
09/15/YYYY	Hospital/ Provider Name	**Case Management Meeting Notes:** Patient has requested to discharge on 9/16. Patient has been working on strengthening in her lower extremities. Patient has to ambulate 40 steps to her bedroom. Patient will discharge back to her home with her children with home health referral for PT/OT to evaluate and treat, nursing for wound care and pysch nurse for high anxiety. Patient also will receive DME 3-in-1 commode.	6676
09/15/YYYY	Hospital/ Provider Name	**Nutritional Assessment:** **Nutrition diagnosis:** PES statement: Inadequate oral intake related to recent small bowel resection with decreased appetite as evidence by average intake is 58% of meals, 19#, 13% significant weight loss per patient. 2. Nutrition Interventions	6677-6678

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		1. Ensure in place thrice daily - Recommend change order to house supplement thrice daily 2. Recommend MVI daily 3. Monitor and encourage per oral intake 4. Monitor weight for changes **Additional Information:** Average intake is 58% of meals on regular diet. CBW is 126#, BMI is 23 which is WNL. Weight loss of 2# since admission. UBW per patient prior to hospital was 145# which is a significant weight loss. Patient has a surgical wound to abdomen and gluteal tear per wound care nurse. Meds rev including Florastor (probiotic). Labs rev included low albumin 2.8. Ensure ordered TID. Ensure is not currently on facility formulary. Recommend change Ensure order house supp TID.	
09/15/YYYY	Hospital/ Provider Name	**Orders:** Discharge to home with Home Health PT/OT, nursing for wound care, Psych nursing DME – 3 in 1 commode	6729
09/16/YYYY	Hospital/ Provider Name	**Nursing notes:** Resident awake and alert. Resident offer no complaints of pain/discomfort. Resident had meds without difficulty. Resident discharge home today with daughter today. Resident given four days of meds to take home with her. Nurse went over discharge instructions with resident. Resident states understanding. Resident expresses no new concerns at this time.	6711
09/16/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Admission date:** 09/06/YYYY Patient has requested to be discharge on 09/16/YYYY. Patient received PT/OT with progression. Patient will discharge home with Home Health PT/OT to evaluate and treat, nursing for wound care and Psych nurse for anxiety. Patient will received DME 3 in 1 commode. **Nutritional status:** Regular as tolerated Alert and oriented, able to make needs known without difficulty, exhibits anxiety, no behaviors, family supportive and involved in care planning. **Plan of care:** Patient will discharge home with children. Patient will receive Home Health PT/OT/Nursing. Patient will receive DME 3 in 1 commode. Patient will follow up with her PCP for health and medication management.	6740-6741, 6727
09/06/YYYY-09/16/YYYY	Hospital/ Provider Name	**Other records:** Plan of Care, Labs, Nursing Notes/Records, Minimum Data Set (MDS), Orders, Admission Record, Social Service Records, Vaccination/Immunization, Assessment, Medication Sheets	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		PDF-Ref: 6606-6625, 6631-6633, 6728, 6627-6630, 6634-6675, 6739, 6679-6720, 6726, 6722-6724, 6602-6603	
09/18/YYYY	Hospital/ Provider Name	**Home Health Initial Nursing Visit Note:** **Intervention provided:** 1. Treatments provided on this visit per physician orders **Details/comments:** Abdominal wound cleansed with normal saline 2. Instruct patient/caregiver on signs and symptoms of disease that require immediate attention. 3. Instruct patient/caregiver on usage and side effects of medication to ensure patient is safe until next visit. 4. Instruct patient/caregiver on nutritional/hydration requirements as diet prescribed by physician. 5. Instruct on basic use of assistive devices to ensure patient is safe until next visit 6. Instruct patient/caregiver in emergency contacts and phone numbers. 7. Instruct on environmental safety issues to resolve immediate safety issues or concerns. 8. Instruct patient/caregiver on service authorization, advance directives, rights and responsibilities, and rights of the elderly and obtain necessary signatures. 9. Discussed plan of treatment, frequency, and disciplines with patient/caregiver. 10. Explore current interventions for patient with signs/symptoms of depression, and make appropriate referrals or inquiries.	6802-6807, 7386-7388
09/19/YYYY	Hospital/ Provider Name	**CT pulmonary angiogram:** **Impression:** CT evidence for a pulmonary embolus. Small left pleural effusion with left basilar atelectasis. Results were called to Megan, Dr. Ruben's Physician Assistant. at 1:15 pm	8822-8823, 8839
09/20/YYYY	Hospital/ Provider Name	**Home Health Physical Therapy Initial Evaluation:** **Assessment:** Difficulty transferring Ambulation difficulties Unable to leave home without assistance Generalized weakness Impaired gait/endurance Pain: 5/10 Location: Generalized abdomen, chest Aching quality **Assessment/plan:** Patient recently discharged from subacute rehab. She is status post abdominal hernia repair and cholecystectomy. During the hospital course she had a bowel perforation and septic shock. She also had a RUE DVT. No BP from RUE. She complains of right lateral thoracic pain. PLOF – independent ambulatory and	6795-6801

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		transfer. The patient presents with decreased functional mobility - SBA sit to stand; decreased gait - SBA amb xsoft without AD, CGA up/down 1 flight of stairs. BLE = WNL. She is at minimum risk for falls as evidenced by Tinetti assessment score of 24/28. Patient could benefit from skilled physical therapy for therapeutic exercise, therapeutic activity, and gait training on level surfaces and stairs, 1w1, 2w4.	
09/22/YYYY	Hospital/ Provider Name	**Home Health Occupational Therapy Initial Evaluation:** **Assessment:** Ambulation difficulties Unable to leave home without assistance Generalized weakness Impaired gait/endurance Pain: 4/10 Location: Thoracic spine Aching, throbbing quality **Assessment/plan:** Patient with abdominal hernia repair and cholecystectomy, had complications with bowel perforation and septic shock and then had RUE DVT, had rehab and discharged home with daughter. Patient lives in independent living with wife. Patient lives in 3 level home with bedroom on 3rd level. Patient independent with ADLs, ambulatory with no device and driving. No significant pas tmedical history. Patient presents with decreased endurance and fatigues easily. RUE has DVT, slight swelling and will contact Dr. regarding clarification of orders for movements. Patient with clutter everywhere and daughter instructed in risk for falls. Patient requires assist with steps to go to bathroom and requires CGA. Patient with SBA for shower. Patient with weak upper body and requires assist with meals. Patient will benefit from OT 2w4 for ADL retraining, therapeutic exercises, HEP and safety and patient education. Patient in consent with POC.	6781-6788
09/24/YYYY	Hospital/ Provider Name	**Home Health Initial Psychiatry Visit note:** **Narrative:** Patient was seen for the conduction of a psychiatric nursing evaluation. On meeting with patient, she was instructed as to the components of this evaluation, the possible findings and potential plan of care. Patient verbalized her understanding of these instructions and was agreeable to having the evaluation done. Patient was encouraged to verbalize her thoughts and feelings surrounding her current health status. Patient spoke about having gone to have a cholecystectomy and abdominal hernia repair done this past August 4th. This surgery had resulted in a perforated colon which caused extensive medical complications. Patient also has a right upper arm DVT. She had to spend time in an ICU and then a rehabilitation facility. She was discharged home on 9/16/14. When asked how this had affected her emotionally, patient responded that while in the hospital and in the rehabilitation facility, she had been very depressed and anxious. However since she had gotten home, her mood had much improved and she was no longer depressed. To assess for depression the PHQ9 scale was administered. The results were not	6766-6775

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		indicative of depression and the Hamilton anxiety scale was also administered and this did not indicate any anxiety. Even though patient stated that she believed she was well emotionally, from observation and talking to her at length, it was observed that she was still suffering the after effects of such extensive medical problems. She is still in a weakened physical state and is dependent on her children to assist her with her activities of daily living. Her expression was also somewhat flat and her affect blunted. The role of the behavioral health nurse was instructed to patient in that she would be provided the services of having someone to share her concerns with regarding her emotional state as a direct result of the changes in her physical state. Coping strategies would be instructed as well as medication monitoring done. The disease processes of depression and anxiety would also be instructed and patient would be assessed and evaluated for signs and symptoms of any of these processes. Patient agreed to receiving these services on a weekly basis and was agreeable to the proposed plan of care.	
09/24/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Subjective:** Patient comes into the office for another postoperative appointment. Last week, she called the office complaining of some tightness just under her right breast. This was not associated with any shortness of breath, and she does have an upper extremity DVT. We sent her for a CT/angiogram of her chest just to rule out a PE. The CT was negative for a pulmonary embolism or pneumonia. A Home Health nurse has been doing wound care for her. She has had some intermittent bleeding at the wound. **Objective:** General: She is not in any acute distress. Abdomen: Soft, with diffuse mild tenderness but certainly no guarding or rebound. The opening at the inferior aspect of her incision is approximately five millimeters. This was probed with a Q-tip and does track about five centimeters superiorly. There was some purulent drainage. There is no surrounding erythema. **Assessment & Plan:** Patient continues to improve. She continues with home physical therapy. We do not think she needs Home Health for wound care anymore. We will stop packing the wound to try to get this to close. We have instructed them on local wound care with just probing the tract once a day with some peroxide and keeping this clean in the shower daily. We will plan to see her back in the office in one month for routine follow-up.	8783-8784
09/29/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Assessment and plan:** Constipation Baseline colonic inertia Now status post exp lap for complication from cholecystectomy Will increased her stool softener	7901

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Can use Dulcolax once a day or Milk of Magnesia Started on Polyethylene glycol	
09/23/YYYY-10/08/YYYY	Hospital/ Provider Name	**Summary of Home Health Physical Therapy visits from 09/23/YYYY to 10/08/YYYY:** **Treatment dates:** 09/23/YYYY, 09/25/YYYY, 10/01/YYYY, 10/02/YYYY, 10/08/YYYY	7414-7418, 6776-6780, 6761-6765, 7429-7432, 7424-7428
10/09/YYYY	Hospital/ Provider Name	**Orders:** Per Megan/ Dr. David Rubin, may pack wound with Iodoform or plain packing strip, lightly. SN as needed visit 10/10/14 to teach caregiver in new protocol. **Goal:** Wound will heal without signs/symptoms of infection or other complications.	7459
10/10/YYYY	Hospital/ Provider Name	**Home Health Final Physical Therapy Visit note:** Patient with decreased activity tolerance. She received skilled physical therapy for therapeutic exercise and functional mobility. Sit to stand improved from SBA to mod I. CGA up/down stairs increased to mod I. The patient is instructed in HEP. Long term goals met. Patient discharged to care of daughter.	7460-7469
09/26/YYYY-10/14/YYYY	Hospital/ Provider Name	**Summary of Home Health Occupational Therapy visits from 10/10/YYYY to 10/14/YYYY:** **Treatment dates:** 09/26/YYYY, 09/30/YYYY, 10/03/YYYY, 10/07/YYYY, 10/10/YYYY, 10/14/YYYY	7452-7455, 6756-6760, 6742-6745, 7419-7423, 7404-7407, 7470-7476
10/16/YYYY	Hospital/ Provider Name	**Home Health Final Occupational Therapy Visit note:** Patient received OT 2w4 for ADL retraining, therapeutic exercises, HEP and safety and patient education and ILS skills. Patient demonstrated increase in strength and endurance. Patient normal with ADLs, requires increased time for bathing, patient demonstrated HEP for upper body strengthening with #1 wt and theraband, able to tolerate 15 repetitions with rest breaks. Patient normal kitchen activity and daughter and son makes meals. Patient functioning independently with ADLs and functional mobility. Patient met goals and discharge from OT. Patient in consent with discharge.	7516-7522
10/22/YYYY	Hospital/ Provider Name	**Follow-up Visit:**	8787

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Subjective: Patient comes back status post lengthy hospitalization for perforated bowel secondary to enterolysis and laparoscopic cholecystectomy. Since her last visit, she continues to improve. Her strength is better. She is eating very well. She has gained weight. Her exercise endurance has improved significantly. **Objective:** Her abdominal incision is clean. There is a small sinus tract approximately 4 cm with a narrowing opening that has been packed with Iodoform gauze and not closing. **Impression/Plan:** I think it is time to quit packing this and have her shower once a day and just probe the area with a peroxide-soaked Q-tip to see if it will further closure. I plan on seeing her back in three months.	
09/22/YYYY-10/24/YYYY	Hospital/ Provider Name	**Summary of Home Health Nursing Visits from 09/30/YYYY to 10/24/YYYY:** **Visits made on:** 09/22/YYYY, 09/25/YYYY, 09/26/YYYY, 09/30/YYYY, 10/07/YYYY, 10/10/YYYY, 10/15/YYYY, 10/24/YYYY	6789-6794, 6751-6755, 6949-6953, 7408-7413, 7477-7480, 7447-7451, 7511-7515
10/29/YYYY	Hospital/ Provider Name	**Home Health Final Nursing Visit Note:** Wound location: Midline abdominal Red-moderate to full granulation tissue noted Bloody, scant exudate CG performed care, SN observed wound size and characteristics. Patient anxiety high as wound size is the same. She is to follow up with Kennestone wound center in two days. **Neurologic:** Oriented to place, person, time, alert. Forgetful. Able to follow multi-step commands, simple commands **Functional:** Decreased strength, lower bilateral **Interventions Provided:** 1. Perform comprehensive assessment to include all co-morbidities **Details/comments:** Instructed on disease process, instructed some wounds slow to heal, but keep up protein at each meal, Vit C, fluids. Patient verbalized compliance. 2. Provide/instruct patient/caregiver on incision site care. (all intervention details must be instructed on prior to marking the intervention goal as achieved) **Details/comments:** Reviewed physician's orders for wound care prior to	7506-7510

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		providing wound care. Instructed on signs/symptoms of infection to incision (redness, drainage, odor)	
10/30/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** Right arm swelling **History of Present Illness:** Patient returns for follow up after she was evaluated for PICC induced right upper extremity DVT 6 weeks ago by my partner, Dr. Patel. She was recommended a 3 month course of anticoagulation with Xarelto which she tolerated without bleeding complications, except an episode of minor epistaxis. She did not wear an elastic sleeve. She continues to experience occasional discomfort in her right arm during physical therapy and she notices intermittent swelling in her right arm. She is recovering from her abdominal operation and she still has an open abdominal wound, for which she is undergoing dressing changes. She describes to me recurrent episodes of bilateral lower extremity edema which resolves with leg elevation. She does not wear elastic compressive stockings. **Review of systems:** Admits to right shoulder or arm pain, right leg pain, left leg pain **Physical examination:** **Extremities:** Mild edema, no areas of discoloration in right and left lower extremity **Assessment:** Edema, extremities DVT, upper extremities **Plan:** Compressive stockings, leg elevation. I gave her a prescription for 20-30 mmHg knee high elastic compressive stockings to wear all the time when on her feet. I also gave her a prescription for a right upper extremity elastic sleeve to use during physical therapy. I recommended patient to complete the originally recommended 3 month course of anticoagulation with Xarelto. Return Visit Request in/on 6 weeks +/- 2 days	12797-12799
10/30/YYYY	Hospital/ Provider Name	**Upper Extremity Venous Duplex Scan:** **Indication:** Chronic venous embolism and thrombosis of deep vessels of upper extremities. Edema. Pain in limb. **Impression:** 1. Upper extremity venous duplex examination utilizing 8-mode, color flow and spectral Doppler. 2. Resolution of previous thrombosis of the right brachial and basilic veins.	12795-12796

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. No evidence of acute deep vein thrombosis in the right upper extremity.	
10/31/YYYY	Hospital/ Provider Name	**Wound Care Visit:** Initial visit to wound center. Patient sent by Dr. Berry primary care MD regarding abdominal wound that has not healed since surgery in August. At that time she had lap cholecystectomy with complication of perforated bowel. She became septic and was in AB Hospital for an extended stay. Since coming home she has used advanced wound care such as silver AFM dressings along with wound irrigation and the wound has not closed. Silver nitrate has also been used. Entrance to wound with epithelization along the track. Dr. Reilly here to see patient. Please see note. Patient is going to discuss with her primary care MD regarding possible surgery to close wound. Will either discuss then with general surgeon or seek referral to physician who will evaluate for possible revision. 5 cm track runs just under the skin. Instructed how to flush and wick lightly with silver AFM strip. Her daughter does the dressing changes and has supplies. Will discontinue home health. Patient will contact WTC next week after speaking with MD.	13690-13692
10/31/YYYY	Hospital/ Provider Name	**Wound Clinic Physician Note:** **Subjective:** Patient presents with non-healing midline abdominal incision following emergent exploration for an iatrogenic bowel perforation. This was several months ago. **Objective:** Wound: Small opening in midline incision which probes cephalad about 4 cm directly beneath the incisional scar **Assessment/Plan:** Non-healing sinus tract which has failed local wound care-recommend surgical exploration and possible primary reclosure.	13693
11/07/YYYY	Hospital/ Provider Name	**Plastic Surgery consultation:** **Concern/Interest:** Need to repair a 2.5 inch pocket if bad tissue that did not heal and will not heal. No belly button either. **Current medications:** Xarelto 20 mg Estradiol hormone 1 mg Lyrica 75 mg Stool softeners Zofran 8 mg Wound Location: Abdomen. What have you been using to try to heal wound: Complication from surgery. Onset of Wound: Associated with previous surgery. Previous Wounds: Has not had pressure sores in the past. HPI Wound Notes: Patient had lap gallbladder removal at NSH 1.5 months ago,	8099-8102

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		discharged home. Returned to hospital to discover that her small intestine was perforated during lap surgery. Was septic in ICU at NSH for 14 days (hospitalized for total of 30 days). Now has abdominal wound that won't heal completely. Her PCP referred her to Kennestone Wound Care Center and they referred her to our practice. **Exam Wound Notes:** 12cm indented, painful vertical laparotomy scar adhesed down to fascia with non-healing sinus tract **Assessment/Plan Wound Notes:** Patient with recent history of lap GB followed by inadvertent bowel injury necessitating emergent laparotomy and 70 day ICU stay. Now with 12 cm indented, painful laparotomy scar with non-healing sinus tract. **Need:** 1. For her to finish her course of Xeralto 2. Then go to Dr. Klass for heme workup to rule out hypercoag as she has had 2 DVTs 3. Also get OP note from Northside as suspect infected suture, questionable did they use permanents. **Plan:** Aggressive excision to include any nonviable tissue and/or permanent sutures. Do not plan on reconstruction of umbilicus at this time. **Follow-Up:** Patient was instructed to follow-up as we will begin pre-authorization.	
11/10/YYYY	Hospital/ Provider Name	**Surgery Scheduling Form:** **Medical clearance:** She needs to come off Xarelto and also get heme workup to rule out hypercoagulable state **Hospital:** Kennestone Outpatient Surgery Center (KOP), Kennestone Main OR and Marietta Surgical Center **Anesthesia:** General **Procedure:** B trunk fasciocutaneous flaps Complex repair trunk 12 cm Abdominal wall debridement to include skin, subcutaneous and fascia about 30 sq cm Surgeon: John Symbas, M.D. Date of surgery: 01/05/YYYY	8103-8104
11/14/YYYY	Hospital/ Provider Name	**Telephone Conversation:** Patient called on 11/14/YYYY. Patient's daughter was flushing abdominal wound this morning and the wound wouldn't track as far as in the past and WOCRN was worried that a pocket would form and trap fluid. Patient has teeth cleaned	8105

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		yesterday and the dentist prescribed Amox 500mg TID for gum irritation. No fevers. She wanted JDS to look at her abdomen wound to make sure it isn't infected. Appt made for Marietta Monday at 4:30pm. Patient happy with appt.	
11/21/YYYY	Hospital/ Provider Name	**Office Visit:** **Reason for exam:** At the request of Dr. Pepper and Dr. Symbas for the evaluation of recurrent thromboembolism. **History of present illness:** Patient comes in for the evaluation of several prior blood clots. She states that when she was 18 years old she had a blood clot in her right arm related to an IV. She was sick with nausea, vomiting, and dehydration and got admitted for IV fluids. She then also recalls being told that she had a pulmonary embolus at St. Joseph's Hospital in August of 2011. She does not recall taking anticoagulation and is unclear of the details. She then this year suffered from a small bowel perforation after a laparoscopic cholecystectomy and ventral hernia repair with lysis of adhesions in August. Shortly thereafter she went into septic shock leading to a 70-day-long ICU stay. From the hospital she was discharged to rehab and finally to home. She is still recuperating from the illness. During the hospital stay, her extremities were swollen as per the daughter. After she returned home from rehab her right arm became more swollen than the others and she was sent for an ultrasound. She was diagnosed with a DVT in that right arm in September. She was started on Xarelto and has been following with a vascular surgeon. She states two weeks ago she had repeat ultrasound which showed resolution of the clot. She was told that she could come off Xarelto. She has a residual abdominal wound remaining from her hospital stay. She has met with Dr. Symbas regarding additional surgery to close the area however, given concerns of prior thromboembolism and need of anticoagulation, she was seen for a hematology evaluation and hypercoagulable workup. Patient also reports having had a TIA in the past. She has also had two miscarriages which may be related to a hypercoagulable state. **Review of systems:** Musculoskeletal: Generalized weakness **Physical examination:** Abdomen: Multiple scars. Wound bandaged **Assessment:** Patient has had recurrent thromboembolism. Per her history this has been two right upper extremity DVTs, one episode or pulmonary embolus as well as a TIA in the past. She also has had two miscarriages which may or may not be related. She does not appear to have a strong family history of same. However, she has an extensive personal history which warrants hypercoagulable workup to make further recommendations in the perioperative period for risk reduction. **Plan:**	7960-7963

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		1. Labs and hypercoagulable workup ordered 2. Obtain her right upper extremity Dopplers from September and November of this year as well as the vascular surgeon's notes and recommendations 3. I would recommend Xarelto for treatment doses for three months from the time of diagnosis for her recent clot however, thereafter she may need prophylaxis. 4. Recommendations regarding upcoming surgery once the above is complete.	
11/27/YYYY	Hospital/ Provider Name	**Lab report:** Anti-thrombin III panel – Normal Factor V Leiden – Mutation not detected Factor VIII activity – Normal Fibrin monomer – Negative Lupus anticoagulant – Not detected MTHFR – Positive for two copies of C677T variant Phospholipid – Negative Protein C activity & antigen, Protein S activity & antigen – Normal Prothrombin G20210A – Mutation not detected Prothrombin fragment, antiphospholipid Ab panel, Cardiolipin Ag, Phosphatidylserine Ig – Normal	7964-7975, 2583-2584
12/01/YYYY	Hospital/ Provider Name	**Wound Care follow up visit:** Patient arrived with daughter with dressing intact, worried that her wound is infected. No signs and symptoms of infection noted. Irrigated wound. Karen in to see to be able to tell patient there is no worsening. Packed with tritec silver and covered with 4x4s and secured with tape. Patient is having this wound excised by Dr. Symbas in a week and a half. POC: Continue daily dressing changes and call if need us. Site: Red Periwound: Intact Length: 0.2 cm Width: 0.2 cm Depth: 5 cm (goes to 11:00 straight under skin, no real depth) Drainage: Moderate, serosanguineous Treatment: Irrigation, silver dressing	13689
12/03/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Coag labs reviewed with Dr. May. + MTHFR variant not known to produce significant risk for thromboembolism or stroke, all other labs WNL. Per MD; In view of history of multiple events patient should take Xarelto 20 mg daily x 14 days post op for risk reduction thromboembolic event. She should start this 24 hrs post op if she has no significant bleeding. She should switch to baby Aspirin 81 mg daily when Xarelto complete for lifetime risk reduction and begin prescription or OTC Folic acid 1 mg daily for MTHFR variant risk reduction. All of this has been explained to patient in detail. Prescription for Folgard and Xarelto has been sent to her pharmacy. Copy of this note and MD note, labs will be sent to vascular surgeon and plastic surgeon. Copy or labs and this note will	7907

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		be mailed to patient. Patient has no further questions or concerns at this time. She will contact our office if she needs follow up appt.	
12/04/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** Right arm swelling **History of Present Illness:** Patient returns for follow-up. Her right upper extremity swelling has resolved. She continues to experience swelling in both her lower legs for which she is able to obtain some control using the prescribed elastic compressive stockings. She experiences intermittent throbbing pain in a bulging varicose vein located on the medial aspect of her right distal thigh. She finished her anticoagulating treatment with Xarelto 4 days ago. She did not have any bleeding complications. Reportedly she was evaluated in the hematology clinic and she was found to have a procoagulant condition. She was prescribed lifelong treatment with Aspirin for this. At this point she is undergoing preparation for delayed primary closure of her abdominal wound. **Review of systems:** Admits to swelling of legs, ulcers or wounds **Physical examination:** Right Lower Extremity: Mild ankle edema, no areas of discoloration, bulging varicose vein on the medial aspect of the distal thigh. Left Lower Extremity: Mild ankle edema, no areas of discoloration **Assessment:** Edema, extremities Limb Pain History of DVT **Order:** Venous reflux study – bilateral (Future order) **Plan:** Compressive stockings, leg elevation I advised patient to continue with the medical treatment recommended in the hematology clinic. I advised her to continue to wear the prescribed elastic compressive stockings all the time when she is on her feet. I also advised her to take the stockings with her in the hospital during the perioperative period of her delayed primary closure of the abdominal wound. I will plan to see her in follow-up in 3 months with a bilateral lower extremity venous duplex ultrasound reflux study.	12800-12802
12/08/YYYY	Hospital/ Provider Name	**Office Visit:** **History of present illness:** Patient words: Discuss wound care surgery	7896-7899

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		She has non-healing abdomen wound from her abdominal surgery in 8/14. She has seen plastics. Awaiting surgery on Thursday. Also noted to have DVT/PE/miscarriages over time, I was not aware of this saw heme for eval. Is awaiting labs for hypercoag workup. Still deconditioned from her hospital stay. Feels too tired to do exercises. Wants to go PT to help with balance, extremities strength, stamina. Very anxious no overt panic attacks but needing Xanax daily. Persistent worry and perseveration. Reliving the events of her traumatic hospital stay. Lives with hightened anxiety. Financially devastated, doesn't want to ask for help. Lives with son and daughter. Daughter is major support. Not sleeping well. **Medications:** Alprazolam 0.5 mg Lyrica 75 mg Zofran 8 mg ProAir HFA Fioricet **Review of systems:** **Gastrointestinal:** Diarrhea (normally moves bowels 1/week, now having liquid stools every other day, grainy, no blood or mucous). **Psychiatric:** Depression. **Physical examination:** **Abdomen:** Midline vertical incision healed except sinus tract at level of umbilicus that tracks superiorly, is packed. Palpation and percussion of the abdomen reveal no rebound tenderness, no rigidity (guarding) and no palpable abdominal masses. **Assessment and plan:** 1. Anxiety - She has tried multiple SSRI's and could not tolerate. She is taking low dose Xanax daily. She is very nervous about upcoming surgery. I think that she would benefit from counseling. She is having PTSD symptoms which is hightening her anxiety. 2. Physical deconditioning - Following 42 days of hospital/rehab stay. Will send her to PT 3. Diarrhea - Given her recent exposure to multiple antibiotics, will check for infx/ C. diff. Stool culture ordered 4. Fatigue – Check labs. Ordered Vitamin B12 5. Deep vein thrombophlebitis of arm – Will get labs from Kelly May. Patient has been told that she will need lifelong Aspirin and Folgard	
12/10/YYYY	Hospital/ Provider Name	**Office Visit:** **Assessment and plan:** Clostridium difficile diarrhea Started on Vancomycin 125 mg every 6 hours, 14 days starting 12/10/YYYY.	7895
12/12/YYYY	Hospital/ Provider Name	**Office Visit:** **Assessment and plan:** Unspecified diagnosis	7894

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		Started on Flagyl 500 mg thrice daily	
12/23/YYYY	Hospital/ Provider Name	**Follow up Visit:** **History of present illness:** Not feeling well. Recently diagnosed with C. diff. On Vancomycin and Flagyl. Past couple of days has been very foggy, sedated. Loss of appetite. Last stool was 10 am yesterday morning has not gone since then. Also has viral syndrome. Feels weak. Muscle aching. Tired. Generally overwhelmed with her health problems. Here with her daughter who is her main support. **Medications:** Zofran 8 mg Polyethylene glycol 3350 Flagyl 500 mg Fioricet Vancomycin 125 mg Alprazolam 0.5 mg Lyrica 75 mg ProAir **Assessment and plan:** 1. Clostridium difficile – Will stop Flagyl; continue Vancomycin. She is improving 2. Abdominal pain, generalized - Stool in the vault with 1 air fluid level KUB X-ray, acute abdomen series 3. Urinary frequency/polyuria 4. Myalgia 5. Vitamin B12 deficiency 6. Allergic rhinitis	7891-7893, 8734-8735
12/23/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** Non-specific small bowel gas pattern. Diffuse clips from CCX/HYS and bowel resection. Moderate fecal debris. No abnormal masses or calcification. Several ovoid densities left lower abdomen, undigested pills questionable 1 cm density projects over lower left kidney, possibly in lower renal calyx. No acute process.	7959
12/26/YYYY	Hospital/ Provider Name	**Visit note:** Patient here to meet with JDS and resign consents. Consents signed and verbalized understanding.	8108
12/29/YYYY	Hospital/ Provider Name	**Office Visit for diarrhea:** **Assessment and plan:** Diarrhea – Given her recent exposure to multiple antibiotics, will check infection/C. diff Stool culture ordered	7890
12/31/YYYY	Hospital/ Provider Name	**Office Visit for nausea:** **Assessment and plan:**	7889

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Nausea – Will continue Zofran. Started Zofran 8 mg every 8 hours as needed	
01/05/YYYY	Hospital/ Provider Name	**Telephone Conversation:** Patient called on 115/YYYY. Patient called this morning to let us know her prelim C. diff report was negative last week, but she has had diarrhea all weekend. JDS notified and will proceed with surgery today as scheduled.	8109
01/05/YYYY	Hospital/ Provider Name	**Operative Report:** **Date of admission:** 01/05/YYYY **Date of operation:** 01/05/YYYY **Preoperative and postoperative diagnosis:** Complex abdominal wound, chronic abdominal wound. **Operation Performed:** 1. Bilateral trunk fasciocutaneous flaps. 2. Abdominal wall debridement skin, subcutaneous tissue and fascia, 30 cm2. 3. Complex closure anterior trunk 12 cm. **Estimated Blood Loss:** Minimal. **Procedure in detail:** The patient was brought to the operating suite. SCDs were placed. General anesthesia was induced. The abdomen was prepped and draped in a sterile fashion. Time-out was performed. The patient's surgical sites were correctly identified. I began by placing a Q-Lip inside the chronic draining sinus with Methylene blue. A generous amount of skin was marked out in an elliptical fashion from her xiphoid down to her pubis measuring at least 12 x 7 cm. This ellipse was incised with a 10 blade and carried down to healthy fascia using Bovie electrocautery. This wedge of tissue was excised towards the midline at the level of her abdominal wall fascia. As we encountered the midline a significant amount of scar tissue was encountered in the midline to be expected from her prior laparotomies. The scar tissues was excised, but her fascia was left intact. The chronic wound that was laden with methylene blue was excise in its entirety. No obvious stitch or foreign material was noted at the bottom of it, only nonviable scar tissue which was excised, again in its entirety, leaving the fascia intact. The wound was then irrigated out copiously with triple antibiotic solution. Multiple level intercostal nerve blocks were then performed with a total of 20 mL of 0.5% Marcaine with Epinephrine. The abdominal wall tissue was elevated just below the Scarpa fascia and above the level of the muscular fascia bilaterally to obtain a tension-free closure in the midline. These fasciocutaneous flaps were a gain advanced towards the midline and briefly stapled into place. Hemostasis was maintained meticulously. The skin was reprepped with Betadine, as was the wound. My gloves were changed and closure proceeded in 3 layers with interrupted buried 2-0 Vicryl pop-offs in Scarpa's fascia , followed by 2 layers of 3-0 Monocryl suture and a fourth layer of Dermabond and paper tape. The patient tolerated the procedure well and was awakened from anesthesia and brought to the PACU in stable condition.	8096-8098

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
10/01/YYYY-01/07/YYYY	Hospital/ Provider Name	**Summary of Home Health Psychiatry Visits from 10/01/YYYY to 01/07/YYYY:** **Treatment dates:** 10/01/YYYY, 10/08/YYYY, 10/15/YYYY, 10/30/YYYY, 11/05/YYYY, 11/13/YYYY, 11/25/YYYY, 12/02/YYYY, 12/18/YYYY, 01/07/YYYY	7433-7446, 7481-7504, 7389-7403, 7360-7385
01/12/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** HFU C. diff, patient is taking oral Vancomycin 250 mg every 6 hours. Patient complaints of soft stools that are forming 4-6 a day. **History of present Illness:** Patient presents today for follow-up from hospitalization at Northside Atlanta for acute clostridium difficile diarrhea and wound infection, discharged on 09/04/YYYY. She had been experiencing diarrhea and wound drainage. She reports the symptoms are resolved. She reports the problem is aggravated by activity, eating, and friction. She reports that the process has been improved by antibiotics, adherence to therapy, time, and surgical revision of the midline abdominal wound. Work-up of the issue to this point has included cultures. Cultures have included stool culture. Results are notable for a C. difficile. She is taking therapy with oral Vancomycin. She is not having any side effects. She feels that overall she is doing better. She denies additional or new problems. She has been very emotional and distressed by her hospitalization and experience of rehab. She is slowly getting better, but still affected by her experience. She thinks het stools are getting better and wants to know how to keep it from returning. **Medications:** Estradiol Florastor 250 mg Lyrica 75 mg Vancomycin 250 mg Xanax 0.5 mg Xarelto 20 mg Zofran 8 mg **Review of systems:** Admits to loss of appetite, nausea, vomiting, diarrhea, anxiety **Assessment:** 1. Clostridium difficile colitis Recurrence after oral antibiotics for abscessed tooth. Stopped after antibiotics ended, tested by her primary and found to have C. difficile although her stools were starting to have form again at that point. Taking oral Vancomycin and feeling better.	229-231, 7955

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		Plan: Complete planned Vancomycin. Resume probiotics for at least 6 months. To call our office if she needs antibiotics for any indication in the next year. 2. Postoperative wound infection Status post revision of her abdominal wound. No present concern for infection. **Plan:** To follow-up with her surgeon as directed. Follow wound care directions to the letter. Follow up with me if fails to heal or signs of infection.	
01/13/YYYY	Hospital/ Provider Name	**Plastic Surgery Follow-up Visit:** **Subjective Evaluation:** Patient is status post wound 8 days ago at Dr. Symbas. The surgery date was 1/5/YYYY. **Plan:** Doing well one week out. Too early to trim sutures. Would like to see her get back to enjoying life.	8110
01/15/YYYY	Hospital/ Provider Name	**Home Health Final Psychiatry Visit Notes:** **Assessment:** Cognitive/Behavioral: Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. Depression screening: PHQ-2 screen: Total score 4 **Pain scale:** Generalized abdomen pain 5/10, dull Total somatic score 13 Total psychic score 15 Total Hamilton anxiety scale score 28 – Severe **Interventions:** 1. Perform comprehensive assessment to include all co-morbidities **Details/comments:** Balancing activities and need for frequent rest periods. Instructed on when to report to nurse/physician. Instructed on medication regimen, side effects/desired effects, potential interactions and refill process. Instructed on disease process. 2. Assess patient for symptoms of generalized depression and items that trigger depression **Details/comments:** She admitted to feeling overwhelmed due to her lengthy illness and this in turn causes her to feel depressed. 3. Psych RN instruct patient/caregiver on identification of stressors and techniques for relaxing and reducing stressors. **Details/comments:** Assessed for implications of ineffective stress coping on patient's physical, spiritual and mental wellbeing. Assessed for skills for coping with stressors. Assessed for implementing relaxation techniques. Monitored effectiveness of relaxation and stress reduction techniques. Explored possible therapeutic approaches of supportive counseling. Instructed on pharmacological agents to reduce stress.	7346-7359

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		Instructed on problem solving techniques. Instructed on non-pharmacological relaxation techniques.	
01/26/YYYY	Hospital/ Provider Name	**Office Visit:** Stools are more solid. Finished Vancomycin 2 weeks ago. **Anxiety/depression:** Hopelessness is none. Seeing Dr. Blue (counselor) once a week. Joined support group (Sepsis Alliance). They have talked about extreme fatigue. She is not able to work again. Still having chest wall pain. She is hurting when she takes a deep breath. No cough or wheeze. Started after her hospital stay. **Medications:** ProAir HFA Flonase Fioricet Lyrica 75 mg Xanax 0.5 mg Zofran 8 mg Polyethylene glycol **Assessment and plan:** 1. Dysuria 2. Vaginitis 3. Vitamin B12 deficiency 4. Costochondritis 5. Urinalysis abnormality	7886-7888
02/06/YYYY	Hospital/ Provider Name	**Office Visit:** The patient is here for a follow up of their fibromyalgia. The patient is feeling poorly, complaining of a lot of pain and achiness. She is having a lot of pain x 3-4 months. The patient complains of abdominal pain, difficulty concentrating at times, fatigue at all the time. Poor sleep, headaches, jaw pain (status post jaw surgery in her 20's), memory impairment, paresthesias (left hand), sleeping poorly and weakness (hands), but denies depression x 1 week with the pain, restless legs or stress (manageable). The pain is described as being located in the entire body (muscles and joints), neck upper shoulders elbows, hands and knees. The stiffness is located in the entire body (generalized), hips and knees. The swelling is located in the hands, ankles and feet. The stiffness is generally worse in the morning and is a problem for minutes (30). They exercise 0 times per week. The patient has difficulty arising from chair, difficulty in walking and difficulty in climbing stairs but does not have difficulty turning doorknobs (decreased strength in hands). Note for "Follow up Fibromyalgia": Patient was hospitalized 32 days and then rehab 11 days - due to sepsis **Medications:**	7881-7885, 7954

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ProAir HFA Flonase Fioricet Lyrica 75 mg Xanax 0.5 mg Zofran 8 mg Polyethylene glycol Cyanacobalamin Fluticasone propionate Metronidazole 0.75% gel vaginal Florastor Aspirin 81 mg Biotin Estradiol-Norethindrone acet **Impression and plan:** 1. Fibromyalgia 2. Knee pain 3. Drug monitoring 4. Vitamin B12 deficiency	
02/10/YYYY	Hospital/ Provider Name	**Plastic Surgery Follow-up Visit:** **Subjective Evaluation:** Patient is status post wound 5 weeks, 1 day ago at Dr. Symbas. The surgery date was 1/5/YYYY. Patient is pleased. Patient has no complaints.	8111
02/27/YYYY	Hospital/ Provider Name	**Cardiology office visit:** **Chief Complaint:** Follow up after lap chole and subsequent septic shock from rupture bowels, then C. diff, having palpitations **Subjective:** Patient not seen since 2011 with history of atypical chest pain, has had a horrible 2014 when she had a lap chole and ruptured her bowels and then was hospitalized at NSH for 30 days, has had 3 surgeries for this since, last one 1/YYYY for wound closure. She is having a lot of left shoulder pain radiating to her back, intermittent, but having more palpitations that bother her, she hurts all over and is very stiff, her fibromyalgia is much worse, she is more forgetful, not back to work yet, has some mental deficit since this. She had been on Xarelto due to upper arm DVT and just got off Xarelto and only on Folgard and Aspirin per her hematologist. She had a negative CTA for PE in 9/YYYY. **Medications:** Alprazolam 0.5 mg Aspirin 81 mg Clotrimazole topical Flexeril 10 mg Multivitamin with minerals	307-311, 621, 629

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		Zofran 8 mg Lyrica 75 mg Florastor **Impression:** 1. Chest pain and SOB Suspect this is all related to her illness I suspect her heart is good with all this recent stresses I do want to do a structural heart evaluation to make sure no residual damage from her septic shock and to look at her valves She is due for a STL too 2. Palpitations Monitor for now If worsen then CER or Holter	
03/02/YYYY	Hospital/ Provider Name	**Office Visit:** **Assessment and plan:** Diarrhea Given her recent exposure to multiple antibiotics, will check for infection/C. diff **Plan:** C. diff toxin/GDH with reflex	7880
03/05/YYYY	Hospital/ Provider Name	**Follow-up Visit for leg swelling:** **History of present illness:** Patient returns for follow-up. Since her last visit in the clinic she underwent delayed primary closure of her open abdominal wound with good result. She continues to wear the prescribed elastic compressive stockings all the time when she is on her feet with good control of her lower extremity swelling. Her right upper extremity swelling has resolved. She does not have any significant pain in her right upper extremity or in her lower extremities. **Review of systems:** Admits for decreased ability to see, nausea, diarrhea, abdominal pain, blood in stools, ulcers or wounds, headache, dizziness, numbness or tingling, loss of balance or coordination, problem speaking, neck pain, left shoulder or arm pain, back pain, painful joints, anxiety **Physical examination:** Right Lower Extremity: Mild ankle edema, no areas of discoloration, bulging varicose vein on the medial aspect of the distal thigh. Left Lower Extremity: Mild ankle edema, no areas of discoloration **Assessment:** Edema, extremities Rule out venous insufficiency **Plan:** Compressive stockings, leg elevation I will see her in follow-up in 6 months to assess her progress with elastic	12803-12805

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		compressive therapy.	
03/12/YYYY	Hospital/ Provider Name	**Follow-up Visit for diarrhea:** **Chief complaint:** Follow-up for C. diff, patient complaints of diarrhea 4 times a day and dental abscess on gums. **History of Present Illness:** Patient presents today for scheduled follow-up of recurrent clostridium difficile diarrhea, after a last appointment on 01/12/YYYY. She had been experiencing diarrhea and wound drainage. She reports the symptoms are resolved. She reports the problem is aggravated by activity, eating, and friction. She reports that the process has been improved by antibiotics, adherence to therapy, time, and surgical revision of the midline abdominal wound. She is not taking therapy with any antibiotics, She feels that overall she is doing better. She reports that her dentist is not comfortable treating her any longer, and that she has an ulcer on her gums and may have an abscessed tooth. **Review of systems:** Admits to headache, dental problems, sore throat, diarrhea, anxiety, depression **Assessment:** 1. Clostridium difficile colitis No symptoms consistent with recurrence. No antibiotic exposure with her. Suspect modest post-inflammatory irritable bowel like symptoms. **Plan:** Double or triple probiotics if one time dose of antibiotics required for dental work. To have new dentist call if longer antibiotic course required. 2. Postoperative wound infection Status post revision of her abdominal wound. No present concern for infection as incision is fully healed. **Plan:** To follow-up with her surgeon as directed. 3. Aphthous ulcer of mouth	232-234
03/25/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Depression/anxiety 4th day in a row where she has not been crying. Generally concerned about recovering from sepsis. She has PTSD from this experience, seeing Richard Blue for counseling, she likes/trusts him. Has not done well on SSRI/SNRI therapy in the past, doesn't want to do this. No active SI/HI. Fibromyalgia is flaring, has gained 20# on the Lyrica, is being weaned off by Fishman (Per patient). She is worried about constipation on traditional pain meds. **Medications:** Alprazolam 0.5 mg Flonase Cyanocobalamin	7874-7879, 8730-8731

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		Fioricet Polyethylene glycol Aspirin 81 mg Metronidazole gel 0.75% vaginal Zofran 8 mg Florastor Biotin Estradiol-Norethindrone Vitamin D Kril oil Folgard **Assessment and plan:** 1. Sepsis - dealing with consequences of this: psychosocial, metabolic, infectious (C. diff). She has good support from her medical team, family, counselors. We discussed antioxidant diet. 2. Joint pain, multiple - Due to fibromyalgia. She is going to PT. Cannot tolerate Lyrica or SSRI/ SNRI therapy. Will try Ultram. 3. Vitamin B12 4. Malnutrition – She wants to check for vitamin deficiency	
03/27/YYYY	Hospital/ Provider Name	**Echocardiogram:** **Summary/conclusions:** 1. Left ventricular ejection fraction is 60% 2. Mild mitral valve regurgitation. **Left Ventricle:** The left ventricular size is small measuring 3.6 cm. LV ejection fraction is 60%. **Left Atrium:** Left atrial cavity size is normal. **Right Ventricle:** Normal right ventricular size and wall thickness. Global right ventricular systolic function is normal. **Right Atrium:** The right atrium is normal in size. **Mitral Valve:** A mild degree of mitral valve regurgitation is seen by color flow Doppler. **Aortic Valve:** The aortic valve is tricuspid. No aortic valve insufficiency. **Tricuspid Valve:** Trace tricuspid regurgitation is detected. The tricuspid regurgitant velocity is 1.74 m/s, and with an assumed right atrial pressure of 10 mmHg, the estimated right ventricular systolic pressure is normal at 22.1 mmHg. **Pulmonic Valve:** There is mild pulmonic valve insufficiency. **Aorta:** The aortic root size at the level of the Sinuses of Valsalva is not well visualized. **Pericardium:** No pericardial effusion seen.	13009-13011, 13006-13008, 13012-13023
03/27/YYYY	Hospital/ Provider Name	**Cardiac Stress Test:** **Interpretation** Ischemia: Normal. Exercise Tolerance: Fair. BP Response to Exercise: Appropriate. Ectopy: Insignificant Arrhythmia.	643-644, 630-640

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03/31/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief Complaint:** Follow up History of dyspepsia, constipation **History of Present Illness:** She and her daughter are here to establish care again with me and has been referred by Dr. Kara Pepper of Laureate Medical Group. She had a complex hospital course after her surgery in August. She had a planned cholecystectomy and hernia repair and she states she had sepsis and was in the ICU and then went to the floor and rehab. She states she has not felt great and her daughter and her son have been helping with her care. Patient states she has developed anxiety and PTSD and is seeing a psychologist and is still trying to recover. She became a bit tearful and stated, "I feel broken". She complaints of generalized anxiety, weakness, memory issues, joint pains. She had C. diff infections x3. She was treated by Dr. McMillan of ID who mentioned fecal transplant if she get another infection. She was last treated with Vancomycin. She has no further diarrhea. She has outpatient physical therapy and had a right arm clot and is now off Xarelto but on Aspirin and Folgard. She sees her fibromyalgia physician, Dr. Fishman was ok with her weaning of Lyrica. She does take Ultram. In terms of her digestive system she was doing great but now complaints of some reflux, bloating and she is moving her bowels daily but complaints of raisin like stools and she was worried a bit about this. She is not on any narcotic medications and is trying a natural approach with healthy diet and avoiding medications that she does not need. She denies nausea/vomiting, heartburn, dysphagia, hematochezia. **Physical examination:** **Abdomen:** Abdomen soft without rigidity or guarding, abdomen non-tender to palpation, normal bowel sounds, no masses present, non-distended, healed surgical scar **Assessment:** Abdominal pain Constipation Heartburn **Orders:** CT abdomen and pelvis with contrast Zantac 150 mg **Instructions:** In terms of heartburn, she has had dyspepsia in the past more than GERD but she may be having some reflux now so I offered her a PPI but she prefers a less	264-266, 270-279

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		potent or natural approach so I rec lifestyle modifications and an H2blocker so she wants to try this first. I will hold off on an EGD for now. In term of her lower symptoms with bloating, constipation, she had this in the past so I rec she try some Miralax and for reassurance I will check a CT of abdomen to rule out any other issues given her history of surgery/bowel infections. I will call her with results and also offered her support in her recovery.	
04/16/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief Complaint:** FUPS **History of Present Illness:** Here today for follow up from a very complicated medical year with GB removal hernia repair complicated by sepsis and near death experience. Patient was in hospital for extensive amount of time - had developed a fistula to abdominal wall and underwent revision approx 6-8 weeks ago. Here today for follow up. Only concern is "can't stop crying". Has seen PCP and also counselor. Has been given script for Zoloft but in distant past remembered that Wellbutrin worked best. On HRT no hot flashes. Complains of poor sleep, lots of anxiety nearly suicidal 2 weeks ago felt like she didn't care if she lived or died even though she survived a near death experience and had a vision or after life experience. No suicidal or homicidal ideation at this time. **Review of systems:** Concerned about a "pocket" on CT scan 1-2 cm **Physical examination:** **Abdominal Exam**: Abdominal exam normal. Normal on visual inspection fresh vertical incision. Absent umbilicus. No redness; no tenderness; liver normal to palpation; spleen normal to palpation; no abdominal mass. **Assessment:** PTSD Adjustment disorder with anxiety and depressed mood Functional urinary incontinence **Plan:** Trial of Wellbutrin - 150 mg daily - if no improvement at all in 2 weeks call for increase in dosage also even if only slight improvement continue meds and follow up in 6 weeks for assessment UCIF- sent for culture	7997-8000
04/16/YYYY	Hospital/ Provider Name	**Urinalysis:** Normal parameter	8088
04/21/YYYY	Hospital/ Provider Name	**Plastic Surgery Follow up visit:**	8112

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Subjective Evaluation: Patient is status post wound: 3 months, 2 weeks, 2 days ago at Dr. Symbas. The surgery date was 01/05/YYYY. **Subjective Evaluation**: Patient wants to discuss some issues with you. Patient is pleased. Patient has minor complaints. **Plan:** 4 months out. Healing very well. Had CT for another reason, and incidental, fluid collection/cyst 1.3 x 0.8 cm. Wound healing and feeling great. This is very likely nothing significant. Going through some rough mental times with what resembles PTSD from near death experience. Advised to see psychiatry and come back in 2-3 months. Questionable US fluid collection mainly to ease her mind.	
05/12/YYYY	Hospital/ Provider Name	**EMS Report:** **Narrative:** Dispatched on an unresponsive female MFD on scene. Patient found lying on couch. Patient had a witnessed syncopal episode by family. Patient states that she has had nausea, vomiting last PM and is having stomach pain. Patient alert and oriented x4, lethargic, respiration non-labored, pulses strong, heart tones crisp. Neuro intact, general weakness noted. Skin pale, cool and dry. O2 administered at 4 LPM via nasal cannula. EKG shows NSR without ectopy. IV attempted x2, Patient refused further attempts. Patient administered 4 mg Zofran IM with some reduction in nausea/vomiting. Patient assisted to stretcher and placed in semi fowler position, secured and transported to St. Joseph's ER without further change.	13050-13054
05/12/YYYY	Hospital/ Provider Name	**ER visit:** **Chief complaint:** Constipation and vomiting **History of present illness:** Patient presents to the emergency department stating she has had vomiting since last evening. The patient states she tried have a bowel movement and felt weak all over. States she feels constipated. She was given Zofran en route by EMS. They were unable to obtain IV access. The patient complains of generalized abdominal pain. No active vomiting at present. **Vital signs:** BP 98/66, pulse 62, resp. rate 18, temp 36.1, SpO2 96% **Physical examination:** **GI:** The abdomen is soft, diffusely tender, without guarding or rebound. **Discussion:** Given the patient's signs and symptoms, a workup was performed including CBC and laboratories and urinalysis. CBC demonstrated normal white count of 9.2, hemoglobin 15, hematocrit 42.9 with 221 platelets. Chemistries were all normal from top to bottom. CT of the abdomen and pelvis was performed with no findings of bowel obstructions and a fluid filled colon, but no other signs of acute	13028-13030

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		findings. The patient was reassured. She will be discharged home with Zofran. She is to return for any worsening symptoms. **Diagnosis:** 1. Abdominal pain. 2. Nausea and vomiting. 3. History of ovarian cancer.	
05/12/YYYY	Hospital/ Provider Name	**CT abdomen and pelvis with contrast:** **Reason for Exam:** Bowel obstruction **Clinical Indication:** Abdominal pain. Evaluate for bowel obstruction. Ovarian cancer post partial colectomy in 2011. Cholecystectomy in 2014. **Findings:** **CT Abdomen with contrast:** New lobular fluid attenuation structure along the periphery of the left lobe of the liver, measuring 1.8 cm (series 5 image 38, series 4 image 8). No additional liver lesions. The hepatic vasculature appears patent. No intrahepatic or extrahepatic biliary ductal dilation. No inflammatory changes suggest pancreatitis. The spleen is not enlarged. No adrenal nodules. Symmetric renal enhancement. No hydronephrosis. The abdominal aorta is normal caliber. No dilated small bowel to suggest obstruction. Enteric anastomosis in the right lower quadrant. The colon is diffusely fluid filled to the rectum, with mild mucosal enhancement along the mid to distal remaining colon. Sigmoid anastomosis appears unremarkable. Mild perirectal vascularity. No definite stranding or fluid collection. No mesenteric mass or nodularity. No ascites. **CT Pelvis with contrast:** The bladder is partially filled. The uterus and adnexa are absent. No pelvic mass or adenopathy. No suspicious osseous lesions. **Impression:** 1. No bowel obstruction. Fluid-filled colon with areas of mucosal enhancement; correlate for colitis and diarrhea. 2. New cystic lesion in the periphery of the left lobe of the liver of uncertain significance. Given history of ovarian cancer recommend short interval follow-up.	13113-13114
05/12/YYYY	Hospital/ Provider Name	**Other records:** Assessment, Medication Sheets, Discharge Instructions, Labs, Work status report, Patient Education, Vaccination/Immunization **PDF-Ref:** 13031-13035, 13045-13046, 13055-13110, 13115-13132, 13620, 13623-13634	
05/13/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Follow up to ER visit at St. Joe's yesterday. Was started on Wellbutrin 2 weeks ago. She has been feeling dizzy and nauseated, fainted while at home yesterday.	7869-7872

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		Called 911 and went to ER yesterday. Still has nausea today, had burning feeling and nausea since the night before. Had some wretching today. No lower GI symptoms. She is very worried that this is return of her sepsis. She is suffering from PTSD related to her hospital stay in the fall 2014. She was started on Wellbutrin 2 weeks ago and has not cried for 13 days. Has some panic symptoms + agoraphobia. She is seeing counselor (PhD), counselor from church and a person who specializes in PTSD. Her hopelessness is gone. No SI/HI. She is persistently worried that something is being missed in her medical care. **Physical examination:** **Abdomen:** Rebound tenderness in right upper quadrant **Assessment and plan:** 1. Nausea - I think she is having side effects from the new Wellbutrin. Her workup in the ER was negative. I do not see any active signs of infection. Will stop her Wellbutrin and if we want to retry it, can do 1/2 tab QHS 75 mg daily. Follow up in 1 week 2. Vitamin B12 deficiency 3. Dysuria	
05/19/YYYY	Hospital/ Provider Name	**Ultrasound of abdomen:** **History:** Abdominal pain **Impression:** Technically challenged examination due to the moderate amount of gas within the bowel. The previously identified cystic abnormality in the left lobe of the liver is not visualized. If characterization of this finding is of clinical interest MR correlation is recommended. Status post cholecystectomy. No evidence of ductal dilatation is present. Probable tiny nonobstructing calculus in the right kidney.	8003-8004
05/26/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** FUPS **History of Present Illness:** Here for follow up - very convoluted history. Recent ER visit for dizziness and passing out. Daughter had called 911. When in ER in Atlanta was discharged with dehydration and constipation. LLQ pain had preceeded the event and patient still with LLQ pain now. Brought CT scan disc - no report - and was told had liver abnormality and renal stone. Ultrasound done by PCP Dr. Pepper. No liver abnormality and right non-obstructing stone. Denies any fever/chills. Infectious disease gave Vancomycin and patient on day 3 or 4. Mild nausea no diarrhea. Has Zofran PRN for nausea. Very anxious. At last visit started on Wellbutrin XL and felt like it worked well for anxiety however when in hospital for fainting. Wellbutrin XL was discontinued. Patient states really needs something for anxiety. Uses Ativan as needed.	8005-8008, 8084-8087

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		Assessment: Colitis Adjustment disorder with anxiety and depressed mood Functional urinary incontinence Ovarian neoplasm of borderline malignancy (distant past) Menopause **Plan:** 1. Discussed LLQ pain likely colitis and usually treated with Cipro - will review CT scan without radiologist and call infectious disease re: best antibiotics. Patient to continue Vancomycin as already prescribed 2. In past on Wellbutrin and will start Wellbutrin now. Will not use XL and will start very low dose 3. Send urine for culture but expect resumption of vesicare should restore bladder function	
05/27/YYYY	Hospital/ Provider Name	**CT abdomen and pelvis with contrast:** **Clinical Information:** Colitis, pain **Findings:** **Upper Abdominal Organs:** Interval cholecystectomy. No intrinsic liver or spleen lesions are detected with the exception of a very subtle wedge-shaped lesion in the periphery of the posterior right hepatic lobe. This is likely either a simple cyst or a tiny infarct and measures 1 cm. This is a have malignant appearance. The pancreas, adrenals, and kidneys have stable appearance with no significant finding. Question minimal amount of fluid around the spleen. **Bowel and mesentery:** Previous colonic surgery. Stomach and small bowel unremarkable. The distal left colon and sigmoid are fluid-filled and there is some indication of slight wall thickening and enhancement. Colitis cannot be excluded. There is no abscess or stranding of the surrounding fat planes. No mesenteric lymphadenopathy or peritoneal free fluid. **Combined impression:** 1. The appearance of the colon suggest the possibility of colitis and perhaps associated ileus. No discrete abscess. 2. Tiny lesion involving the periphery of the right hepatic lobe is likely a tiny infarct or cyst.	8009-8010
07/06/YYYY	Hospital/ Provider Name	**Telephone Conversation:** Patient called on 7/6/YYYY. Patient called she is concerned with a small open area near abdominal incision and describes the area as "blue and pin size." Patient has also experienced nausea since Saturday. An appt was made for her to be evaluated by Dr. Symbas for tom (7/7/15)	8113
07/07/YYYY	Hospital/ Provider Name	**Plastic Surgery follow up visit:** Patient is status post wound: 6 months, 2 days ago at Dr. Symbas. The surgery date was 1/5/YYYY. Patient is pleased. Patient has minor complaints.	8114

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07/17/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Here today to follow up on Wellbutrin. Concerned about vaginal irritation and possible recurrent hernia - abdominal wall. Last visit had LLQ pain - and CT consistent with colitis - infectious disease increased duration of Vancomycin and now. No LLQ pain however abdomen is bulging and occasionally very firm. Bowel movements regular now. Very concerned about hernia. Previous GB /hernia repair complicated by sepsis and septic shock and prolonged wound healing, eventually abdominal wound repaired by plastic surgeon - Dr. John Symbas. **Review of system:** **Psychological symptoms:** Anxiety about health; depressed regarding recurrent hernia and possible need for surgery. **Abdominal Exam:** Abdomen abnormal on visual inspection protuberant through vertical incision - totally different from last exam – nontender. Abdomen mass > 10 cm - possible hernia; no abdominal tenderness; no hepatomegaly. **Assessment:** Ventral hernia Vaginitis Adjustment disorder with anxiety and depressed mood Menopause **Plan:** 1. Ultrasound today but exam consistent with hernia - discussed surgeons in area and also discussed need for me to discuss with PCP - Dr. Pepper and also Plastic surgeon – Dr. Symbas - will consider surgery here eg Dr. Strifling/ Steiner/ Abedi/ Greenlee vs University setting in GA 2. Reassurance - no yeast infection 3. No change in meds - however briefly mentioned Wellbutrin and HRT	8012-8016, 8017-8018, 8084
07/22/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **History of present illness:** Patient words: vomiting, sweats, feeling tired x 3 weeks She has felt "off balance". She saw her GYN last week for routine FU for Wellbutrin. She noted that her belly was tender, nauseated, not eating much. GYN was worried that she had hernia and SBO. Patient came back to ATL before testing was done. She woke up 2 nights ago with vomiting and diarrhea. Today she was able to eat chik Fil a and keep food down. She feels dehydrated. She is having sweats, last yesterday, no fever. **Physical examination:** Abdominal: tenderness - worst in epigastrium and LLQ Rigidity (guarding) - Generalized. **Assessment and plan:**	7865-7868, 8732-8733

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		1. Abdominal pain, periumbilic – Patient with multiple abdominal surgeries. Sudden onset nausea/vomiting/diarrhea. Will check labs and image abdomen. Follow up with results when available. To ER if symptoms progress overnight. 2. Anxiety - She is having PTSD symptoms, which is hightening her anxiety. She has been able to tolerate the Wellbutrin. Ready to increase her dose. Will do so after we address her acute abdominal issues. 3. Vitamin B12 4. Vitamin D deficiency **Note:** CT abdomen shows diastasis with abdominal wall hernia. Follow up with patient today shows symptoms are improving. Her daughter has similar GI illness. Symptoms were likely viral.	
07/23/YYYY	Hospital/ Provider Name	**CT abdomen with contrast:** **Clinical indication:** Abdominal pain **Impression:** No acute intra-abdominal abnormality seen. Broad-based hernia involving the midline abdominal wall above the level of umbilicus without evidence for bowel incarceration.	8881-8882
08/26/YYYY	Hospital/ Provider Name	**Office Visit for hearing loss:** Patient with a chief complaint of hearing test, had septic shock, wants to see if there is any damage. **History of Present Illness:** This patient is seeing me today at the request of Dr. Pepper. She presents with subjective hearing loss x approximately 10 months. After a lap chole last year, she went into septic shock from a perforation bowel. She was in a coma for weeks, and was on IV antibiotics and other medications for a long period of time. She has noticed that since then, her hearing is down. She has some ringing in the ears and some dizziness as well. She is still having reparative surgeries, most recently wound closure and tissue repair, and she still needs an incisional hernia repaired. **Assessment:** Sensorineural hearing loss bilateral May be from long course of high dose IV antibiotics (including Vancomycin) **Plan:** An Audio was ordered today because of the patient's complaint of hearing loss. The audio was performed by our audiologist with results as above. Consider binaural hearing aids Would recheck audio in approximately 6 months to monitor mild asymmetry	7939-7941
08/27/YYYY	Hospital/ Provider Name	**Cardiology Follow-up Visit:** **Chief Complaint:** 6 month follow up. Complaints of chest pain, no new complaint. Shortness of	312-314, 913-920, 6399-6400

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		breath on exertion **History of Present Illness:** Patient comes in with atypical chest pain and shortness of breath and dyspnea on exertion as well as some intermittent palpitation. She had a complete cardiac workup with echo and a stress test that was entirely normal. She did have mild mitral regurgitation but this was minimal and there was no vegetation noted. Her symptoms are better but she still having them her chest pain occurs with deep inspiration and also with movement. She has a bitter taste in the back of her throat and previously was on Nexium but now has been off of it. Her shortness of breath is with activity usually. She has been diagnosed with a surgical incisional hernia and is scheduled to undergo to Midtown to get this repaired. **Assessment/ Plan:** 1. Chest pain Atypical noncardiac, normal treadmill test. I suspect her pain is a combination of her prior sepsis and inflammation and scarring. It could also be related to her incisional hernia, or her reflux symptoms, she did have some DVTs in the past and has been on Xarelto which is now stopped. There may be a pruritic component to her chest pain. I'm gonna refill her Nexium 40 mg a day and see if this helps some her symptoms. She can undergo the incisional hernia repair without issues from a cardiac standpoint. 2. SOB (Shortness of breath) Lungs sounds clear multifactorial etiologies. Noncardiac. Continue monitor symptoms. 3. Mild mitral regurgitation Mild by echo no evidence of vegetation or prior endocarditis with her sepsis. By exam minimal.	
09/10/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** Leg swelling **History of present illness:** Patient returns for follow-up. She continues to wear the prescribed elastic compressive stockings most of the times when she is on her feet with good control of her lower extremity edema. She does not have any significant swelling in her upper extremities. She is going to be evaluated by a general surgeon for possible repair of her ventral hernia. **Assessment:** DVT upper extremity **Plan:** Compressive stockings, leg elevation I encouraged patient to take her elastic compressive stockings to the hospital at the time of her ventral hernia repair and to use them during the perioperative period. In addition to this she will require prophylactic measures for DVT in a high risk patient.	12806-12808

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/11/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **History of present illness:** Low temp and BP. Cough. Chest pain. Loss of voice. Monday had loose stool, no BM in a couple days. No nausea/vomiting. Low BP last few days (Lasix daily usually, held be of low BP). Swelling has resolved on Lasix. Temp 95.9 last night. 2 days cough. Minor compared to coughs she has had in past. Yellow mucus. No hemoptysis. Chills yesterday no rigors, feeling cold. Sore throat x2 days, better now. Headache today. Hoarseness x2 days, better today. Chest pain started 10 days ago (Wed). Heart checkup fine with Dr. Chang. Chest pain both sides transversely, SOB on lying down with the pain. Hurts sitting down. No injury from cough, no known injury. Last night pain was worst it has been. Action of lying down questionable not sure if aggravates the pain. Pneumonia - has had many time. Bronchitis has had many times. Septic shock/coma last 8/YYYY. No recent antibiotics. **Assessment and plan:** 1. Cough – Chest 2 view 2. Chest pain – EKG 3. Hypotension – Labs ordered 4. Shortness of breath – Pulse ox 5. Leg pain **Attending addendum:** I personally saw and examined this patient. She is well known to me. Very anxious, dealing with PTSD from sepsis last year. Afraid that when she gets sick she will have sepsis again. Her current chronic symptoms are anxiety, fatigue, low BP. She has new cough. Her CXR is normal today. Her BP typically runs low, and this week's measurements are within 10 points of her baseline. Her exam is consistent with post nasal drip and will treat as such with nasal steroids, Zyrtec D.	7855-7860, 7938
09/30/YYYY	Hospital/ Provider Name	**Office Visit for hernia:** **Chief Complaint:** Hernia Patient noticed a small ventral hernia approximately 3 months ago. She reports that the hernia has enlarged over the past 2 months. Reports discomfort and occasional abdominal pain. She has an episode of severe pain and distension in 5/15 which prompted her to go to the ED. CT abdomen/pelvis was negative for obstruction. She has a good appetite, eating well, no nausea or emesis. **Physical examination:** **Abdomen:** Non-distended, non-tender. Large incisional hernia easily reducible, non-tender to palpation. **Assessment/ Plan:** Incisional hernia	701-703

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient with an unfortunate history following a lap cholecystectomy. She was complicated with a bowel perforation following her lap chole and underwent an ex-lap and SBR at an OSH, shock now presenting with an incisional hernia. Will plan for an exploratory laparotomy, abdominal wall reconstruction with possible mesh and possible bowel resection. Patient will be contacted by the clinic regarding possible dates. Patient will need a bilateral carotid ultrasound given history of TIA and an echocardiogram before her preop evaluation.	
09/30/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with contrast:** **Clinical Indication:** Ventral hernia. Ovarian cancer. **Impression:** 1. Interval significant decrease in size of small subcapsular cystic lesion in the left hepatic lobe. 2. No other evidence of metastatic disease. 3. Diastasis of the rectus abdominis muscles is unchanged. **Other records:** Orders, assessment, labs (PDF-Ref: 932-935, 936-962, 965-966, 1006)	963-964, 930-931
10/13/YYYY	Hospital/ Provider Name	**Prescription Record:** Patient is cleared to have hernia surgery from a cardiac standpoint. Patient may hold Aspirin 7 days prior to procedure.	2588
11/03/YYYY	Hospital/ Provider Name	**Office Visit for preoperative evaluation:** Patient presents to Pulmonary Clinic today for a preoperative evaluation for an upcoming abdominal surgery (incisional hernia repair) on December 1st with Dr. Galloway. Patient is accompanied by her son today and reports an extensive abdominal surgery history which is most notable for the development of septic shock after a bowel perforation back in August 2014. She reports a lengthy ICU stay at the time and being mechanically ventilated for fourteen days. She notes a cardiac arrest during this period with subsequent ROSC as well as a short period of HD/CVVH. She also reports an extensive amount of delirium during this hospitalization, both while in the ICU as she began to recover as well as on the floor, and she reports that memories of this delirious period "still bother her today" and contribute to her anxiety about this upcoming surgery as well as "in general". Patient notes that since recovering from this prior extensive hospitalization that she has been bothered by intermittent pain in her chest as well as intermittent feelings of anxiety. She notes that she will often experience intermittent dyspnea as well (primarily at rest) and she notes that this tends to occur one to two times per week. She reports that it resolves "fairly quickly" with general relaxation techniques as well as as needed Xanax. She denies any childhood pulmonary issues, including asthma, and she also denies any significant respiratory issues as	802-804

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		an adult. She reports being prescribed a regimen of BID Advair sometime after her August 2014 hospitalization but reports that she stopped using it "a while ago" as she "did not need it". She reports no recent hospitalizations for any respiratory related issues and also denies any prior evaluations by a pulmonologist. Patient denies the presence of any dyspnea currently but does note intermittently feeling short of breath after climbing a flight or two of stairs. She denies the presence of any wheezing or chest pain during these periods. She does note intermittent chest pain at rest, as noted above, which is also intermittently reproducible and she was told recently by her primary care physician that she has "costochondritis". She reports suspecting this as well as she researched her symptoms "extensively" online. She denies any recent fevers or chills as well as any frank dysphagia, episodes of aspiration, choking, paroxysmal nocturnal dyspnea, orthopnea, lower extremity swelling, rashes, nausea, vomiting, diarrhea, dysuria, hematuria or melena. She reports that prior symptoms of reflux seem to have improved with resumption of her Nexium regimen. She also reports a recently "negative" cardiac evaluation with Dr. Chang. **Assessment/Plan:** 1. Chest pain 2. Pre-operative exam Patient's clinical appearance today as well as her overall pulmonary history, she currently appears optimized from a pulmonary standpoint and no further evaluation is recommended from a pulmonary end of things at this point in time. For now, then, will recommend: 1. No further testing or evaluation from a pulmonary standpoint in regards to proceeding to the OR with the General Surgery Service 2. Aggressive IS in the perioperative period along with extubation as soon as possible (as clinically dictated), early mobilization, as needed bronchodilators to assist with airway clearance and robust mechanical and pharmacological VTE prophylaxis (as clinically dictated) 3. As needed Ibuprofen for treatment of her costochondritis and would also recommend continued follow up with her PCP for optimization of her anti-anxiety regimen 4. A return to clinic on an as needed basis going forward	
11/03/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Clinical indication:** Chest pain **Impression:** No acute cardiopulmonary process.	749
11/23/YYYY	Hospital/ Provider Name	**Carotid ultrasound:** **Reason for exam:** History of TIA, cardiac surgical clearance **Impression:** 1. No hemodynamically significant stenosis involving either the right or left ICA. 2. Normal peak systolic velocity without detection of stenosis by direct	1000-1001

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		measurement of the right or left ICA. **Other records:** Assessment, orders (PDF-Ref: 971-999, 1002-1003)	
11/24/YYYY	Hospital/ Provider Name	**IR Consultation Report:** **Reason for consult:** IVC filter placement **History of present illness:** Patient with extensive PMH including multiple abdominal surgeries and bowel perforation leading to septic shock in 2014. Scheduled to undergo incisional hernia repair on 12/1/YYYY. **Assessment:** Patient status post multiple abdominal surgeries scheduled for incisional hernia repair on 12/1/YYYY, with expected prolonged immobilization post-operatively. **Plan:** IVC filter placement Mallampati Pharyngeal Visualization Score: Class III: Soft palate, base of uvula. ASA Status: Sedation Plan moderate sedation. Risks, options and complications of sedation were discussed, understood and accepted by the patient.	147-149
11/24/YYYY	Hospital/ Provider Name	**Procedure report:** **Procedure:** Inferior venacavogram IVC filter placement **Indication:** Planned ventral hernia repair. Prophylactic filter placement. **Findings:** 1. There is no iliofemoral or ileocaval thrombus. 2. There are single renal veins bilaterally. The IVC is normal in caliber. There is no aberrant anatomy. 3. The filter is appropriately positioned below the lowest renal vein. 4. The right internal jugular vein is ultrasonographically patent and compresses. Needle entry was documented. Images were stored to PACS. **Impression:** No evidence for iliofemoral or ileocaval thrombus. Uneventful image guided placement of infrarenal option Elite IVC filter as described. **Recommendation:** This is a retrievable filter. The patient be scheduled for a clinic visit in 8-10 weeks.	149-151, 140-146
	Hospital/ Provider Name	***AB University Hospital (12/01/YYYY-12/17/YYYY)***	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
12/01/YYYY	Hospital/ Provider Name	**@0808 hours: History and Physical:** **Chief complaint:** Large ventral hernia **History of present illness:** Patient presents to AB University Hospital with a chief complaint of the above and for a complex abdominal wall reconstruction with myofascial flap advancement, component separation, lysis of adhesions, mesh/biologic mesh placement and possible bowel resection on 12/01/YYYY. She was evaluated by Dr. Galloway on 09/30/YYYY. She was seen in pre-admit testing on 11/23/YYYY. *History reviewed.* Approximately 5 months ago, the patient noted a small ventral hernia. The hernia has gradually enlarged. Dr. Symbas referred the patient to Dr. Galloway for further evaluation and treatment. The patient underwent a CT scan of the abdomen and pelvis on 09/30/YYYY, and this demonstrated interval significant decrease in size of small subcapsular cystic lesion in the left hepatic lobe. No other evidence of metastatic disease. Diastasis of the rectus abdominis muscles is unchanged. The aforementioned surgery has been recommended. Currently at the time of her pre-admit testing appointment, the patient states she has intermittent abdominal pain over the last week or 2. She is not taking any pain medication. The pain can be a 10 on a 1-10 scale and at the time of her pre-admit testing appointment it is a 5 or 6. The patient has nausea. Vomiting was 3-4 days ago. She denies any fever or chills. Her bowels are moving all right. She denies any hematochezia. Her last colonoscopy was in 2014. **Vital signs:** BP 105/58, pulse 65, resp. rate 16, temp 36.4, SpO2 98% **Physical examination:** **Gastrointestinal:** Abdomen is soft with active bowel sounds, with a moderate to large ventral hernia, without organomegaly, masses or tenderness. **Plan:** 1. Complex abdominal wall reconstruction with myofascial flap advancement, component separation, lysis of adhesions, mesh/biolo9ic mesh placement and possible bowel resection on 12/01/YYYY. 2. Preoperative bowel prep was reviewed with patient. She is to be on a soft diet 2 days prior to surgery and a clear liquid diet the day prior to surgery. The day prior to surgery she is to take MiraLAX as directed. Patient is unable to take Dulcolax laxative tablets. She is told if she is not running clear that she can take magnesium citrate the day prior to surgery if needed. She was given prescriptions for Neomycin and Flagyl to take the day prior to surgery. NPO after midnight. 3. The patient has been cleared by Pulmonary Medicine and Cardiology preoperatively.	158-164

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		4. Patient underwent an inferior vena caval filter placement on 11/24/YYYY in Interventional Radiology. This is a retrievable filter. 5. The patient was evaluated by a hematologist, Dr. Kelly May, on 11/21/YYYY, for evaluation of recurrent thromboembolism (see Dr. May's notes in paper chart from 11/21/YYYY and 12/03/YYYY). Multiple studies were done and per note on 12/03/YYYY, coagulation labs were reviewed. Positive MTHFR. Not known to produce significant risk for thromboembolism or stroke, all other labs within normal limits. Per MD: In view of history of multiple events, the patient should take Xarelto 20 mg daily x14 days postoperative for risk reduction of thromboembolic event. She should start this 24 hours postoperative if she has no significant bleeding. She is to switch to baby Aspirin 81 mg daily when Xarelto is complete for lifetime risk reduction and begin a prescription for over-the-counter Folic acid 1 mg daily for MTHFR variant risk reduction.	
12/01/YYYY	Hospital/ Provider Name	**@0816 hours: Acute Pain Combination Note:** **Chief complaint:** Ventral hernia repair/abdominal wall reconstruction. **History of present illness:** Patient requiring intubation, provoked RUE DVT status post 3 months treatment, with history of multiple abdominal surgeries who was scheduled for a ventral hernia repair/abdominal wall reconstruction with Dr. Galloway. Procedure: Continuous thoracic epidural Indication: Postoperative analgesia **Impression and plan:** Ventral hernia **Plan:** Status post placement of thoracic epidural.	1103-1108
12/01/YYYY	Hospital/ Provider Name	**@0926 hours: Operative Report:** **Preoperative and postoperative diagnoses:** 1. Recurrent ventral hernia. 2. Intermittent partial small bowel obstruction secondary to intraabdominal adhesions and intermittent intestinal incarceration within the hernia. **Procedures performed:** 1. Exploratory laparotomy with extensive lysis of adhesions requiring 4 hours of additional operative time. 2. Proximal jejunal small bowel resection with antegrade side-to-side jejunal-to-jejunal anastomosis. 3. Complex abdominal wall reconstruction with the following: a. Excision of old Biomesh. b. Right and left modified myofascial flap advancements. c. Implantation of Seprafilm followed by 12 x 12 inch multilayered Vicryl mesh as an underlay blowout patch. d. Implantation of 16 x 20 cm Fortiva BioMesh as an underlay blowout patch. e. Primary closure of midline myofascial bundles over the Biomesh. f. Soft tissue excisional debridement of hernia sac, attenuated fascia, and redundant subcutaneous tissues and skin encompassing 600 sq cm (20 x 30 cm).	1119-1123, 1109-1119, 1141-1142, 1012

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		g. Soft tissue flap advancement and rearrangement abdominoplasty to cover residual abdominal wall defect of 600 sq cm (20 x 30 cm). 4. Please note that the level of difficulty and complexity of this operation should be increased by 100% due to the following factors: a. Multiple prior surgical procedures. b. Increased lysis of adhesions time and dissection time secondary to obliterative peritonitis. c. Difficult lysis of adhesions to separate abdominal viscera from the hernia defect and old mesh. d. Increased operative time of 7 hours. **Procedure in detail:** The patient is brought to the operating room and placed on the table in supine position. A satisfactory level of general anesthesia is achieved. A call to order is performed, and all items of care identified and agreed upon by those present. Each member of the surgical team, anesthesia staff, and nursing service identify themselves per protocol. The patient receives 2 g of Ancef and 500 mg of Flagyl 30 minutes prior to the incision and has been placed in bilateral sequential compression stockings for DVT prophylaxis. The abdomen is sterilely prepped and draped. We enter the abdomen over virgin territory in the epigastrium and extend our incision down through the attenuated skin and subcutaneous tissues of the abdominal wall overlying the large hernia. We gently separate out abdominal contents as we come down through our skin and subcutaneous tissues, and we extend the incision to the lower abdomen in the midline below the level of the hernia defect. We then spend approximately 4 hours of difficult adhesiolysis as we separate out the abdominal viscera from the hernia sac and the surrounding abdominal wall defect and mobilize the anterior abdominal wall away from our viscera. During this time, there is densely adhered bowel to the upper edges of the hernia defect where the old mesh has separated. We are unable to remove this area of small bowel without extensive deserosalization. Therefore, we elected to resect this small area of proximal jejunum. The loops feeding into this area are dissected free from the surrounding small bowel and colon and omentum. We transect it on either side with the GIA stapler. The mesentery is taken down with a LigaSure. The specimen is removed along with a section of the old Biomesh. Once this is accomplished, the stapled ends of our proximal and distal jejunum are imbricated with 3-0 silks placed in Lembert fashion. An antegrade side-to-side anastomosis is then carried out in 2 layers with a running 3-0 PDS interlocking posterior and carried around anteriorly as a Connell suture. The outer layer has been form with interrupted 3-0 silk placed in Lembert fashion. Several sutures are placed in our angles to secure the corners of the anastomosis. The mesenteric defect is carefully closed with running 2-0 Vicryl. We then perform additional adhesiolysis distally to make sure there are no areas of further obstruction. Once we have fully freed up all the small bowel from the ligament of Treitz to the terminal ileum, I am satisfied that we have relieved several areas of twisted and severely kinked small bowel that had essentially been living out of domain within the hernia sac. Copious irrigation is performed. I run the small bowel several times to ensure no damage. Once I am satisfied, we layer the small bowel back in and layer the remaining omentum over the top of that. We lay in several pieces of Seprafilm over the omentum, being careful not to lay any	

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		Seprafilm near our anastomosis. Abdominal wall reconstruction is then performed. We complete the excision of the old Biomesh. The skin flaps are raised circumferentially, and modified right and left myofascial flaps are created and advanced to the midline. Despite being able to close these in the midline, it leaves the midline area somewhat weakened and attenuated, and therefore, we implant a 12 x 12 multilayered Vicryl mesh as an inlay blowout patch. We then implant a 16 x 20 Fortiva Biomesh as an underlay blowout patch as well. We are then able to primarily close our midline myofascial bundles with a running PDS imbricating to yield a nice flush surface. A subfascial drain is left between our Biomesh and our midline closure. Following this, an extensive soft tissue excisional debridement of the remaining hernia sac, attenuated fascia, redundant subcutaneous tissues, and skin is performed and encompasses 20 cm in width and 30 cm in length for a total of 600 sq cm. The remaining flaps are copiously irrigated with warm saline followed by IrriSept solution. Hemostasis is achieved. Our flaps are then advanced as a soft tissue flap advancement and rearrangement abdominoplasty to cover our residual abdominal wall defect of 600 sq cm. The flaps are anchored together over two 19-French Blake drains utilizing 2-0 Vicryl sutures placed in figure-of-eight fashion. The skin is then closed with staples. Appropriate dressings are applied. The patient is placed in an abdominal binder and transported to the Intensive Care Unit in stable condition having tolerated the procedure well. **Estimated blood loss:** 200 cc. **Specimens:** Included the small bowel. **Drains:** Included 1 subfascial 19-French Blake drain and 2 subcutaneous 19-French Blake drains. **Complications:** There were no complications to this procedure.	
12/01/YYYY	Hospital/ Provider Name	**@1727 hours: Critical Care Consult:** **Reason for consult:** Post op ICU care Patient now status post exp lap, extensive LOA, Small Bowel Resection (SBR), Ventral Hernia Repair (VHR) Estimated blood loss 50 5 L crystalloid 500 ml albumin 1000 urine output Arrived to ICU extubated, vital signs stable. Epidural with Bupivacaine/Hydromorphone at 8 ml/hr **Vitals:** BP 109/60, pulse 83, resp. rate 13, temp 37, SpO2 97% **Physical examination:** **Respiratory:** Lungs are clear to auscultation bilaterally, Respirations are non-labored, Breath sounds are equal. **Gastrointestinal:** JP x 3 to suction (serosanguineous); incision with dressing clean/dry/intact. Abdominal binder in place.	1091-1100

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		Extremities: Normal visual exam, Normal pulses. **Impression and plan:** 1. Neurology Postoperative pain **Plan:** Acute pain service following Epidural with Bupivicaine/Hydromorphone at 8 ml/hr Lidoderm patches. 2. Gastrointestinal GERD - Plan: IV Protonix Ventral hernia – status post repair - NPO 3. Hematology/Oncology Acute blood loss anemia – Check CBC. Transfuse for hemoglobin < 7 unless active bleed. Follow up drain output DVT – SCDs, subcutaneous Heparin for DVT prophylaxis 4. Psychiatric History of anxiety – resume Wellbutrin, Lyrica once able to take per oral Noted patient on home Ativan 0.5mg per oral thrice daily => add 0.5mg IV every 8 hours PRN anxiety.	
12/01/YYYY	Hospital/ Provider Name	**@1828 hours: Nursing Notes:** Patient admitted direct from OR at 1725 via bed extubated on face mask. Patient drowsy but awakens easily, 18 gauge in right hand, 16 gauge in right arm, 20 gauge in left hand, epidural with Bup/Dilaudid going at 8cc/hr, Plasmalyte at KVO, 3 JPS placed to wall suction #1 on right side abdomen, #2 and #3 on left side of abdomen, abdomen binder intact, Foley to BSB. Patient complaining of pain, a 10 level. Labs sent, BS 156, IVFs started, bolus of epidural administered for pain. Weaned O2 to 4 liters NC, placed end tidal NC on patient. Patient has history of ventral hernia repair with complications of perforation, ICU stay 2 month, ICU psychosis with Traumatic stress disorder. No family at bedside at this point. Patient following simple commands. Plan to wean O2 as able, comfort measures, PRN pain meds for breakthrough pain, reorient patient, supportive care.	1239-1240
12/01/YYYY	Hospital/ Provider Name	**@2230 hours: Critical Care Event Note:** Called to patient bedside for multiple episodes of vomiting bilious material. Patient continues to complain of nausea, had no NGT post-op. Ordered additional 4mg Zofran x1 for nausea, contacted surgery resident on call to determine if any contraindications for NGT placement given recent surgery. Patient had addition episode of emesis after Zofran and NGT was placed with KUB after to confirm placement of tube. NGT placed to LIWS.	1239
12/01/YYYY	Hospital/ Provider Name	**@2240 hours: X-ray of abdomen:** **Reason for exam:** Aftercare following naso-gastric tube placement	1989-1990

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: Nasogastric tube tip coils in the proximal body, in satisfactory position.	
12/02/YYYY	Hospital/ Provider Name	**@0958 hours: Critical Care Progress Notes:** **Subjective:** I feel bad with nausea and itching **Vitals:** BP 96/56, pulse 78, resp. rate 10, SpO2 100% **Physical examination:** GCS 15 **Gastrointestinal:** Soft, tender to palpation, drains x3, NG tube **Labs:** **High:** Glucose 118 **Low:** Hemoglobin 10.8, hematocrit 33.1, protein 5.5, albumin 3.2 **Impression and plan:** 1. Neurology Postoperative pain from surgical incision Plan: Epidural with Hydromorphone and Bupivacaine at 8 cc/hour Pain service following, call with all pain issues. 2. Gastrointestinal Nausea – from medications/surgery - Zofran Ventral hernia - NG tube to LCWS for nausea. Abdominal binder on when moving or ambulating. PT/OT. Monitor drain outputs closely, notify surgery if change in amount or color. 3. Psychiatric Anxiety PTSD – As needed Lorazepam	1231-1239
12/02/YYYY	Hospital/ Provider Name	**@1435 hours: Progress Notes:** Patient declined to work with PT today. Will follow up 12/3/15 as schedule permits.	1231
12/02/YYYY	Hospital/ Provider Name	**@1626 hours: Acute Pain Progress Notes:** **Subjective:** Extubated and transferred to the ICU for further monitoring. Patient complains of 10/10 pain this AM but endorsed that RN boluses from epidural helped. Also complains of itching all over but said that Benadryl helped. Agreed to try a Bupiv/Fentanyl epidural at 10 ml/hr (previously 8) but this didn't provide pain relief. Agreed to switch to a LA epidural and Dilaudid PCA as a plan B since the Fentanyl didn't change much. **Medications:** Heparin 5000 units Lidocaine 5% topical	1225-1230

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		Pantoprazole 40 mg Hydromorphone 10 mg Lactated ringers 1000 ml Sodium chloride 0.9% 1000 ml Sodium chloride 0.9% 175 ml + Bupivacaine 375 mg (Epidural in NS 175 ml + Bupivacaine 375 mg) 175 ml **Impression and plan:** Acute pain **Plan:** Start 0.15% Bupivacaine epidural at 8 ml/hr Start Dilaudid PCA at 1/6/10 with 2 ml every 2 hours PRN RN boluses Continue Lidoderm patches Will continue to follow.	
12/02/YYYY	Hospital/ Provider Name	**@1935 hours: General Surgery Progress Notes:** **Subjective:** Doing well this morning. Had NG placed overnight for post-op nausea/vomiting. Small volume bilious output. No bowel movement/flatus. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressing in place with scant shadowing on gauze **Impression and plan:** Neuro: Epidural, APS management appreciated CV: NAI, Hemodynamically stable Respiratory: NAI, wean O2 FEN/GI: NPO, NGT to LIWS, NS at 100 change to D5 1/2 today, AROBF, pull back NG by 10cm, JP drains to wall suction day 2 GU: Foley in place for strict intake + outputs, plan to discontinue 12/3 Heme/ID: Discontinue periop antibiotics today, AM labs, afebrile Endo: NAI Prophylaxis: Subcutaneous Heparin (remote history of Xarelto 30 days for UE DVT), sed, ambulate, PT/OT, IS	1221-1225
12/03/YYYY	Hospital/ Provider Name	**@0706 hours: General Surgery Progress Notes:** **Subjective:** Possible ICU delirium overnight, though patient seems more somnolent and very mildly confused, easily reoriented, complains of abdominal pain. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Impression and plan:** Neuro: Epidural, APS management appreciated CV: NAI, Hemodynamically stable Respiratory: NAI, wean O2	1218-1221

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		FEN/GI: NPO, NGT to LIWS, D5 1/2 at 100, AROBF, JP drains to wall suction day 3 GU: Foley in place for strict intake+outputs, plan to discontinue 12/3 Heme/ID: Discontinue periop antibiotics today, AM labs, afebrile Endo: NAI Prophylaxis: Subcutaneous Heparin (remote history of Xarelto 30 days for UE DVT), sed, ambulate, PT/OT, IS **Disposition:** Likely Transfer to Floor (TTF) today	
12/03/YYYY	Hospital/ Provider Name	**@1449 hours: Critical Care Progress Notes:** **Subjective:** Can I have this tube out of my nose? **Physical examination:** Gastrointestinal: Soft, tenderness appropriate to palpation, drains x3 to suction (serosanguineous), NG tube (bilious). NPO. **Labs:** **High:** WBC 11.5 **Low:** Sodium 135, BUN 3, hemoglobin 10.6, hematocrit 32.8 **Impression and plan:** 1. Neurology Postoperative pain from surgical incision Plan: Epidural with Hydromorphone and Bupivacaine at 8 cc/hour Lidoderm patches x2 surrounding incision Pain service following, call with all pain issues. 2. Gastrointestinal Nausea – from medications/surgery, improving - Zofran Ventral hernia – NPO until surgery ok with per oral intake – awaiting return of bowel function. NG tube to LCWS for nausea (thick, bilious). Abdominal binder on when moving or ambulating. PT/OT – ambulated this morning. Monitor drain outputs closely, notify surgery if change in amount or color. 3. Psychiatric Anxiety PTSD – As needed Lorazepam. Patient drowsy this morning. Will decrease Ativan dose to 0.25 mg IV every 8 hours from 0.5 mg every 6 hours as needed.	1211-1218
12/03/YYYY	Hospital/ Provider Name	**@1854 hours: Acute Pain Progress Notes:** **Subjective:** Still complaining of 8/10 pain but patient appears somnolent and has an epidural level. Family thought she was doing excellent, in contrary. Walked around with PT today. **Impression and plan:** Extubated and in the ICU but having difficulty with pain control.	1208-1211

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		Plan: Continue 0.15% Bupivacaine epidural at 8 ml/hr Continue Dilaudid PCA at 1/6/10 with 2 ml every 2 hours PRN RN boluses Add IV APAP 650 mg every 8 hours Will consider asking surgery team about Toradol tomorrow depending on pain level Continue Lidoderm patches Decrease Lorazepam 0.5 to 0.25 mg every 6 hours PRN as she appears fairly somnolent Will continue to follow.	
12/04/YYYY	Hospital/ Provider Name	**@0931 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient more oriented this morning. Had mild nausea with NGT to bag and was switched back to suction. No nausea since. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Impression:** Patient now POD 3 after ex-lap, LOA, SBR of approx. 20 cm small bowel including old small bowel anastamosis, complex abdominal wall reconstruction with Vicryl and biologic underlay blowout mesh, primary fascial closure 12/2/15. **Impression and plan:** Neuro: Epidural, APS management appreciated CV: NAI, Hemodynamically stable Respiratory: NAI, room air FEN/GI: NPO, NGT to LIWS. Will attempt to placed NGT to drainage bag today. If becomes nauseous place back on wall suction, D5 1/2 at 100, JP drains to wall suction Heme/ID: Antibiotics discontinued. AM labs pending, afebrile Endo: NAI General: Out of bed, chlorseptic spray and Benadryl ordered per patient. **Disposition:** Likely Transfer to Floor (TTF) today	1205-1208
12/04/YYYY	Hospital/ Provider Name	**@1547 hours: Acute Pain Progress Notes:** **Subjective:** Still complaining of 8/10 pain but only pushed her PCA button 8x in the last 24 hours (8 ml). Patient said she didn't want to get "ICU psychosis." Explained to her that Dilaudid has a very low chance of causing that, and even if it did, she is the only person who is pushing her PCA button so overdoing it with the PCA would be unlikely. Encourage her to use the PCA for her pain. **Impression and plan:** Extubated and in the ICU but having difficulty with pain control. Added a PCA	1200-1203

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		however patient isn't using it. **Plan:** Continue 0.15% Bupivacaine epidural at 8 ml/hr Continue Dilaudid PCA at 1/6/10 with 3 ml every 2 hours PRN RN boluses Encourage patient to use PCA May give Toradol 30 mg IV every 8 hours if patient is still complaining of pain over the weekend Continue Lidoderm patches Continue Lorazepam 0.25 mg every 6 hours PRN anxiety Will continue to follow.	
12/05/YYYY	Hospital/ Provider Name	**@1134 hours: General Surgery Progress Notes:** **Subjective:** Did not sleep well last night, very anxious. Felt nauseated slightly, NG placed to suction with minimal output. Placed back to bedside bag. History of chronic nausea. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Labs:** **Low:** BUN 1, potassium 3.1, hematocrit 30.5, calcium 7.4 **High:** Glucose 123 **Impression and plan:** Neuro: Epidural, APS management appreciated CV: NAI, Hemodynamically stable Respiratory: Stable on room air FEN/GI: NPO, NGT to bedside bag. D5 1/2 at 100, JP drains to wall suction Heme/ID: Antibiotics discontinued. CBC within normal limits, afebrile, needs midline General: Out of bed, chlorseptic spray and Benadryl ordered per patient.	1196-1199
12/05/YYYY	Hospital/ Provider Name	**@1230 hours: Acute Pain Progress Notes:** **Subjective:** Patient pain better controlled this AM. States she still has some increased discomfort near surgical area. Encouraged patient to press PCA. Patient denies nausea/vomiting, weakness. **Impression and plan:** PCEA and PCA in place, pain better controlled today. **Plan:** Increase 0.15% Bupivacaine epidural from 8 ml/hr to 9 ml/hr Encourage patient to use PCA May give Toradol 30 mg IV every 8 hours if patient is still complaining of pain over the weekend Continue Lidoderm patches	1193-1196

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		Continue Lorazepam 0.25 mg every 6 hours PRN anxiety Will continue to follow.	
12/06/YYYY	Hospital/ Provider Name	**@0916 hours: Acute Pain Progress Notes:** **Subjective:** Patient pain better controlled this AM. Encouraged patient to press PCA. Patient denies nausea/vomiting, weakness. Patient states pain is a 7/10, which is very well tolerated for her. **Impression and plan:** PCEA and PCA in place, pain better controlled today. **Plan:** Continue CEI 0.15% Bupivacaine at 9 ml/hr, can consider transitioning to per oral meds once at patient diet advanced. Continue Dilaudid PCA at 1/6/10 with 3 ml every 2 hours PRN RN boluses Encourage patient to use PCA Continue Lidoderm patches Continue Lorazepam 0.25 mg every 6 hours PRN anxiety Will continue to follow.	1190-1193
12/06/YYYY	Hospital/ Provider Name	**@1639 hours: General Surgery Progress Notes:** **Subjective:** NG out yesterday, going well overall. No new complaints. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Labs:** **Low:** BUN 3, hemoglobin 9.2, hematocrit 29.3, calcium 7.4 **Impression and plan:** Neuro: Epidural, APS management appreciated CV: NAI, Hemodynamically stable Respiratory: Stable on room air FEN/GI: NPO, D5 1/2 at 100, JP drains to wall suction. AROBF, ice chips tomorrow. Heme/ID: Antibiotics discontinued. CBC within normal limits, afebrile, needs midline General: Out of bed, chlorseptic spray and Benadryl ordered per patient.	1187-1190
12/07/YYYY	Hospital/ Provider Name	**@0806 hours: Acute Pain Progress Notes:** **Subjective:** No events overnight. Patient on a clear liquid diet. Pain is tolerable. Discussed removing epidural and patient was okay with this. **Impression and plan:**	1184-1187

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Thoracic CEI and PCA in place, pain is controlled. **Plan:** Discontinue epidural this afternoon Continue Dilaudid PCA at 1/6/10 with 3 ml every 2 hours PRN RN boluses for another day Encourage patient to use PCA Continue Lidoderm patches Continue Lorazepam 0.25 mg every 6 hours PRN anxiety Will continue to follow.	
12/07/YYYY	Hospital/ Provider Name	**@1243 hours: General Surgery Progress Notes:** **Subjective:** No acute events overnight. NGT discontinued without any nausea/vomiting. Drains to bulb suction. Patient complaining some urinary symptoms. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Labs:** **Low:** BUN 2, hemoglobin 9.9, hematocrit 31.1, protein 5.3, albumin 2.4, calcium 7.6 **Impression and plan:** Neuro: Epidural, APS management appreciated Respiratory: Stable on room air FEN/GI: D5 1/2 at 75, JP drains bulb suction. AROBF, clear liquid diet. Heme/ID: Antibiotics discontinued. CBC within normal limits, afebrile, needs midline General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Febrile x1 overnight (isolated). Will do fever work-up with continued fevers.	1180-1183
12/07/YYYY	Hospital/ Provider Name	**@1539 hours: PICC assessment:** **Indications:** Inability to obtain peripheral IV access No indication for central line, midline more appropriate, will discuss with team.	1177
12/07/YYYY	Hospital/ Provider Name	**Pathology Report:** **Collected date:** 12/01/YYYY **Final Pathologic Diagnosis:** A. Clinically "biologic mesh," removal: Dense fibrous connective tissue with patchy giant cell reaction. B. Jejunum, resection: Segment of small intestine with remote entero-enteric anastomosis, patchy giant cell reaction, and fibrous serosal adhesions. Four benign lymph nodes. No neoplastic tissue is identified.	1983-1985

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
12/08/YYYY	Hospital/ Provider Name	**@0916 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient was tearful this AM because she got behind on her pain med's while sleeping and is stating some frustration. Drains to bulb suction. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Labs:** **Low:** BUN 1, calcium 7.8 **Impression and plan:** Neuro: Epidural, APS management appreciated. Ibuprofen 600 mg every 6 hour and Ice packs added for pain control Respiratory: Stable on room air FEN/GI: D5 1/2 at 42, JP drains bulb suction. AROBF, full liquid diet; Dulcolax 10 mg suppository added (gas but no BM) Heme/ID: Antibiotics discontinued. CBC within normal limits, afebrile, status post midline General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request.	1174-1177
12/08/YYYY	Hospital/ Provider Name	**@1027 hours: Acute Pain Progress Notes:** **Subjective:** Walking around the unit, using her PCA but sometimes has to catch up with the pain. Open to trying oral meds but "everything" makes her nauseated. **Impression and plan:** Status post thoracic CEI and PCA, the latter of which was removed today. **Plan:** Discontinue PCA today Dilaudid 2 mg per oral every 6 hours PRN mild-moderate pain Dilaudid 0. 5 mg IV every 4 hours PRN severe pain Continue Lidoderm patches Continue Lorazepam 0.25 mg every 6 hours PRN anxiety Will sign off now. Call for questions.	1171-1174
12/09/YYYY	Hospital/ Provider Name	**@1121 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient complains of dry lips and Vaseline/chap-stick were provided. Pain is controlled and patient is agreeable to changing to PO meds in effort to get discharged tomorrow. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema	1164-1167

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		around incision. **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, regular diet; Dulcolax 10 mg suppository. Patient had BM. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT.	
12/10/YYYY	Hospital/ Provider Name	**@0836 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient is still complaining of dry lips. Pain controlled. Had soft BM yesterday. Tolerating diet well. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, regular diet; Dulcolax 10 mg suppository. Patient had BM. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Discharge on Friday.	1160-1162
12/10/YYYY	Hospital/ Provider Name	**@1515 hours: X-ray of abdomen:** **Reason for exam:** Nausea with vomiting **Impression:** Nonspecific paucity of small bowel gas with scattered colonic gas and air-fluid levels.	1988-1989
12/11/YYYY	Hospital/ Provider Name	**@0848 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient denies any emesis since yesterday evening (450 bilious). Patient reports drinking a small amount but otherwise avoiding food. Is anxious to go home and to prevent vomiting, but was counseled to take her PO intake cautiously. **Physical examination:** **Gastrointestinal:** Soft, non-distended, appropriately tender, OR dressings	1156-1159

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		removed incision clean, dry, intact, scant bruising/non-blanching erythema around incision. **Labs:** **Low:** BUN 3, hemoglobin 9.1, hematocrit 29.3, calcium 8.0 **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, clear liquid diet; Dulcolax 10 mg suppository. Patient had BM. Will follow up drain output. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Discharge on Friday.	
12/12/YYYY	Hospital/ Provider Name	**@0942 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Without emesis overnight. Patient will have KUB this AM. Without any acute issues and requesting food. **Labs:** **Low:** BUN 1, calcium 7.6 **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, clear liquid diet; Dulcolax 10 mg suppository. Patient had BM. Will follow up drain output. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Discharge on Friday. Follow up KUB.	1153-1156
12/12/YYYY	Hospital/ Provider Name	**@1437 hours: X-ray of abdomen:** **Reason for exam:** Nausea and vomiting. 10 days status post small bowel resection and complex abdominal wall reconstruction. **Impression:** Non-obstructive bowel gas pattern.	1987-1988
12/13/YYYY	Hospital/ Provider Name	**@1001 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Tolerated fulls well and requesting regular diet. Patient reports one minimal BM and continued gas. She is also requesting B12 shot that she receives weekly.	1081-1084

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Labs: **Low:** BUN <1, calcium 8.0 **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, regular diet; Dulcolax 10 mg suppository. Minimal Zofran changed to PRN, Reglan changed IV to per oral. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Discharge on Friday.	
12/14/YYYY	Hospital/ Provider Name	**@1223 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient tolerating regular diet. Had some diarrhea overnight. Will do calorie count today. Likely home tomorrow. **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs Respiratory: Stable on room air FEN/GI: Heplock, JP drains bulb suction. AROBF, regular diet; Dulcolax 10 mg suppository. Minimal Zofran changed to PRN, Reglan changed IV to per oral. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Possible discharge tomorrow.	1149-1152
12/14/YYYY	Hospital/ Provider Name	**@2308 hours: X-ray of abdomen:** **Reason for exam:** Abdominal distention. **Impression:** Non-obstructive bowel gas pattern.	1986-1987
12/15/YYYY	Hospital/ Provider Name	**@1039 hours: General Surgery Progress Notes:** **Subjective:** NAEO. Patient had emesis overnight x2 of around 400cc per. Patient subjectively backed down on diet. Got IV Zofran and GI cocktail. Ordered IV KUB and will order 2 V KUB this AM. **Labs:** **Low:** BUN 5, hemoglobin 10.4, hematocrit 33.2 **High:** Platelet 494 **Impression and plan:** Neuro: Discontinue epidural. Per oral Dilaudid 2 mg every 6 hours, Ibuprofen 600mg every 6 hours and ice packs	1145-1148

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Respiratory: Stable on room air FEN/GI: mIVF restarted at 75cc/hr; GI cocktail and IV Zofran given overnight, JP drains bulb suction. AROBF, regular diet; Dulcolax 10 mg suppository. Zofran PRN, Reglan changed from every 6 hours to AC and HS. Will discuss possibility acquiring CT scan today. General: Out of bed, chlorseptic spray and Benadryl ordered per patient. Vaseline for sore from Foley per patient request. Home medications restarted (Lyrica, Neurontin). Return to clinic in 2 weeks with per oral IV CT. Discharge with Zofran. Possible discharge tomorrow.	
12/15/YYYY	Hospital/ Provider Name	**@1105 hours: X-ray of abdomen:** **Reason for exam:** Abdominal distention. **Impression:** Non-obstructive bowel gas pattern.	1986
12/17/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Admit date:** 12/01/YYYY **Hospital Course:** Patient was admitted under the care and direction of Dr. John R. Galloway. The patient was well-known to him and he had evaluated her on the outpatient basis with regards to her recurrent ventral hernia and partial small bowel obstruction. The patient was taken to the operating room as planned on 12/01. Please see Dr. Galloway's dictated operative report in which he describes the details of the procedures performed which included an exploratory laparotomy with lysis of adhesions x4 hours, proximal jejunal small bowel resection with an antegrade side-to-side jejunal-to-jejunal anastomosis, and a complex abdominal wall reconstruction with excision of old bio mesh, right and left modified flap advancements, implantation of Seprafilm, followed by a 12 x 12 multilayered Vicryl mesh as an underlay blowout patch, implantation of a 16 x 24 ___ bio mesh, primary closure of midline myofascial bundles of the bio mesh, soft tissue excisional debridement of hernia sac, attenuated fascia, and redundant subcutaneous tissue of 600 sq cm, soft tissue flap advancement and rearrangement abdominoplasty to cover the residual abdominal wall defect of 600 sq cm. Please note that this was quite a difficult operation over 7 hours. Postoperatively, the patient was managed in the ICU until the transfer to floor order was completed on 12/04/YYYY. Physical therapy had already been started. The patient was already showing some signs of nausea which she would struggle with throughout her stay. On the floor, physical therapy resumed. Her NG tube remained to suction for a few days, and JP's were to bulb suction only. Pain Service continued managing her PCA, which she was using moderately and having a great deal of anxiety about. We were awaiting return of bowel function essentially, observing on the 7th that she had not had any significant bowel movement. We added Ibuprofen to her pain regimen as pain service signed off on 12/08. Social Services consult was obtained regarding questionable ability for patient's pace of food and medicine, which seemed incongruent with what we had seen, but nonetheless, Social Services provided multiple service options for where she could obtain services.	1066-1068

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		By the 10th, the patient was already having some significant nausea and emesis, so an X-ray was obtained. This was done shortly after she was transferred to oral meds. The plan was that she would discharge later that week, but the patient did have some episodes of emesis and was unable to take in all the food she needed. She was without emesis for a day or so, so again had planned to discharge on the 12th, but then it was noted that she was not eating sufficient calories to sustain life, and so she remained inpatient and calorie counts were instituted. She did have another bout of emesis, so a suppository was utilized as well on the 13th or so. Another X-ray was obtained on the 14th after another episode of emesis. Fortunately it showed no obstructive bowel gas pattern. We provided liquid protein supplements, some of which the patient found that she could tolerate in order to provide the amount of hydration and protein calories she needed. Therefore, on 12/17 she was determined stable enough for discharge.	
12/01/YYYY-12/17/YYYY	Hospital/ Provider Name	**Other records:** Checklist/Verification List, Medication Sheets, Plan of Care, EKG, Assessment, Patient questionnaire, Orders, Anesthesia Record, Patient Education, Social Service Progress Notes, Occupational Therapy Records, Physical Therapy Records, Nursing Notes/Records, Nutritional Assessments, Discharge Instructions, Input / Output Record, Vaccination/Immunization, Consent **PDF-Ref:** 1013-1020, 1023-1030, 1041-1042, 1050-1051, 1101-1102, 1123-1127, 1136-1141, 1143-1144, 1230-1231, 1991-1995, 1996-1999, 1199-1200, 1203-1205, 1178-1179, 1183, 1168-1171, 1240-1247, 1163-1164, 1034-1038, 1156, 1152, 2590, 1007-1008, 1048-1049, 1052-1065, 1068-1080, 1145, 1248-1982, 2001-2579, 6315-6332	
12/23/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Hospital follow up. 8 hour surgery for hernia repair. NG tube left her with some L ear pain. Patient complains of left arm pain, worried that there is a clot. Incentive spirometry doing daily. Belly pain is at baseline, controlled. She is moving her bowels, has lots of gas. Eating low fiber diet. Her mood is anxious, she was off her Wellbutrin for 11 days, just restarted last week. Thinks there is blood in her urine, has to lean to side to mechanically empty her bladder. **Physical examination:** **Abdomen:** Large vertical incision, incision still stapled, well healing **Assessment and plan:** 1. Anxiety - She is restarting her meds post op. Will get her therapeutic on meds, increase if needed 2. Abnormal urinalysis 3. Vitamin B12 deficiency	7850-7852
12/30/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **History of Present Illness:** Patient status post CAWR on 12/1/15; discharged home without drains and off of	698-700

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		TPN on 12/17/15; presents today for first POV. Since discharge from the hospital she has noticed that her GERD is worse than ever before. Still struggling with nausea but stopped taking Reglan after discharge. Denies diarrhea. Having good BMs. Has weaned down Dilaudid PO significantly and as a result dry mouth is improving but still present. Notes fatigue/lethargy and feels anxiety and depression are worse as well. Per daughter, not eating much but is staying hydrated. Still using scop patch and Phenergan. **Physical examination:** Midline incision well-healed with staples and retention sutures in place Ext warm/dry without edema **Assessment/ Plan:** 1. Ventral hernia Status post CAWR on 12/1; doing well Scan looks good today All drains out Will discontinue staples and retention sutures today 2. Small bowel obstruction Complains of GERD and nausea Stopped Reglan at home; needs to re-start Will also add PPI for reflux **Orders:** RTC in 1 months Re-start Reglan (5mg per oral QAC) Prescription for Protonix 40 daily Prescription for Oxycodone 5 mg disp 50 to help wean Dilaudid Continue to wear abdominal binder; no heavy lifting Focus on staying hydrated Recommend Biotine mouthwash for dry mouth	
12/30/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with contrast:** **Reason for exam:** Ventral hernia **Findings:** Evaluation of the lungs is compromised by respiratory motion. Bilateral breast implants. **CT Abdomen with contrast:** Liver has normal size and attenuation. The previously seen left subcapsular fluid attenuation hepatic lesion measures approximately 9 x 4 mm (series 5, image 45), stable compared to prior. No new suspicious hepatic lesions. Status post cholecystectomy. Common bile duct is not dilated. Spleen has normal size, contour, and attenuation. Stomach is unremarkable. Pancreas is without suspicious lesions or ductal dilation. Adrenals are without nodules. Kidneys are normal in size and enhance symmetrically. No renal calculi or hydronephrosis. No free fluid in the abdomen. No	2627-2628, 2596-2597

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		pneumoperitoneum. Interval jejunojejunal anastomosis. No bowel obstruction or bowel wall thickening. Stable surgical changes from sigmoid anastomosis. Interval placement of IVC filter, positioned inferior to the renal veins. No enlarged abdominal lymph nodes. **CT Pelvis with contrast:** Bladder is fluid-filled and thin-walled. The uterus and adnexa are surgically absent. No pelvic free fluid. Scattered nonenlarged bilateral inguinal lymph nodes. Extensive postsurgical changes from exploratory laparotomy and anterior abdominal wall reconstruction. Fluid associated with the mesh just posterior to the anterior abdominal wall measuring up to 17 mm in thickness (series 4, image 52). Several cutaneous surgical staples along the anterior midline abdomen. No aggressive osseous lesions. **Impression:** 1. Extensive postsurgical changes from exploratory laparotomy, anterior abdominal wall reconstruction, and jejunojejunal anastomosis. Fluid associated with the mesh just posterior to the anterior abdominal wall. No free abdominal fluid, pneumoperitoneum, or bowel obstruction. 2. Interval placement of IVC filter, positioned inferior to the renal veins. **Other records:** Assessment, orders (PDF-Ref: 2598-2606)	
01/07/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief complaint:** History of upper extremity deep venous thrombosis. **History of present illness:** Patient returns for follow-up. Recently she underwent a complex repair of her ventral hernia at Emory. Prior to the procedure she underwent placement of a retrievable inferior vena cava filter to prevent pulmonary embolism. Her abdominal operation was largely uneventful except for some difficulty in achieving peripheral IV access. Now she experiences severe heartburn and she is undergoing evaluation for gastroesophageal reflux which, reportedly, will include an EGD. She will find out the details of this over the next days. She does not have any upper extremity swelling or pain. She did not notice any significant swelling or pain in her lower extremities either. She did not experience any acute chest pain or dyspnea. **Review of system:** Constitutional: Weakness, lack of appetite. Cardiovascular: Chest pain/tightness/squeezing. Gastrointestinal: Nausea, vomiting, diarrhea, abdominal pain. Genitourinary: Pain or burning on urination Musculoskeletal: Neck pain, back pain Psychiatric: Anxiety. **Physical exam:**	8852-8854

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Right upper extremity: Mild edema. **Left upper extremity:** No edema. **Assessment and plan:** DVT, UE. **Plan**: I encouraged patient to follow up with her abdominal surgeon to find out if any additional procedure is planned following her ventral hernia repair. Otherwise she would benefit by having her inferior vena cava filter retrieved. She would like me to perform this procedure. I advised her to bring me the CT of the abdomen and pelvis performed after her hernia repair to assess the positioning and location of her inferior vena cava filter. She will call me to schedule this procedure in the near future. We will plan to perform it at AB Hospital Forsyth.	
	Hospital/ Provider Name	***AB University Hospital (01/07/YYYY-01/08/YYYY)***	
01/08/YYYY	Hospital/ Provider Name	**@0103 hours: History and Physical:** *(Admission assessment performed at 2306 hours on 01/07/YYYY)* **Chief complaint:** Gastroesophageal reflux **History of present illness:** Patient with complex surgical history secondary to complicated post-operative course following a laparoscopic cholecystectomy, recently admitted for ex-lap, LOA, SBR and CAWR with Vicryl and biologic under way on 12/1/15 with Dr. Galloway (discharge 12/17 in good condition, off TPN), who presents to the hospital today for increasing Gastroesophageal Reflux (GER) symptoms. Patient was last seen in clinic on 12/30, where her GER symptoms were noted causing her to have poor PO intake and feel dehydrated. Plan at that time was to restart Reglan, add a PPI for GER, continue abdominal binder, and focus on staying hydrated. Since this clinic visit, patient says that her reflux continues to be a major problem. She is not able to keep food or liquids down easily secondary to the pain in her esophagus. She was taking a nutritional shake regularly, but says that it has become increasingly difficult to take this as well. She is making approximately "3-4 cups" of urine daily. She has had no emesis recently, but did have an episode of non-bloody, non-bilious emesis 4 days ago. Over the last couple of days she has had good bowel function, although she says it is runny like diarrhea. **Physical examination:** **Gastrointestinal:** Soft, Non-distended, Mildly tender to palpation diffusely, Midline incision clean/dry/intact and epithelialized - healing appropriately. **Impression and plan:** Status post ex-lap, LOA, SBR, CAWR/VHR on 12/1/15 now presenting with increased GER symptoms, PO intolerance and dehydration. **Plan**:	2727-2729, 2702

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		- Admit to General Surgery, Dr. Galloway attending - Plan for EGD tomorrow - NPO, mIVF - Admission labs: CBC, CMP, Mg/Phos, coags - Chest X-rays, 2-view KUB - Urinalysis given dysuria - Reglan, Protonix for GER and GI motility - Phenergan for nausea control - Subcutaneous Heparin/SCDs for DVT prophylaxis	
01/08/YYYY	Hospital/ Provider Name	**@0148 hours: X-ray of abdomen and chest:** **Clinical indications:** Abdominal pain unspecified. **Chest:** The lungs are expanded and clear with exception of minimal basilar atelectasis. No pleural effusion is seen. The heart size is normal as are the hilar and mediastinal contours and visualized bony thorax. **Abdomen:** Two views of the abdomen show a normal bowel gas pattern with scattered surgical changes and IVC filter. No abnormal masses or calcifications are seen. No free air is seen. **Impression:** No evidence of acute process in the abdomen or pelvis.	2851
01/08/YYYY	Hospital/ Provider Name	**@1200 hours: Procedure Report for EGD:** **Indications:** Epigastric burning pain, inability to tolerate per oral **Impressions:** Small to moderate hiatal hernia and bile reflux into stomach **Recommendations:** Return to floor for ongoing care. Follow-up appointment with referring physician.	2735-2736, 2737-2741
01/08/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 01/07/YYYY. **Hospital course:** Patient was admitted underwent EGD with the below findings, and stabilized with improved symptoms on Carafate. She tolerated a regular diet and was deemed appropriate for discharge home on the same day. **Discharge condition:** Good **Discharge disposition:** Home with family	2712-2713
01/07/YYYY-01/08/YYYY	Hospital/ Provider Name	**Other records:** Input / Output Record, Labs, Plan of Care, Nursing Notes/Records, PACU Record, Anesthesia Record, EKG, Checklist/Verification List, Patient Education, Discharge Instructions, Assessment, Orders, Vaccination/Immunization	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		PDF-Ref: 2630-2685, 2689-2711, 2713-2726, 2730, 2734, 2742-2748, 2852-2853, 2854-2902, 2905-2938	
01/11/YYYY	Hospital/ Provider Name	**Pathology Report:** **Collected date:** 01/08/YYYY **Final Pathologic Diagnosis:** Stomach, antrum, biopsy: - Reactive/chemical gastropathy. - No H. pylori organisms identified.	2849-2850
01/22/YYYY	Hospital/ Provider Name	**Lab report:** **Low:** RBC 3.66, hemoglobin 11.3 C. difficile toxin assay feces – Negative	811-812
01/22/YYYY	Hospital/ Provider Name	**Telephone Conversation:** Patient finally called her ID doctor's office and was told they won't have results of her stool sample back for another 3 days. She is rather upset about this because after having C. diff times before, she feels she knows what it looks/feels/smells like, and she is certain she has it and should begin treatment. Per discussion with Dr. Galloway, will start her on Vancomycin 250 mg BID. Will order stat C. diff toxin assay and CBC. Will also get her set up to see someone in our ID department who specializes in C. diff and fecal transplants C. diff toxin test came back negative. Had patient stop the Vancomycin. Started her on Lomotil and Metamucil to control diarrhea. No need for ID appointment at this time.	2903-2904
01/26/YYYY	Hospital/ Provider Name	**Office Visit:** **History of present illness:** Patient words: complicated symptoms Recurrence of diarrhea for 8 days with LUQ abdominal pain, she has had this pain for months and has been recently told by GI due to H. pylori infection currently has received 1 week of triple antibiotic treatment. There has been associated thrush in her mouth. Visit with GI Dr. Kongora 1 week ago, questionable C. diff, Emory tested stool Friday and she reported negative C. diff. **Physical examination:** Abdomen: Soft, no mass, no organomegaly, vertical scar well healed, mild epigastric tenderness, no guarding, normoactive bowel sounds. **Assessment and plan:** 1. Diarrhea: Suspect a SE of antibiotics but am concerned for C. diff, will check stool, would like to have her stop antibiotics, have left a message to discuss treatment with Dr.	7842-7848

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		John Galloway. 2. Abdominal pain, acute epigastric: This pain has been chronic for her and recent EGD showed HH, will advise to try Dexilant after completion of her triple antibiotic therapy, plan to discuss treatment with her general surgeon as well as with GI. 3. Thrush. 4. Vitamin B12 deficiency. **Addendum note:** Spoke with patient after review of patient with Dr. Galloway nurse and Dr. Kongara, explained that EGD consistent with small to moderate HH, did not show any ulceration and biopsy negative for H-pylori, it is possible that the POCT H. pylori test was a false +. Patient states that her stomach pain is improving with the triple antibiotic treatment and in light of negative C. diff test done at Emory last Friday have advised her to complete the meds as prescribed. Additionally advised her to continue PPI after triple antibiotic triple to treat the HH and associated reflux, have switched her from Nexium to Dexilant. She reports the diarrhea is better with Lomotil and over all feeling better. I will advise further once labs are results, she will follow up as scheduled with Dr. Galloway on 2/3 and call me with any concerns.	
02/03/YYYY	Hospital/ Provider Name	**Follow up Visit:** **Chief complaint:** Hospital follow-up, labs today. **History of present illness:** Presents today with multiple complaints including abdominal pain, reflux, diarrhea, IVC filter removal. Was treated with triple abdomen for presumed + H. pylori. Carafate worked well for her reflux. Would like her IVC filter removed. Abdominal pain getting better but still bothers her at times. Went to an outside hospital ER and got a KUB which was negative. **Physical examination:** Abdomen: Soft, non-distended, non-tender, well healed surgical incision. No hernias **Assessment/ Plan:** 1. Ventral hernia: - Resolved - Plan for CT scan A/P with contrast in May or June - RTC May/June after CT scan - Continue binder; information for custom fit binder given to patient - Continue Tramadol for pain 2. GERD (gastroesophageal reflux disease): - Continue Carafate as this has helped her (liquid only); prescription given	695-697

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		- Continue PPI, may need to supplement with H2 blocker occasionally 3. Diarrhea: - Resolving with Lomotil, patient does not like taking Lomotil so has discontinued this medication but the diarrhea is resolving nonetheless. 4. Presence of IVC filter - Will make referral to radiology for IVC filter removal	
02/03/YYYY	Hospital/ Provider Name	**Lab report:** **Low:** BUN 2, RBC 3.79 **High:** Alkaline phosphatase 98	816-820
02/03/YYYY	Hospital/ Provider Name	**Fecal Leukocyte stain:** Collected date: 01/26/YYYY Fecal leukocyte: Not detected	7912-7913
02/05/YYYY	Hospital/ Provider Name	**Culture and Sensitivity Test:** **Collected date:** 01/26/YYYY Shiga toxin: Not detected Salmonella and Shigella: No isolated Ova and parasites, stool conc and pern smear: No ova or parasites seen	7822-7823, 7820-7821
02/25/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** Follow up. EKG. Complaint of chest pain, palpitations. Complaint of shortness of breath. **History of Present Illness:** Patient is here following up her extensive bowel surgery for her ventral hernia as well as multiple small bowel obstruction she also was recent he diagnosed with H. pylori and was placed on triple therapy questionable and has done externally well. She does have intermittent episodes where out the blue she felt like she ate too much initial have this shortness of breath and chest pressure sensation the last episode was about a month ago. She also has chest pains but these are atypical and unchanged. She is getting stronger since her surgery. **Assessment and plan:** 1. Chest pain – some atypical features and better with H. pylori treatment, monitor symptoms 2. GERD - much better with Carafate liquid. 3. Shortness of breath - normal cardiac exam no issues, no cardiac evaluation needed. None cardiac and more related to GERD RAD reaction and this is getting better with her treatment. Monitor for now.	821-823
02/26/YYYY	Hospital/ Provider Name	**Bilateral lower extremity venous duplex scan:** **Indication**: Edema.	760-761, 6446

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: Bilateral lower extremity venous duplex scanning was performed revealing no evidence of acute superficial or deep venous thrombosis in either lower extremity.	
03/03/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief Complaint:** Patient with history of right upper arm DVT had IVCF placed on 11/24/YYYY prior to surgery, she now returns for evaluation for IVCF removal. Recent ultrasound exam of the lower extremities was negative for DVT. **History of Present Illness:** Patient is here following up her extensive bowel surgery for her ventral hernia as well as small bowel obstruction. She was recently diagnosed with H. pylori and was placed on triple therapy and has done externally well. She has intermittent episodes when she has shortness of breath and chest pressure sensation the last episode was about a month ago. She also has chest pains but these are atypical and unchanged. She is getting stronger since her surgery. **Review of Systems:** General: Fatigue or tiredness. Has not returned to work after surgery. Eyes: Visual changes, Blurred vision Ears, Nose, Mouth, Throat: Ear pain Respiratory: Shortness of breath Cardiovascular: Palpitations/fluttering in your chest, Chest Pain Gastrointestinal: Nausea, Vomiting, Diarrhea, Constipation Genitourinary: Blood in urine Musculoskeletal: Joint pain, Back pain Neurological: Headache, Dizziness, Numbness, Tingling, Weakness Endocrine: Urinary frequency Hematological: Easily bruises Skin: Dryness Psychiatric: Anxiety, Sleeping problems **Assessment**: Ok for IVCF removal. **Plan**: Filter removal scheduled for Thurs, March 8th at 1 PM.	724-726, 3030-3033
	Hospital/ Provider Name	***AB University Hospital (03/08/YYYY)***	
03/08/YYYY	Hospital/ Provider Name	**Moderate Sedation Consultation:** **History of present illness:** Patient with history of right upper arm DVT status post IVC filter placement on 11/24/YYYY. Recent ultrasound negative for lower extremity. Plan to remove IVC filter.	2959-2961

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: Mallampati Pharyngeal Visualization Score: Class I Sedation Plan moderate sedation. ASA status classification Class 1: A normal healthy patient.	
03/08/YYYY	Hospital/ Provider Name	**IR procedure report for vein filter removal IVC:** **Indication**: Completed ventral hernia repair. No longer bedbound. **Findings**: 1. There is no significant thrombus within the infrarenal IVC filter. 2. The filter was removed without incident. 3. Post removal cavography shows no contrast extravasation or leak. The IVC is intact. **Impression**: No evidence for significant captured within the infrarenal IVC filter. Uneventful image guided retrieval of an infrarenal IVC filter as described.	3007-3009, 2944
03/08/YYYY	Hospital/ Provider Name	**Lab report:** **Low:** BUN 6, RBC 3.90, INR 0.90 **High:** Creatinine 1.01	832-834, 2941
03/08/YYYY	Hospital/ Provider Name	**Other records:** Anesthesia report, Flow Sheet, Plan of Care, Orders, Assessment, Input / Output Record, Medication Sheets, Vaccination/Immunization **PDF-Ref:** 2947-2958, 2962-3006, 3010-3029	
03/14/YYYY	Hospital/ Provider Name	**Follow up Visit:** **History of present illness:** Patient words: Here to recap after her surgery. Had 8 hour hernia repair. She developed hiatal hernia which is awaiting repair. She was treated for H. pylori. She is doing better. Mood is good. Has hearing loss. She has started back to work, going to be on a TV show. **Assessment and plan:** 1. MTHFR mutation: She will stay on Folguard and Aspirin. Will need Xarelto if she had surgery 2. Peptic ulcer disease: Impression: Also with hiatal hernia. Awaiting surgery summer 2016. Current plans: Changed Dexilant 60 mg. 3. Anxiety, unspecified, if primary Impression: She is doing well on Wellbutrin SR 100 HS. 4. Vitamin B12 deficiency.	7693-7695, 7691-7692

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		5. Fatigue.	
05/25/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis without contrast:** **Clinical indication:** ventral hernia, GERD, diarrhea. **Impression:** Postsurgical changes from abdominal wall reconstruction with interval decrease in fluid associated with the mesh posterior to the anterior abdominal wall. No evidence of interval complication.	32-33
05/25/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** 4 month follow-up – CT at 7:45 AM. **History of Present Illness:** Status post ventral hernia repair with small bowel resection in 12/YYYY for incisional hernia and chronic Small Bowel Obstruction (SBO). She returns today for routine follow up and CT abdomen/pelvis. She did have her IVC filter removed recently without issue. She is tolerating a regular diet. She has had some improvement in her diarrhea but now seems to alternate between diarrhea and constipation. She is concerned about bilateral leg swelling and varicose veins, as well as an area of fullness above her incision. Her GERD symptoms have improved significantly since her last visit with Carafate and she would like a referral to a local GI doctor today. **Review of systems:** Respiratory: Shortness of breath Cardiovascular: Palpitations/fluttering in your chest Gastrointestinal: Nausea, Diarrhea, Constipation Neurological: Headache Psychiatric: Anxiety, Depression, Sleeping problems **Physical examination:** Abdomen: Soft, non-tender, non-distended, well healed incisions, no hernia recurrence **Assessment/Plan:** 1. Ventral hernia. 2. GERD (gastroesophageal reflux disease). 3. Small bowel obstruction. Status post repair of ventral hernia. She is doing very well from a surgical standpoint, and her CT shows intact hernia repair. She is concerned about some soft tissue fullness at the top part of her incision. Recommended Vitamin E or collagen lotion application with massage twice daily and plan to reassess the appearance in a few months. Reminded the patient that scar remodeling and full recovery from this major operation will take many months and up to two years. She will make an appointment with Northwest Gastroenterology to follow for her GERD and constipation/ diarrhea. Return to clinic in 3 months.	691-694

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
07/06/YYYY	Hospital/ Provider Name	**Office Visit:** Patient words: Patient is complaining of body aches, sleeping a lot and sinus drainage. General not feeling well. "doesn't think she will ever be happy again" She is seeing her counselor regularly. Her fibromyalgia is flaring. She saw Fishman who increased her Lyrica but it made her loopy (225 mg). She is sleeping 10-14 hours/night. She is teary, apathetic. Not really anxious any more. Doesn't enjoy life. **Review of systems:** Psychiatric: Panic Attacks. **Assessment and Plan:** Depression, major, recurrent Anxiety symptoms resolved. Now predominantly depression. She has struggled since her hospital stay in 2014. Still seeing her therapist regularly. I think the Lyrica may be contributing to her symptoms. Will try to increase her Cymbalta to help with her symptoms and perhaps down titrate her Lyrica.	7678-7679
07/25/YYYY	Hospital/ Provider Name	**Office Visit:** Initial visit, referred by Dr. Pepper, PCP Patient is referred for evaluation of migraine headaches. Her daughter is a migraine patient of mine. She had a period of time back in about '00 where migraines were pretty frequent, then they tapered off and were occurring only every few months. Thinks that neck injury in MVA is what set them off in the first place. She got sick with septic shock in '14 and since that time they have become more frequent and severe again. Still not terribly frequent but she lacks good acute therapy. They are typically bilateral frontal/retro-orbital, "crushing". Radiate to her ears, teeth. + associated photophobia and phonophobia, worse with activity. They are debilitating, spends most of the time in the bed when they occur. They last at least a couple of days and sometimes longer. She recalls that when she used to have them previously she would see visual scotomata "like sparks, this hasn't happened recently. + comorbid fibromyalgia and depression, has been working with both Dr. Pepper and Dr. Fishman on these. Thinks some of the meds for these may be exacerbating the migraines, feels like she is in a constant "brain fog". She is trying to taper off of the Lyrica, feels like it didn't help at all with her fibro symptoms. Relpax makes her too sleepy/foggy to be effective. Fioricet worked well in the past but doesn't seem to work as well now. Zofran sometimes helps with the nausea. **Assessment and plan:** 1. Intractable migraine without aura and without status migrainosus 2. Depression, major, recurrent Impression: anxiety symptoms resolved. Now predominantly depression. She has struggled since her hospital stay in 2014. Still seeing her therapist regularly. Feels like transition to Cymbalta is helping summer '16 3. Fibromyalgia	7675-7677

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
08/10/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** 4 month follow-up. **History of Present Illness:** Status post ventral hernia repair with small bowel resection in 12/YYYY for incisional hernia and chronic SBO. She was last seen in clinic with CT scan in 5/YYYY and was doing quite well at that time. She comes back with some concerns over the last 4-6 weeks. Was tolerating diet and had a good appetite until her psychiatric meds were adjusted (specifically Cymbalta added and Lyrica and Wellbutrin increased). Her mood changed and became more depressed, loss of appetite and interest, increase sleep and fatigue as well. Has improved over the past week however as some her medication doses have decreased but still not as she was 2 months ago. She is complaint of some exertional abdominal pain at the midline when getting up from seated position or bending over. This is stable. She also has some difficulty in starting the defecation or urinating process and feels that she has to strain to do either. She has small bowel movements every 2 days or so. Last saw GI specialist in February but did not agree with their assessment so doesn't follow with them anymore. **Physical examination:** Abdomen: Soft, NT, ND, midline wound well healed and there is a soft tissue fullness superiorly on the wound but no hernia defect is palpated. **Assessment/Plan:** 1. Abdominal pain: The difficulty defecating and urinating is concerning for pelvic floor dysfunction and we will refer to Dr. Niall Galloway and his partner Dr. Espy of urology for evaluation and studies as necessary. We have not obtained an MRI of the bowel yet so we will order this and see her after this is complete. She describes a lot of psychiatric dysfunction which we are certainly not experts at she will follow-up with s in 3 months after urology consultation and MRI of assessment and plan with small bowel protocol is complete. 2. Anxiety. 3. Status post repair of ventral hernia.	688-690
08/30/YYYY	Hospital/ Provider Name	**Office Visit for cough:** **History of present illness:** Persistent cough. Sick for 10 days. Tried Mucinex, chloraceptic, halls. Started Zpack and Prednisone. 1000% better but still coughing. Dry hacking cough triggered by tickle in her throat. Spitting yellow phlegm. Mood overall is better since coming off the Lyrica. She is still anxious, still hopeless, no suicidal. She is still seeing her therapist. Still anxious. **Assessment/Plan:** 1. Cough. 2. Anxiety unspecified - She continues to see her counselor, Richard Blue PhD.	7672-7674

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		She has not been wiling in see a Psychiatrist. I would like to try a low dose of Latuda or similar if cost is not an issue. Will continue to see her regularly. 3. Vitamin B12 deficiency.	
08/30/YYYY	Hospital/ Provider Name	**X-ray of chest:** Miniscule infiltrate superior lingual. Remainder of left lung/right lung clear. No effusion or adenopathy. Tiny subtle area of emerging lingual pneumonia.	7810
	Hospital/ Provider Name	***St. Joseph's Hospital (09/06/YYYY-09/07/YYYY)***	
09/06/YYYY	Hospital/ Provider Name	**ER visit for abdominal pain:** **History of Present Illness:** Patient presents to Emergency department complaint of increasing abdominal pain x1.5 week that's burning in nature as well as a burning mouth pain, which she's currently taking magic mouthwash for with minimal relief. Associated symptoms include a low-grade fever of 100.1 on and off for the past week, nausea, and dizziness. She's had a normal BM this am. Patient's had multiple abdominal surgeries for obstruction and hernias, is followed by Dr. Galloway. She was scheduled for an MRI last week, but was unable to get it done and she was advised to go to the ED by his office today since she's in so much pain. **Physical examination:** **Gastrointestinal:** Soft, Normal bowel sounds, Tenderness: Moderate, epigastric, right lower quadrant, Guarding: Negative, Signs: None. **Medical decision making:** Patient with extensive abdominal surgical history including small bowel and colon resection from previous obstructions presents to ED for worsening abdominal pain for the past 1.5 weeks. Lab work shows elevated WBC and CT scan shows a stable abdominal fluid collection, but unclear as to whether it's sterile or infectious. Discussed patient's plan of care with Dr. Segerman and patient is to be admitted under IMS with General Surgery consult. IMS and General Surgery indicates patient would not benefit from admission to SJH and advises transfer to EUHM. Discussed with Dr. Stetler at EUHM and he's reviewed patient's results and CT scans and advises discharge home with bowel regimen and follow up with Dr. Galloway in the office this week. **Re-examination/re-evaluation:** **2215 hours:** Discussed patient's case with IMS, Dr. Mather for admission **2230 hours:** Discussed patient's case with Dr. Wilkiemeyer, General Surgeon on-call, and he advises that patient needs to follow-up with her Emory Surgeon at main campus. **2315 hours:** Discussed with Dr. Stetler at EUHM and he's reviewed patient's CT scan results and lab work. He believes she can benefit from a good bowel regimen for the extensive stool in her bowels and follow-up with Dr. Galloway in the office this week. Patient's fluid collection in her abdomen is table and most likely sterile and therefore, does not need to be transferred to EUHM. He also advises that the patient needs to go to EUHM in the future for her abdominal pain	371-377, 418-423, 13605

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		due to her extensive surgical history **2330 hours:** Discussed all results and findings with the patient and patient's family. Advised follow-up with Dr. Galloway in the office this week and will give prescription for Miralax as well. Patient and family verbalized understanding and is in agreement with the treatment plan. **Impression and Plan** **Diagnosis:** Generalized abdominal pain. Constipation. Oral candidiasis. **Plan:** **Condition**: Stable. **Disposition**: Medically cleared, Discharged to home.	
09/06/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis without contrast:** **Clinical indication:** Abdominal pain unspecified. **Impression**: 1. No significant change in appearance of fluid collection associated with the anterior abdominal wall mesh, as described above. No extra luminal accumulation of enteric contrast. It is unclear whether this collection is sterile or infected. 2. Unchanged 8 mm indeterminate left inter polar region renal lesion. Given stability in size since 2014, this likely is a benign finding.	377-378
09/07/YYYY	Hospital/ Provider Name	**@0011 hours: Discharge assessment:** Condition at disposition: Improved Transport mode: Ambulatory	13142
09/06/YYYY-09/07/YYYY	Hospital/ Provider Name	**Other records:** Discharge Instructions, Orders, Plan of Care, Assessment, Discharge Instructions, Patient Education, Vaccination/Immunization, Medication Sheets, Input / Output Record **PDF-Ref:** 13159-13239, 13242-13269, 13608-13619	
09/13/YYYY	Hospital/ Provider Name	**MRI of abdomen and pelvis with contrast:** **Clinical indication:** Patient with abdominal pain. Past medical history significant for ventral hernia repair with small bowel resection in 2015 for incisional hernia and chronic small bowel obstruction. Also history of colon cancer with resultant adhesions and partial colectomy. **Impression**: 1. Pancake shaped fluid collection anterior to the abdominal wall hernia mesh repair within the rim enhancement, not significant changed in size. Differential	3099-3101

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		includes seroma, resolving hematoma although superinfection cannot be excluded. 2. Multiple small bowel adjacent to the fluid collection/hernia mesh. Underlying fistulous connection of the bowel with this fluid collection cannot be excluded. However, no new fluid collection or intraperitoneal fluid collection identified. No bowel obstruction. 3. Prominent but not enlarged mesenteric and peritoneal nodules/lymph nodes. Continued attention on follow-up.	
09/13/YYYY	Hospital/ Provider Name	**Other records:** Assessment, History and Physical, Plan of Care, Orders, Medication Sheets, Input / Output Record, Pre-sedation assessment, Flow Sheet **PDF-Ref:** 3041-3050, 3052-3055, 3057-3098, 3102-3114	
10/17/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief complaint:** Follow-up **History of present illness:** Patient status post ventral hernia repair with small bowel resection in 12/YYYY for incisional hernia and chronic SBO. She was last seen in clinic back in August and her concerns remain about the same. Her appetite is up and down and she is struggling with fatigue. This is likely secondary to her fibromyalgia and changes in her medications. She is off of Lyrica at this point but continues to take Cymbalta and Wellbutrin, which are monitored by her PCP who she will be seeing Thursday. She continues to have abdominal pain with positional change, which is stable. She continues to strain with defecation and urination, but this is somewhat improved since her last visit. She has not seen Dr. Galloway's team in urology, but has an appointment in November. She has about two BMs per day. **Review of systems:** **Neurological:** Still does not feel that she has recovered the or emotionally from her severe sepsis syndrome **Physical examination:** **Abdomen:** Midline wound well healed and there is a soft tissue fullness superiorly on the wound but no hernia defect is palpated, soft, nontender, nondistended, positive bowel sounds **MRI:** Stable fluid collection anterior to mesh **Assessment and plan:** 1. Ventral Hernia: No hernia present on imaging or exam. Exercise and PT is encouraged while wearing abdominal binder. Advised not to lift more than 20 pounds. Follow up in 6 months. The need for a follow-up CT scan will be determined at that time. 2. Urinary straining: Appointment with Dr. N. Galloway's team in urology in November.	685-687

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. Fibromyalgia, anxiety, depression: Per her PCP. Advised to seek out a wellness specialist. **Addendum:** 1. Ventral hernia No evidence of recurrence. The bulge she feels in her epigastrium is just redundant subcutaneous tissue. Based on CT scan and exam, I believe she can tolerate increasing her exercise levels in hopes of improving her stamina. I suggested swimming, a brisk walking program and light weight gym workouts; all with her binder in place. 2. Generalized abdominal pain This is not unexpected giving the significant nature of her recent him complex abdominal wall reconstruction. Nonnarcotic treatment program is encouraged. Judicious use of Tramadol is appropriate. 3. GERD (gastroesophageal reflux disease) Continue PPI, Carafate, and general antireflux measures. I agree that she should be followed by a gastroenterologist. The folks at Emory St. Joseph's we will do a fine job. 4. PTSD (post-traumatic stress disorder) Her brush with death from sepsis syndrome has really impacted on her quality of life and ability to function. I believe her psychologist and primary care physician are working hard to help her with medical and nonmedical measures. Her chronic fatigue may be related to hormonal issues and checking thyroid function studies, adrenal, pituitary and gynecological hormones would be appropriate. This was discussed with her in detail so that her primary care physician can order the appropriate lab work. A complete micronutrient evaluation might identify deficiencies that could be easily corrected with appropriate vitamin and mineral supplementation and dietary measures; and, therefore, I suggested to patient that she identify I engage a health caregiver who is a "wellness specialist" that specializes in and coordinates a total body wellness program that would emphasize diet and nutritional management, exercise and physiotherapy, yoga and stress relief programs along with appropriate emotional and spiritual support. 5. Fibromyalgia She might benefit from consultation with rheumatology as well as a immunologist. She will take this under advisement.	
11/01/YYYY	Hospital/ Provider Name	**Office Visit urinary incontinence:** **History of present illness:** Patient presents for voiding dysfunction. She has a complicated history that includes a bowel perforation during a lap cholecystectomy. She required an ex lap and repair. She spent time in the ICU after. She has since had an abdomen reconstruction for a hernia. She is here with recurrent UTIs. She has had both micro and gross hematuria. She sometimes has to strain to void, and does not feel like she empties well. She is on Vesicare and has been for many years. She has	846-847, 848-852

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		UTI 2x per month. Her only SUI is with significant cough. She struggles with constipation and takes a daily stool softener. **Physical examination:** Abdomen: Tender in lower abdomen incision well healed from previous surgery GU: Mild cystocele and rectocele **Assessment and plan:** 1. Hematuria. Urinalysis today with positive blood, will plan for cysto for further evaluation, recent MRI showing fluid collection anterior to abdomen mesh. 2. Straining during urination. Patient also with constipation she was given a handout on ways to improve bowel function.	
11/04/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Abdominal surgery follow up. Still has fluid around the mesh. Not thought to be infected. Wants to recheck CBC. Depression - better off Lyrica. She is on Wellbutrin SR 100 once day. **Assessment and plan:** 1. Depression, major, recurrent - Stabilized but not under optimal control. Will increase her Cymbalta. If she cannot tolerate due to insomnia will consider increase her Wellbutrin. Latuda made her mood worse. She is still seeing Dr. Blue weekly 2. Fibromyalgia 3. Insomnia 4. Urinary frequency 5. Vitamin B12, vitamin D deficiency 5. Routine check	7660-7664
	Hospital/ Provider Name	***AB University Hospital (11/11/YYYY-11/12/YYYY)***	
11/11/YYYY	Hospital/ Provider Name	**@1952 hours: X-ray of abdomen:** **Clinical indication:** Abdominal pain unspecified. **Impression:** Moderate colonic stool burden.	3228
11/12/YYYY	Hospital/ Provider Name	**@0003 hours: ER visit for constipation:** **History of Present Illness:** Patient presents with history of long standing reflux, fibromyalgia, anxiety, depression, previous SBO and abdominal surgery followed by Dr. Galloway presenting with constipation x 5 days. Patient also endorses abdominal discomfort, nausea and vomiting noting last bowel movement 5 days ago, however is passing flatus. She has triage X-ray with no evidence of obstruction and moderate colonic stool burden. Patient notes she does not eat a lot of fruits and vegetables but is interested in increasing fiber content of stool. The onset was 5 days ago. The course/duration of symptoms is constant. Character of	3119-3129

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		constipation unable to defecate. The relieving factor is none. Risk factors consist of prior bowel obstruction. Therapy today: none. Associated symptoms: abdominal pain, nausea and vomiting. **Vitals:** BP 121/75, pulse 95, resp. rate 16, temp 37.6, SpO2 95% **Medical decision making:** Patient presents with constipation confirmed by X-ray. I have low suspicion for obstruction. Leukocytosis unconcerning, urine clean, chest X-ray negative, no focal infectious symptoms by history. No anion gap, healthy otherwise tonight. Patient wants to be discharged and pursue home bowel regimen which will include Miralax, Magnesium citrate, mineral oil go lightly and enema. I have spent more than 20 minutes discussing lifestyle modifications including exercise and good nutrition and our interaction has been delightful. **Labs:** **High:** Anion gap 12, alkaline phosphatase 111, WBC 15.1, hematocrit 43.9 **Urinalysis:** Hazy, specific gravity 1.027, protein 30, blood small, squamous epithelial cells 13, mucus 4+, hyaline cast 6 **Impression and plan:** **Diagnosis**: Constipation. **Plan**: **Condition**: stable.	
11/11/YYYY-11/12/YYYY	Hospital/ Provider Name	**Other records:** Labs, Patient Education, Vaccination/Immunization, Medication Sheets, Orders, Plan of Care, Assessment, Nursing Notes/Records, Discharge Instructions **PDF-Ref:** 3130-3137, 3141-3176, 3179-3227, 3229-3239, 3243-3251, 6341-6346	
11/14/YYYY	Hospital/ Provider Name	**Office Visit:** **History of present illness:** Called in last Friday with nausea/vomiting. Told to go to ER for imaging. She called her abdomen Surgeon (Galloway) and he advised similar. She passed out yesterday. She had a leg cramps and felt intense pain then felt very woozy then passed out. Son says she was out for 8 mins. Went to Emory Clifton ER. She was told that she was impacted and that is why she was vomiting. WBC reportedly 15. She has traced her insomnia and muscle cramps and RLS since she started the Cymbalta. **Assessment and plan:** 1. Nausea and vomiting - Resolved. Due to severe constipation. 2. Constipation - baseline colonic inertia. She has started fleet and mag citrate and is now moving her bowels 3. Syncope – sounds vasovagal. Will get records from Emory. She is feeling	7655-7658, 7653-7654

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		better today 4. Depression, major, recurrent - Stabilized but not under optimal control. Latuda made her mood worse. She is still seeing Dr. Blue weekly. Wean Cymbalta to 30 daily for up to two weeks then stop. Once off the Wellbutrin, will increase her Wellbutrin. 5. Urinary frequency - waking her up 4-5/night. Will increase her Vesicare. Has follow up with Uro. Check urine today.	
11/15/YYYY	Hospital/ Provider Name	**Cystoscopy procedure Report:** **Pre and post-operative diagnosis:** Recurrent UTI's, hematuria, voiding dysfunction. **Procedure:** Diagnostic cystoscopy **Findings:** No bladder lesions or stones, short urethra 1 cm	727-728, 768-769, 780-785, 855-857
	Hospital/ Provider Name	***AB University Hospital (11/18/YYYY-11/22/YYYY)***	
11/18/YYYY	Hospital/ Provider Name	**ER visit:** **History of Present Illness:** The patient presents with abnormal lab test and patient sent to ED by Dr. Galloway's office for elevated WBC and possible sepsis. She had her labs done at her primary care doctor's office on Monday and WBC was 11. On Wednesday she had repeat labs and WBC was 15.1. She was called by Dr. Galloway office to come to the ED. On Sunday and Monday she had a syncopal episode and has been complaining of dizziness, lethargy, and weakness. She has had an increase in her abdominal pain. Her abdominal pain started in LLQ and goes up to epigastric region and is a burring pain. +nausea and one episode of vomiting on Monday. Lab test value patient was notified of lab results by: doctor's office WBC 15.1. Associated symptoms: abdominal pain. Risk factors consist of multiple abdominal surgeries. Prior episodes: frequent. Therapy today: none. Additional history: none. **Vitals:** BP 123/85, pulse 104, resp. rate 16, temp 36.7, SpO2 97% **Physical examination:** **Abdomen:** Moderate generalized tenderness. **Medical decision making:** Patient has diffuse abdominal tenderness without guarding. Patient is very fixated on her WBC. I notified her that it was elevated and this is a non-specific value and it was better than it was. Lactic acid is elevated. Will get BC and urine cultures. CT done as per recommendations by Dr. Galloway office. Will give pain medications and IVF. Dizziness is either orthostatic vs vasovagal. I do not feels that she has an acute infection or sepsis. **2339 hours:** CT shows not abscess but due to complicated surgical history of	3900-3910

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		since Galloway sent her here, will have surgery consult. Patient aware of labs, CT results, and plan of care. **0200 hours:** Surgery does not feels that she needs to be admitted to their services but recommends admission to HMS. Dr. Neely notified and did not accept admission at this time. He would like one liter of NS and repeat CBC and lactic acid. Will do this. Patient and family notified of plan of care. Denies dizziness when she stands up. She does remain fixated on her WBC number. **Labs:** **High:** Lactic acid 3.3, WBC 12.3 **Low:** RBC 3.88 **Urinalysis:** Squamous cell 8 **Impression and plan:** Leukocytosis **Condition:** Stable **Disposition:** Patient care transitioned to Mark Rosing	
11/18/YYYY	Hospital/ Provider Name	**@1942 hours: X-ray of chest:** **Clinical indication:** Shortness of breath. **Impression**: No acute cardiopulmonary process.	4238-4239
11/18/YYYY	Hospital/ Provider Name	**@2227 hours: CT abdomen and pelvis with contrast:** **Clinical Indication:** Abdominal pain unspecified. Constipation for 5 days. Still passing flatus. Complex surgical history with multiple small bowel resections and partial colectomy. **Impression**: 1. Stool burden throughout the colon. No bowel obstruction. 2. No significant interval change in elongated fluid collection anterior to the abdominal wall hernia mesh repair, previously characterized as either seroma or resolving hematoma on MRI. Sterility cannot be determined by imaging.	4237-4238
11/19/YYYY	Hospital/ Provider Name	**@0310 hours: Consultation Report:** **Chief complaint:** Abdominal labs. Patient has fever and or illness. **Reason for consultation:** Abdominal pain **History of present illness:** Patient presents with past medical history significant for fibromyalgia, hiatal hernia status post ventral hernia repair with small bowel resection and complex abdominal wall reconstruction with mesh in 12/YYYY for incisional hernia and chronic SBO. She was last seen in surgery clinic 10/17/YYYY with complains of chronic fatigue likely secondary to her fibromyalgia and changes in her	3995-3996

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		medications following episode of severe depression. She presents today to ED with 2 episodes of syncope in last week and abdominal pain. Had a single episode of nausea and vomiting a few days ago. Patient has a history of chronic constipation, however passing gas and having BM's. She was seen at the ED 11/11/YYYY for constipation and leukocytosis to 15k, placed on bowel regimen. She has had 2 episodes of syncope since last visit to ED, and given leukocytosis was advised to present in ED for extensive work-up. Of note patient endorses occasional shooting pain in face, eyes and abdomen and extremities, likely secondary to fibromyalgia. In ED patient afebrile, mild tachycardia to 104, labs significant for WBC 12.8 and lactate 3.3. CT abdomen with no intraabdominal pathology or obstruction, stable anterior abdominal wall seroma. Surgery consulted for further surgical exam. **Physical examination:** **Abdomen:** Soft, well healed ant abdominal wound, no palpable masses, non peritonitic, mild localized LLQ tenderness. **Assessment and plan:** Patient presents with fibromyalgia status post ventral hernia repair with small bowel resection and complex abdominal wall reconstruction with mesh in 12/YYYY for incisional hernia and chronic SBO presents with recurrent syncope **Plan**: - CT scan reviewed with radiology, no intra-abdominal pathology - Stable anterior wall seroma on CT not likely source of leukocytosis, will continue to follow as outpatient. - Patient will benefit from complete syncopal work-up. - Some dehydration, rehydrate appropriately. - Leukocytosis trending down, will recommend complete sepsis work up. - No acute surgical intervention at this time. - Recommend Medicine admit for syncopal and sepsis work-up.	
11/19/YYYY	Hospital/ Provider Name	**@0805 hours: ER addendum:** **Vitals at 0727 hours:** BP 119/58, pulse 69, resp. rate 18, SpO2 97% **Medical decision making:** Surgical team has seen the patient and recommends HMS evaluation. Patient was not orthostatic on exam. Will admit the patient to HMS, obs status. **Labs at 0519 hours:** **High:** WBC 10.2 **Low:** RBC 3.27, hemoglobin 10.3, hematocrit 30.9 **Impression and plan:** Elevated WBC Syncope	3885-3899

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Condition: Stable **Disposition:** Admit	
11/19/YYYY	Hospital/ Provider Name	**@0915 hours: History and Physical:** **Chief Complaint:** Abdominal pain and syncope. **History of Present Illness:** Patient presents with history of multiple complications and surgery including cardiac arrest/septic shock complicating cholecystectomy at Northside 2 years ago presents with recurrent abdominal pain x 2 weeks. Patient reports she has been drinking well, mostly water but some tea felt lethargic Sunday and lay down. Son woke her up and upon sitting she said she felt dizzy and said she was going to pass out and did. Patient had another episode of syncope on Monday while at doctor office getting blood. Patient had cystoscopy Tuesday and reports WBC was elevated at 15 prior to procedure and was given 1 dose of Levaquin as prophylaxis. Patient denies dysuria. WBC elevated last night with tachycardia. Abdominal pain has been constant x 2 weeks and tramadol at home did not help much but Morphine in ED treated it well. It goes from umbilicus and goes up to epigastrium where it is the worse. Feels like boiling acid and it is improved with eating. Currently pain is 6/10. Patient was here 11/12 in ED with constipation and has taken Miralax twice daily since then with good BM. Patient reports when she came to ED last night she felt very dizzy every time she stood up but this morning she went to BR and felt somewhat unsteady because she just woke up but not bad. **Physical exam:** **Gastrointestinal:** Tender epigastrium to umbilicus. Some tenderness in left flank. **Impression and Plan** Patient presents with history of multiple abdominal surgeries presents with abdominal pain and syncope. 1. Syncope - suspect volume depletion despite good fluid intake. - Unfortunately orthostatics not done prior to IVF so will do workup including echo - Telemetry - Orthosattics in morning 2. GERD: Abdominal pain - patient was treatment for presumed H. pylori per Surgery clinic note but review of EGO by Dr. Haack was negative for H. pylori on biopsy and showed hiatal hernia. - Symptoms today would be suggestive of duodenal ulcer but with negative ulcer in Jan unsure how likely this would be now as patient reports pain in Jan was much worse. - Rec outpatient GI followup - Cont carafate, PPI	3990-3994

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		3. SIRS criteria with tachycardia and leukocytosis on presentation to ED but improved with antibiotics in ED. - Leukocytosis of 15 on Tuesday with Levaquin on Tuesday for cystoscopy muddies the water. Patient may have had UTI partially treated. - Blood culture obtained in ED. - UA negative in ED but got antibiotics Tuesday. Patient reports no dysuria but pulling sensation at end of urination. Will send off urine culture, if pas would start antibiotics. - Will not start antibiotics preemptively as patient reports she gets C. diff easily	
11/20/YYYY	Hospital/ Provider Name	**@0008 hours: Progress Notes:** **Subjective:** Patient denies fevers, chills, night sweats, she has gained 30 lbs in the last year. Appetite is normal and she now has regular bowel movements every day with Miralax. No vision changes, cough, chest pain or shortness of breath. No dysuria, chronic hematuria, stable. She reports right-sided headache with OS watering and left ear pain since 2 days. She also noticed "charley-horses" in her legs since 2 weeks. Also chronic muscle spasms with good effect from Flexeril. **Physical examination:** **Abdomen:** Status post multiple surgeries, normoactive bowel sounds, Soft, tenderness to palpation in LUQ, non-distended, normal bowel sounds. **Assessment/Plan:** 1. Syncope: - Orthostatic BP negative this morning (although after 1 L NS), but symptomatically improving with fluid resuscitation - Continue telemetry - Cardiac echo ordered - May consider tilt table test 2. Initial concern for SIRS: Currently no signs of infection, WBC downtrending from 15-> 10 without antibiotic therapy - Urinalysis negative, 2x blood culture and urine culture pending - Given 1 x dose of Levaquin as outpatient which may be masking underlying ongoing infection, will continue to monitor for signs of infection - General surgical consulted, appreciate recs. - Per General surgical note: stable abdominal seroma, no signs of infection 3. Muscle spasms: given multiple abdominal surgeries and small bowel resections, concern for electrolyte or vitamin deficiency. - Labs Ordered. 4. Abdominal pain: Status post multiple surgeries, most likely secondary to chronically stable abdominal wall seroma - Continue home meds Miralax, probiotics, PPI	4036-4041

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		5. Headache, ear pain, OS watering differential diagnosis sinusitis: - Start NaCl nasal spray TID. - Consider X sinus if no improvement of symptoms. 6. Depression/anxiety: - Continue Welbutrin and Cymbalta. **Addendum by Mehta, Meera on 06:22:** I agree with Dr. Engels assessment/plan as above. Patient with a complicated history (elective CCY complicated by septic shock requiring and multiple abdominal surgeries) who presents for syncope and abdominal pain. Unclear the etiology of her syncope (Orthostatics taken after fluids) but she did have some nausea/emesis 1 week prior. She noted some palpitations so she is on telemetry and TTE ordered but likely related to volume depletion. Additionally there was a concern for SIRS/sepsis from unclear source. She was pan-cultured, results are pending. General Surgery evaluated the patient and believe that abdominal pain/SIRS was not related to the stable abdominal seroma. She felt relief with Carafate so may be related to underlying acid reflux. At this point, it has largely resolved and therefore will continue to monitor for worsening of symptoms. **Addendum by Durick, Paul G on 12:12:** Patient seen and evaluated with resident today. Agree with assessment and plan as outlined in today's note. Syncope likely due to orthostasis. Improved with fluids. Continue to complete formal cardiac workup for syncope as well as infectious workup given initial leukocytosis.	
11/20/YYYY	Hospital/ Provider Name	**@0726 hours: General Surgery Progress Notes:** **Subjective:** Patient did well overnight. Pain controlled. Feels dizzy this morning and looks a little dry. Having some nausea on general diet. **Physical examination:** **Abdomen:** Soft, non-tender, non-distended **Impression and Plan:** - PRN IV pain medications as needed. - Hemodynamically stable, EWOB. - Continue fluid hydration - patient looks a little dry. Titrate to UOP. - Aggressive bowel regimen to include Senna, Milk of magnesia, and possibly enemas PRN in addition to twice daily Miralax, Colace. - Cardiac echo, carotid duplex for syncopal work up. - Will continue to follow.	4032-4035
11/20/YYYY	Hospital/ Provider Name	**@1138 hours: Progress Notes:** **Subjective:** Doing well this morning. No LH when sitting up. Ate breakfast with some nausea that resided without intervention. No vomiting, no diarrhea, though has been constipated. She has some blurry vision, but no floaters. No palpitations, chest	4029-4032

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		pain. **Labs:** **High:** Glucose 121 **Low:** Hemoglobin 10.8, hematocrit 32.9 **Assessment and plan:** 1. Syncope: Patient reports LH (Possible Prodrome) and syncope in the setting of a flu shot, indicating this may be vasovagal. Patient's lightheadedness may indicate some volume depletion, though she reports no diarrhea, poor PO intake, or polyuria. Unlikely seizure (no bowel /bladder incontinence), and POCT Glucose >80 at presentation. - EKG NSR - TTE pending. 2. Concern for Sepsis: WBC 15 in clinic 11/11, now downtrending to 9.8 with one dose of Levaquin. Lactate 3.3, but no clinical signs of infection (no cough, no diarrhea). Seroma on CT and abdominal exam stable, and patient is afebrile, so unlikely a source for infection. - Repeat lactate - UA negative, Urine culture <1000 cfu - Blood culture no growth till date (NGTD) - General Surgery consulted, appreciate recs - Unlikely infected seroma per abdominal exam and imaging. 3. Abdominal Tenderness: Likely due to multiple surgeries and seroma. May have some increased fecal loading contributing. - CT Abdomen with no new findings - General surgery consulted, appreciate recs: no surgical intervention needed at this time - Continue Miralax, Senna, Colace, may add Mag citrate - Continue PPI 4. S/P small bowel resection: Has had muscle spasms, which may reflect metabolic insufficiencies. BMP within normal limits. Folate >20, B12 >900. 5. Depression/Anxiety: Continue Wellbutrin and Cymbalta.	
11/21/YYYY	Hospital/ Provider Name	**@0814 hours: Echocardiogram**: **Indications**: Syncope. **Conclusions**: 1. Left ventricular ejection fraction is 60-65%. 2. Mild diastolic dysfunction with an impaired relaxation pattern and normal left atrial pressure. 3. There is no outflow obstruction.	3997-4000

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		4. Trace mitral valve regurgitation. 5. Saline contrast bubble study was negative, with no evidence of any intracardiac shunt. 6. There is no obvious cause for syncope in this study. The aortic valve and ascending are normal. 7. The right sided chambers and pressures are normal. 8. These findings need clinical correlation.	
11/21/YYYY	Hospital/ Provider Name	**@0815 hours: Progress Notes:** **Subjective:** Doing well this morning, though had persistent nausea overnight. No vomiting. Had 4 loose BM yesterday, no melena. She had some heartburn overnight, treated with famotidine and GI cocktail. She continues to have LH when changes position from sitting to standing. **Physical examination:** **Gastrointestinal:** Soft, Tender to palpation in epigastric and LUQ. Surgical scar midline appears well-healed. **Impression and Plan:** 1. Syncope: Most likely the lightheadeness is related to Cymbalta discontinuation. Differential includes autonomic insufficiency, though this should be addressed when patient is 3 weeks out from Cymbalta discontinuation. - EKG NSR - TTE negative - Discontinue Cymbalta, with fall precautions at home (patient's son and daughter live with her). 2. Nausea: Continues to have BM. - Discontinue Cymbalta - Zofran 4mg every 4 hours scheduled - Bowel regimen 3. Concern for Sepsis: - Unlikely infected seroma per abdominal exam and imaging. 4. Abdominal Tenderness: Likely due to multiple surgeries and seroma. May have some increased fecal loading contributing, though now had 4 BMs. - CT Abdomen with no new findings - Continue Miralax, Senna, Colace, may add Mag citrate - Continue PPI 5. Status post small bowel resection: Has had muscle spasms, which may reflect metabolic insufficiencies. 6. Depression/Anxiety: Wellbutrin and Cymbalta held yesterday, though may be having withdrawal syndrome as described above.	4025-4029
11/21/YYYY	Hospital/	**@0836 hours: General Surgery Progress Notes:**	4022-4025

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Subjective**: No acute events overnight (NAEO), now having diarrhea. **Physical examination:** Abdomen: Soft, non-tender, non-distended **Labs:** **Low:** Hemoglobin 11.1, CO2 18 **High:** Glucose 137 **Impression and plan:** - No acute surgical intervention indicated - Stable anterior wall seroma on CT not likely source of leukocytosis - would not recommend draining. - Continue aggressive bowel regimen, PRN enemas. - Continue syncope work up per primary.	
11/22/YYYY	Hospital/ Provider Name	**@0831 hours: General Surgery Progress Notes:** **Subjective:** NAEO, no abdominal pain. Still having BMs. States she has some issues with reflux and ace epigastric discomfort with eating. **Impression and plan:** - No acute surgical intervention indicated - Stable anterior wall seroma on CT not likely source of leukocytosis - would not recommend draining. - Continue aggressive bowel regimen, PRN enemas. - Continue syncope work up per primary. - Patient states she has history of H. pylori treated in the past, questionable PUD (Peptic Ulcer Disease), would consider GI consultation for further workup - Will sign off	4019-4022
11/22/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 11/18/YYYY **Hospital course:** **Discharge diagnoses:** 1. Syncope, orthostatic vs vasovagal by history, likely due to medication side-effect vs Cymbalta discontinuation syndrome. 2. Nausea, resolved. 3. Chronic abdominal pain 4. Status post partial small bowel resection. 5. Prior diagnosis of depression, PTSD, and fibromyalgia. **Hospital Course by Problem List:** **1. Syncope:** As above, patient presented with multiple episodes of syncope and pre-syncope over the few days prior to admission. All of the episodes were stereotyped and occurred after standing up abruptly. She reported a stereotyped prodrome of a "hot flash", feeling very hot, nausea, dimmed vision, followed by loss of	3954-3957

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		consciousness. She denied any significant vomiting, and denied any diarrhea prior to admission. She had been eating and drinking well. Orthostatics were not obtained prior to fluid administration in the ED, and were negative afterwards. Her cardiac and neurologic exams were normal. An EKG and telemetry monitoring was unremarkable. She had a TTE which was unremarkable as well. She received IV fluids and antiemetics with symptomatic improvement. She explained that her PCP was weaning her off Cymbalta, and she had recently reduced the dose to 30 mg every other day 3 days prior to admission. She was also taking multiple other centrally acting medications, including Lyrica, Gabapentin, Wellbutrin, Flexeril, Tramadol, and Xanax. Her symptoms were very suggestive of Cymbalta withdrawal (Cymbalta discontinuation syndrome), characterized by dizziness, gait imbalance, nausea, vomiting, and hot flashes. We discussed this and she opted to stop the Cymbalta completely. She was counseled on the importance of standing from a sitting position slowly and being careful with positional changes. She was reassured by her work-up and symptomatically improved. She felt well on the day of discharge and will follow-up with her PCP (referral placed to see a new PCP here as well). **2. Nausea:** As above, her persistent nausea with lightheadedness and dizziness was concerning for Cymbalta discontinuation syndrome. Most likely exacerbated by multiple abdominal surgeries and possible adhesions. Senna was added to her bowel regimen and she was given Zofran as needed. Her nausea had subsided by discharge. **3. Chronic abdominal pain:** She complained of a sharp pain in the abdominal wall on admission. A CT of the abdomen obtained in the ED revealed a resolving seroma vs hematoma in the anterior abdominal wall, unchanged from prior. General surgery was consulted and felt that there was no acute surgical issue. She was given Gabapentin as needed for pain and given an aggressive bowel regimen. Her pain had improved by discharge but she had ongoing sharp pain. She will follow-up with her PCP and GI. **4. Leukocytosis:** She presented with a WBC count of 12.3 on admission; a lactate was checked in the ED and was elevated at 3.3 but had normalized to 0.8 immediately after fluid resuscitation. She did not appear systemically ill throughout her stay. Blood cultures were negative and UA revealed contamination. She had no symptoms of systemic infection. General surgery did not feel that her abdominal wall seroma was infected. Her leukocytosis resolved by discharge without specific intervention. **5. Status post small bowel resection:** She complained of muscle spasms on admission. Multiple vitamin levels were checked. Folate >20, B12 >900, zinc, and selenium normal. Iron and TIBC were normal but ferritin was low at 11. As she complained of restless leg syndrome, we advised her to take PO ferrous sulfate 325 mg daily to see if this helps.	

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		6. Depression/Anxiety: As above, her Cymbalta was stopped. She had recently weaned off Lyrica as well. Her Wellbutrin was continued. She requiring a few doses of PRN Ativan. **Discharge medications:** Aspirin 81 mg Bupropion (Wellbutrin) 100 mg Cyanocobalamin (Vitamin B12) 1,000 mcg Docusate (Colace) 100 mg Estradiol 1 mg Famotidine 20 mg Lactobacillus rhamnosus GG Multivitamin with minerals Pantoprazole 40 mg Polyethylene glycol 3350 (Miralax) 17 gm Senna 17.2 mg Alprazolam 0.5 mg Flexeril 10 mg **Discharge condition:** Good **Disposition:** Home with family	
11/18/YYYY-11/22/YYYY	Hospital/ Provider Name	**Other records:** Input / Output Record, Assessment, Discharge Instructions, Patient Education, Medication Reconciliation Record, Rhythm Strips, Nursing Notes/Records, Orders, Medication Sheets, Vaccination/Immunization **PDF-Ref:** 3859-3868, 3879-3884, 3911-3953, 3958-3989, 4001-4019, 4042-4236, 4240-4336, 4342-4381, 6347-6358	
11/23/YYYY	Hospital/ Provider Name	**Ultrasound carotid bilateral:** **Reason for exam:** History of TIA, cardiac surgical clearance **Clinical indication:** History of TIA **Impression**: 1. No hemodynamically significant stenosis involving either the right or left ICA. 2. Normal peak systolic velocity without detection of stenosis by direct measurement of the right or left ICA.	138-139
	Hospital/ Provider Name	***St. Joseph East (11/26/YYYY-11/28/YYYY)***	
11/26/YYYY	Hospital/ Provider Name	**Consultation Report:** **Reason for consultation:** Small bowel obstruction **Chief complaint:** Patient came in via POV for abdominal pain, nausea, vomiting and decreased LOC, patient's abdomen distended and form. Patient reports pain	7747-7748

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		10/10 on pain scale, patient vomiting during triage. **History of present illness:** Patient travelled for Thanksgiving holiday who presents with worsening abdominal pain and nausea/vomiting which progressively worsened on 11/25/16. At that time, she presented to SJE ER with nausea/vomiting and 10/10 abdominal pain especially in the LLQ. Reportedly, she filled at least 5 bags with emesis while in ER. She was subsequently transferred to surgical floor where a NGT was placed with minimal output. Since her time on the floor, her nausea has improved and her abdominal pain has abated. She had a bowel movement. **Reviewer's comment: Records related to ER visit on 11/25/YYYY are not available for review.* **Review of systems:** Nausea, LLQ abdominal pain **Physical examination:** **Abdomen:** Soft, non-distended, no guarding/rebound, LLQ tenderness (improving) **Discussion:** I diagrammed and discussed the pathophysiology of bowel obstruction. It seems the with conservative measures including hydration, her overall symptoms have improved. She had a bowel movement and may be resolving this issue entirely. I discussed the expected goals which she would have to meet in order to avoid surgical intervention. Notably, I repeated her labs this afternoon and her leukocytosis has resolved. Lactate is pending. **Assessment/plan:** Small bowel obstruction Keep NGT Serial abdominal exams Defer surgical intervention at this time If she continues to progress, her diet can be advanced and potentially discharged if criteria is met.	
11/26/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Indication**: Vomiting and chest pain. **Impression**: No acute process on the portable exam.	7758
11/26/YYYY	Hospital/ Provider Name	**CT of chest abdomen pelvis with contrast:** **History**: Weakness, abdominal distension, nausea and vomiting. **Impression**: Dilated mid small bowel with debris consistent with partial small bowel obstruction. Transition point in the right lower quadrant likely secondary to adhesions. No free fluid or free air.	7782-7784

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No acute intracranial abnormality. No pulmonary mass or infiltrate identified.	
11/28/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 11/26/YYYY. **Hospital course:** Sepsis (present on admission), undetermined source, likely secondary to ileus vs partial small bowel obstruction Abdominal pain Dehydration Nausea and vomiting Lactic acidosis History of recurrent sepsis History of recurrent C-diff History of ileus and small bowel obstruction Status post hysterectomy, BSO and appendectomy (for history ovarian cancer no chemotherapy or radiation therapy) GI prophylaxis with Peptid and Florastor DVT prophylaxis with sequential compression device. **Plans:** Start IV Levaquin IV Peptid Discontinue Zosyn Discontinue IV Vancomycin for sepsis, patient and her daughter says Vancomycin usually they give for her sepsis She said she sees six different specialists (including ID surgeon etc.) Start oral Vancomycin (history of recurrent C. diff)	7749-7751, 7752-7757
11/29/YYYY	Hospital/ Provider Name	**Office Visit:** **Assessment and plan:** Clostridium difficile diarrhea. Plan: C. diff toxin/GDH with reflex	7651-7652
11/30/YYYY	Hospital/ Provider Name	**General Surgery Follow up Visit:** **Chief Complaint:** 3 hospital trips in 3 weeks for nausea/vomiting. Loss of appetite. **History of Present Illness:** Patient has had a 2.5 year history of bowel and abdominal problems status post a bowel perforation in August of 2015. She underwent a December 2015 VHR and bowel resection for Chronic PSBO. She did well for several months, though she never fully recovered. But in the past 3-4 weeks, she has had worsening of her nausea, abdominal pain and vomiting. She additionally has had some syncopal episodes which prompted the ER visits. She was in at EUH 11/18-11/22 and then was in Kentucky for a few days (her children "made her go" with them) and she stated she was told she had sepsis and "twisted bowel." Her daughter showed	682-684, 861-865

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		pictures of the Critical care unit signs in her room with monitors and IV's hooked up to her. She was told has had a blockage and they wanted to do surgery on her but she said she can't have surgery anywhere but Atlant/Emory. So they used the NG tube, which was a relief and it opened her up eventually. She got K+ and IV fluids and was on Piperacillin, Zosyn, Flagyl and Vancomycin. She is concerned now that she has C. diff as she had orange and smelly stools since then in a small "blob" come out like thickened liquid consistency. She had 7 BMs yesterday. She also states she is having more gas pain. Lots of burning as she points to her epigastric area. She has been to urology for her voiding dysfunction and saw Dr. Herrell who stated she was doing fine from their perspective. **Physical examination:** **Gastrointestinal:** Tenderness to palpation at the epigastric region. **CT Scan:** Disc reviewed with Dr. Rohit Mittal and compared to prior here. No significant change. Both show heavy stool load distal bowels. No obstruction or transition point identified. **Assessment and plan:** 1. Nausea and vomiting, likely intermittent PSBO, dysmotility The only identifiable cause of these episodes that could contribute is some dehydration. She may get these intermittent blockages even when fully hydrated with her history, but keeping hydrated will reduce the number of them. Having diarrhea will increase the likelihood of them. She expressed understanding of this and will restart pedialytes, gatorades, or rehydration salts. Continue Senna, Miralax, and other fiber to assist moving bowels regularly. 2. Dehydration: Current labs are WNL generally, but patient needs to maintain hydration to keep bowels functioning, so Propel Gatorade, RHS. 3. Diarrhea/Concern for C. diff. Stool sample cup given and patient will return it when filled. Consider PO Vancomycin, as patient as had this prior, so would need to move to less resistant antibiotic. 4. GERD - May continue Dexilant, but can also substitute Protonix for 2 weeks to test if it helps better now for some reason. Prior had been on Nexium, which did not help. If it does help, she can continue but if not, return to Dexilant. Likely the reflux will improve if she also keeps her bowels moving forward and not backing up from getting dry. 5. PTSD - continue care with psychiatrist. 6. Urology/Voiding dysfunction - continue per their plan, but no cancer no kidney stone and to only monitor cyst.	
12/07/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Follow up hospital visit. She was admitted to Emory and a hospital in TN. She was told that she was septic, started on antibiotics then developed diarrhea. Started empirically on Vancomycin for C. diff. She is still taking this. Saw her surgeon last week who is running the C. diff testing. She is still having green stools. She is nauseated.	7648-7650

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Feels light headed when she stands up. Drinking enough fluids 64 hours including Gatorade. Anxiety is very high. Still reliving the trauma of her sepsis two years ago. Going through court case. **Assessment and plan:** 1. Syncope – sounds vasovagal. Will get records from Emory. She is feeling better 2. Small bowel obstruction – resolved. Extensive abdominal surgery history/adhesions. Ordered X-ray abdomen KUB 3. Anxiety – Most active issue in combination with PTSD 4. Fibromyalgia	
12/07/YYYY	Hospital/ Provider Name	**X-ray of chest and abdomen:** Abdomen: Non-specific small bowel gas pattern. Moderate fecal debris. Scattered abdominal/pelvis clips. No abnormal masses or calcification. No acute process	7746
12/28/YYYY	Hospital/ Provider Name	**General Surgery Follow up Visit:** **Chief Complaint:** Follow up **History of Present Illness:** Patient was approximately one year out from exploratory laparotomy with bowel resection and ventral hernia repair for chronically incarcerated bowel. Her course was complicated by sepsis and she has had difficulties of PTSD as well as anxiety in addition to bouts of C. difficile colitis. She was recently admitted at Hospital in Kentucky last month for urosepsis as well as syncope. She continues to struggle with chronic constipation and has been doing an aggressive bowel regimen including Miralax daily with magnesium citrate, glycerin suppositories, Fleet's enemas. Currently she is having grainy loose stools daily. She did see a gastroenterologist however was told that her problems were surgical. Her primary care has been managing her bowel regimen so far and feels that she may have pelvic floor to suction. She does continue see Dr. Niall Galloway. Additionally, her primary care physician is managing her syncope as well. With regards for anxiety she has weaned herself off of most of her and antidepressants and antipsychotics. Overall she reports that she maintains good hydration and has clear yellow urine output. **Physical examination:** **Gastrointestinal:** soft abdomen with well healed incisions, no obvious hernia recurrence **Assessment and plan:** 1. Constipation The patient is to return to her gastroenterologist as there is no surgical solution to her dysmotility problems. The patient is not interested in pursuing any further surgical intervention. She needs medical management of her constipation/dysmotility. She may also benefit from some pelvic PT.	680-681

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. Small bowel obstruction - No evidence of obstruction currently 3. GERD (gastroesophageal reflux disease) - Taking Dexilant and Carafate daily 4. Straining during urination - Seeing Dr. Niall Galloway 5. Incisional hernia - No evidence of recurrence 6. Status post repair of ventral hernia 7. Syncope - Being managed by her PCP 8. PTSD (post-traumatic stress disorder) - Managed by her PCP 9. History of ventral hernia	
02/15/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Patient presents for syncope. Multiple episodes since Thanksgiving. She can be sitting or standing. Feels it coming on. Feels light headed when she goes from sitting to standing. Will start to see spots, will feel pain in her L ear and then will start to feel light headed like she is going to pass out. Will get weak and have to sit/lay down. Feels exhausted. Feels like the fatigue is always in the background and this is contributing. She has chronic nausea. Is exhausted by minimal activity but this is getting better. Repeat labs in December were still normal. **Assessment and Plan:** 1. Near syncope - sounds vasovagal. Her BP generally runs low. I have tested her for adrenal insufficiency which was negative but I wonder if she has mild disease that was evident on the Cortrosyn test. She has chronic nausea which has been evaluated. She does better when she was on Pred for Bronchitis. Will try her on Fludrocort and see how she does. 2. Depression, major, recurrent – Better. She is still seeing Dr. Blue weekly. She is doing well on Lexapro, will leave her there 3. Vitamin B12 deficiency	7638-7642
02/25/YYYY	Hospital/ Provider Name	**Cardiology Follow-up visit:** **Chief complaint:** Follow-up for EKG. Complaint of chest pain, palpitation. Complaint of shortness of breath. **History of Present Illness:** Patient is here following up her extensive bowel surgery for her ventral hernia as well as multiple small bowel obstruction she also was recent he diagnosed with H. pylori and was placed on triple therapy questionable and has done externally well. She does have intermittent episodes where out the blue she felt like she ate too much initial have this shortness of breath and chest pressure sensation the last episode was about a month ago. She also has chest pains but these are atypical and unchanged. She is getting stronger since her surgery. **Assessment/Plan:** 1. Chest pain: some atypical features and better with H. pylori treatment, monitor symptoms. 2. GERD (gastroesophageal reflux disease) much better with Carafate liquid. 3. SOB (shortness of breath) normal cardiac exam. No issues. No cardiac evaluation needed. None cardiac and more related to GERD RAD reaction and this is getting better with her treatment. Monitor for now.	653-655

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
02/27/YYYY	Hospital/ Provider Name	**Cardiology Follow-up Visit:** **Chief Complaint:** Follow-up visit. Patient reports frequent episodes of chest heaviness, palpitations associated with SOB, and dizziness. Patient reports lower extremity swelling. **History of Present Illness:** Patient with history of atypical chest pain with a negative cardiac workup as well as mitral regurgitation is very mild. She was doing well from a heart standpoint except that she's been having multiple issues with alter her gallbladder surgery and a microperforation. I was not diagnosed and subsequent sepsis she was admitted to AB University Hospital and has had multiple omissions the Emory reverse hospital small bowel obstruction. Unfortunately she was sent home with only a white blood count and socially developed another septic episode where she was admitted emergently in Kentucky where she was in the ICU for 4 days. Continues is that she has gotten off a lot of her psychotropic drugs and she is only on low-dose of Lexapro 10 once a day and she takes then excess needed. High Y she does have frequent chest heaviness and sharp pins sensation can wake her up out of sleep. These palpitations that occur and she has shortness breath with this. While she was at Emory she did get an echocardiogram and this was basically normal. She does have a chronic battle with dehydration because of her scars and small bowel sections. And she does take Fludrocortisone to try to maintain her volume she did have a history of syncope whenever she gets dehydrated. **Assessment/Plan:** 1. DVT (deep venous thrombosis): History of DVT and IVC filter now off that has been removed. 2. GERD (Gastroesophageal reflux disease): Reflux disease limiting her therapy for her costochondritis. She is under excellent seems to be doing okay with this again some of her symptoms are related her small bowel obstruction and chronic scars. 3. Mild mitral regurgitation: No sniffed and MR by examination echocardiogram done recently shows very minimal contrast bubble study was also negative done at AB University Hospital. 4. SOB (shortness of breath): Chronic not active at this time only associate with palpitation. She has been unremarkable. 5. Syncope.	649-652
04/28/YYYY	Hospital/ Provider Name	**Office Visit for immunology workup:** Patient presents today for scheduled follow-up of recurrent Clostridium difficile diarrhea and sepsis episodes, after a last appointment on 03/12/YYYY. She is experiencing fatigue. She reports the symptoms are resolved. She reports the problem is aggravated by activity, eating, and friction. She reports that the process has been improved by antibiotics, adherence to therapy, time, and surgical revision of the midline abdominal wound. Work-up of the issue to this point has included no labs, cultures, imaging or surgery. She is not taking therapy with any antibiotics. She feels that overall she is doing better. She denies additional or new problems.	239-241, 7728-7732

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Physical examination: Abdomen: Nontender to palpation, normal bowel sounds, tone normal without rigidity, or guarding, no masses present, incision healed, abdominal contour scaphoid. **Assessment:** 1. Clostridium difficile colitis: No symptoms consistent with recurrence. No antibiotic exposure with her. Suspect modest post-inflammatory irritable bowel like symptoms. **Plan:** Double or triple probiotics if one time dose of antibiotics required for dental work. To have new dentist call if longer antibiotic course required. 2. Sepsis: Past episode at initial presentation to our practice. Repeat episode while hospitalized in Kentucky recently. **Plan:** See orders for immunity work-up. Follow-up with me in 1-2 weeks. 3. Fibromyalgia Labs ordered Follow up in 2 weeks	
05/02/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with contrast:** **Clinical Indication:** Incisional hernia **Impression:** Anterior abdominal wall hernia mesh repair with persistent although decreased fluid associated with the mesh. Sterilely cannot be determined by imaging.	750-751
05/12/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **Chief Complaint:** Follow-up for immunology work-up, lab review. Patient complains of nausea and dizziness. **History of Present Illness:** Patient presents today for scheduled follow-up of recurrent clostridium difficile diarrhea and sepsis episodes, after a last appointment on 04/28/YYYY. She is experiencing fatigue. She reports the symptoms are moderate. She reports the problem is aggravated by activity and eating. She reports that the process has been unchanged by time. Work-up of the issue to this point has included lab work. See the document list for scanned results. She is not taking therapy with any antibiotics. She feels that overall she is without change. **Assessment:** 1. Clostridium difficile colitis: 2. Sepsis: Past episode at initial presentation to our practice. Repeat episode while hospitalized in Kentucky recently. **Plan:** No active infectious problems. Remain on alert for new processes. 3. Fibromyalgia: 4. Hypogammaglobulinemia: Total IgG in the low-normal range at 933, sub-class 1 and sub-class 3 deficiency. Could explain her recurrent difficulties with sepsis	242-244

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		following procedures. IgA and IgM in the normal range. Tetanus and diphtheria below levels of protection. **Plan**: Check Pneumococcal antibody titers and challenge today with TdAP vaccine. Reassess tetanus and diphtheria antibody levels at 8 weeks and consider pneumococcal challenge. **Plan:** Labs ordered. Follow-up in 8 weeks.	
05/17/YYYY	Hospital/ Provider Name	**General Surgery Follow up Visit:** **History of Present Illness:** *History reviewed* With regards to greater ventral hernia repair, she has since healed up very well from that and does not have any recurrent hernia symptoms. Patient does report that she has some concerns for cosmetic appearance of the superior portion of her incision but otherwise no other issues. With regards to her bowel movements patient still has her baseline issues with constipation and has a bowel movement every other day while being on a bowel regimen. She nonetheless is eating and is having taking slight fruits and pepperoni in Sprite and shakes and vegetables and so forth. **Assessment/Plan:** 1. Status post repair of ventral hernia. 2. Generalized abdominal pain. - No acute surgical intervention indicated. Patient's incision held up very well as well as her hernia and there are no physical signs or clinical signs (recurrence of symptoms) account indicated that she has a recurrent hernia. Furthermore patient had a CT scan 2 weeks ago which again demonstrated the repair is intact. - Again referred the patient to follow with GI and with a pelvic floor dysfunction specialist regarding her issues with constipation and so forth. She is going to see one of the Uro-Gynecologist at Piedmont. - Explained to the patient that the mild fullness at the superior portion of her incision is mainly fat and skin and there is no fluid seen on the CT or on exam. No plans as of today for any surgical intervention. - Return to clinic in 6 months without any imaging. Probable CT scan in 12 months.	676-678, 679
06/12/YYYY	Hospital/ Provider Name	**Office Visit:** Patient is tearful today. Overwhelmed with EHR health and mood. In sepsis support groups. In the bed for 15-20 hours/day. Her whole body hurts. The court case is still ongoing, awaiting Galloway's deposition in August. Still seeing Dr. Richard Blue for counseling. Still reliving her ICU stay trauma. No suicidal but feeling overwhelmed. Not sleeping well due to RLS. Trying to get back on CPAP to help with this. Whole body hurts. Feels very different from fibromyalgia. The pain is affecting her mood, just wants a break from the pain. She is in PT. Seeing Rheumatology, Infectious disease. She has an antibody deficiency. **Assessment and Plan:**	7627-7629

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		1. Anxiety and depression: Has good support from family and counseling. Pain is worsening her mood. Will have her see rheum this week for trigger point injection if seemed appropriate. I have again suggested that see psychiatry as mood is depressed and she has not responded well to medications that I have tried. Will increased her Lexapro. 2. Fibromyalgia 3. Vitamin 812 deficiency Follow-up in 1 month.	
06/27/YYYY	Hospital/ Provider Name	**Follow-up Visit for immunology workup:** **History of Present Illness:** Patient is experiencing fatigue. She reports the symptoms are moderate-severe. She reports the problem is aggravated by activity and eating. She reports that the process has been unchanged by time. Work-up of the issue to this point has included lab work. She is not taking therapy with any antibiotics. She feels that overall she is without change. **Assessment:** 1. C. diff colitis: No symptoms consistent with recurrence. No antibiotic exposure with her. Suspect modest post-inflammatory irritable bowel like symptoms. 2. Sepsis: No active infectious problems. Remain on alert for new processes. 3. Fibromyalgia 4. Hypogammaglobulinemia	246-249
07/28/YYYY	Hospital/ Provider Name	**Follow-up Visit for immunology:** **Chief complaint:** Follow-up IGG. **History of present illness:** Patient presents today for scheduled follow-up of recurrent clostridium difficile diarrhea and sepsis episodes, after a last appointment on 06/27/YYYY. She is experiencing fatigue. She reports the symptoms are moderate-severe. She reports the problem is aggravated by activity and eating. She reports that the process has been unchanged by time. She is not taking therapy with any antibiotics. She feels that overall she is without change. She remains fiated on the idea that IV Vitamin C will return her to her previous state of health. **Assessment:** 1. Clostridium difficile colitis 2. Sepsis: No active infectious problems. Remain on alert for new processes. 3. Fibromyalgia 4. Hypogammaglobulinemia: Total IgG in the low-normal range at 933, sub-class 1 and sub-class 3 deficiency. Could explain her recurrent difficulties with sepsis following procedures. IgA and IgM in the normal range. **Plan**: Watch closely over time.	250-252
08/17/YYYY	Hospital/	**Follow-up Visit for leg pain:**	7608

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**Assessment and plan:** Leg pain. **Current plans:** Nerve conduction study of 7 to 8 nerves Complete electromyography with nerve conduction study.	
08/21/YYYY	Hospital/ Provider Name	**Office Visit for leg pain:** Patient has been suffering with pain in her feet and legs ever since her hospitalization in the fall of '14. Pain is mostly in the lower legs and feet, burning, tingling, sharp stabbing pains. To a lesser degree gets the same type of symptoms in her elbows. This has been severe and she feels hopeless about the situation, "I'm about to give up". Has been seeing Dr. Fishman and Dr. Pepper, started her on low dose prednisone a couple of months ago which she doesn't think helped. Hasn't tolerated Cymbalta, Gabapentin. Started back on rechallenge of low dose Lyrica a few days ago. Continues to have very frequent and severe migraines as well. Over the last three months the migraine frequency has been at least 15-20 days per month. **Assessment and plan:** 1. Numbness and tingling Severe, debilitating pain and paresthesias in both feet and lower legs and to a lesser degree arms since fall '14. Exam non-localizing with some functional features. 2. Intractable migraine without aura and without status migrainosus. Migraines beginning in about '00 following MVA with neck trauma, became much less frequent for a while but now recurrent since '14. Have significantly increased in frequency '17 to now chronic migraine. 3. Leg pain 4. Depression, major 5. Sepsis 6. C. difficile diarrhea 7. Fibromyalgia	7606-7607
08/22/YYYY	Hospital/ Provider Name	**Follow-up Visit for leg pain:** **Assessment and plan:** Numbness and tingling EMG/NCS performed, full report to be scanned. Briefly, it is a normal examination. There is no electrophysiologic evidence for a generalized large fiber polyneuropathy, nor lumbosacral radiculopathy in the right leg or median or ulnar neuropathy in the right arm. Discussed with patient that this result does not rule out a so-called "small fiber" polyneuropathy as is often seen in patients with fibromyalgia. Discussed with patient and daughter, could do skin biopsy for ENF density which could confirm presence of small-fiber polyneuropathy but because it isn't informative about etiology, I don't think it is necessary at present. Continue	7604-7605, 7721-7723

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		titrating up Lyrica.	
08/25/YYYY	Hospital/ Provider Name	**MRI of lumbar without contrast:** **Clinical history:** Low back pain, bilateral leg pain. **Impression:** Lumbar facet degeneration with mild spinal and left lateral recess stenosis at L4-5.	597-598
09/27/YYYY	Hospital/ Provider Name	**Office Visit for constipation:** Patient presents with concerns about constipation. Has a history of chronic constipation with acute exacerbation the past few days. She last moved bowels 5 days ago, small movement after 2 enemas and a suppository. Treatment is Miralax daily, apple cider vinegar and tea. She did accidentally miss 2 doses of Miralax last week and thinks this is contributing. She has a GI Dr. Kavita Kongora. Patient is concerned that constipation may lead to sepsis. There has been nausea but no vomiting. Overall she is feeling better then she has in recent past. **Review of system:** **Gastrointestinal**: Abdominal pain and constipation present. **Assessment and plan:** Constipation: This is chronic suspect due to her inactivity and use of meds, no evidence of obstruction bowel sounds are throughout, have added low dose Linzess to be used daily until has BM. Ok to resume her bowel med regimen once successful with BM. **Current Plans:** KUB X-ray, (stool present no obstruction, will send to radiologist for over read). - Started Linzess 72 mcg.	7593-7594
11/06/YYYY	Hospital/ Provider Name	**Follow-up Visit for immunology:** **Chief Complaint:** Follow-up for Immunology subclass deficiency and history of sepsis. **History of Present Illness:** Patient presents today for scheduled follow-up of recurrent clostridium difficille diarrhea and sepsis episodes, after a last appointment on 07/28/YYYY. She is experiencing fatigue. She reports the symptoms are moderate-severe. She reports the problem is aggravated by activity and eating. She reports that the process has been unchanged by time. She is not taking therapy with any antibiotics. She feels that overall she is without change. **Assessment:** 1. Clostridium difficile colitis: No current symptoms consistent with recurrence. 2. Sepsis: Resolved 3. Fibromyalgia: 4. Hypogammaglobulinemia:	253-255, 256-259

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: Watch closely over time. Check level today and every 6-12 months.	
	Hospital/ Provider Name	***St. Joseph's Hospital (11/14/YYYY)***	
11/14/YYYY	Hospital/ Provider Name	**ER visit:** **History of present illness:** Patient states that she began to have epigastric abdominal pain on Wednesday. She also received an epidural for her back pain on Wednesday. On Thursday, she began to feel lethargic, like she was going to throw up, extremely nauseated, and felt like she was going to pass out. She says that her white count was checked by her primary care doctor and it was 19, and she was told that was because of the steroid shot she had in her back. The next day, her white count was only 9. She also says her hemoglobin is down. She has had no black or bloody stool, but her stool did look a little dark today. She is on Dexilant. She also has Carafate for breakthrough pain, and she says she has taken it 3 times already today. She says the epigastric pain is burning and it feels like there is a volcano in there. She has not vomited although, "I have tried to". Patient was septic in 08/YYYY, due to bowel perforation during surgery for her gall bladder. She also was septic in 11/YYYY, but does not know the source of that sepsis. She says, "I am not a candidate for my hiatal hernia to have surgery because I have no immune system". She states that her immune system has never recovered from her sepsis. **Physical exam:** **Abdomen**: Tender in the epigastrium with rebound, hyperactive bowel sounds. **Rectal**: Brown stool, hemoccult negative **Extremities**: Diffusely tender in the calves. **Progress:** Patient is well-appearing and nontoxic to my mind. It is clear she suffers from multiple problems but she does not look septic in the least. I did perform a stool occult test on her and it was negative. I am not sure why she is now anemic. While we are discussing her results and I am telling her negative results, she tells me that she has an ache in 1 of her bottom right incisors and she thinks she has a gum infection. I do look at the tooth and the gum is slightly red, but there is no fluctuance, no drainable abscess, it is tender to percussion. She says she can't afford to see a dentist. I will write her for a course of antibiotics (Penicillin) and have made several suggestions to her in terms of dentists she can follow up with, including local dental schools. I am not sure what is causing patient1s symptoms overall. I do think she likely has a gastritis versus peptic ulcer. She is already on Dexilant. I will discharge her home to follow up with her GI doctor. **Diagnosis:** Epigastric pain, generalized weakness, gum infection/periodontal disease.	364-367

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Disposition: Discharge home **Other records:** EKG, Labs (PDF-Ref: 369-370, 362, 403-409)	
11/14/YYYY	Hospital/ Provider Name	**X-ray of abdomen acute with chest:** **Clinical indication**: Abdominal pain unspecified. **Impression**: No acute abnormality.	367-368
	Hospital/ Provider Name	***St. Joseph's Hospital (11/15/YYYY)***	
11/15/YYYY	Hospital/ Provider Name	**ER visit for abdominal pain:** **History of present illness:** *History reviewed* Patient was seen here yesterday with a 24 hour history of epigastric pain and vomiting. Plain films and labs were unrevealing. She was discharged home. However since getting home last night, she continued to vomit. She was not able to eat or drink. She has gotten progressively weaker. The pain goes from the umbilicus to the mid chest. It does not go to the back, neck or jaw. She got markedly lightheaded and out of breath standing up today and then passed out. Shortness of breath has resolved now, but she is still having some moderate pain in her abdomen and presents now for further care. Small bowel movement yesterday and small bowel movement today are reported. **Physical exam:** **Abdomen**: Nondistended. Bowel sounds are present, but diminished. There is mild periumbilical and left lower abdominal tenderness. **Differential Diagnosis**: Patient presents with what appears to be persistent abdominal pain. Will need to rule out small bowel obstruction or inflammatory process given her rapid return from yesterday. In addition, she has not been eating or drinking. Looks dehydrated, and I suspect her syncope is orthostasis. She did have some brief shortness of breath prior to that may have simply been due to hypotension. I see nothing that suggests pneumonia or aspiration, though we will get a chest x-ray. **Emergency department course:** She will be given a cocktail of Haldol, Benadryl, Dilaudid here along with IV fluids, and evaluation was performed. Electrolytes are normal. CBC shows a mild nonspecific leukocytosis which is different than yesterday. Troponin is negative. X-ray reveals no pneumonia. Patient resting comfortably. To CT scan. This showed a distal small bowel obstruction with no signs of perforation. Patient re-evaluated by me after return from CT scan. Mildly tender. No peritoneal findings. NG tube at that time was ordered to decompress the patient. I have discussed the case with General Surgery, Dr. Patel, who will come and see the patient. He agrees with the conservative approach. NG tube suction. I have also discussed the case with the hospitalist given her syncope and chest pain. She will require telemetry admission for further diagnostics for this as well. I have answered the	351-354

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		patient her family is all their questions. **Impression**: 1. Acute chest pain. 2. Acute syncope. 3. Acute abdominal pain. 4. Small bowel obstruction. **Plan**: Telemetry admission to the hospitalist with general surgery consultation.	
11/15/YYYY	Hospital/ Provider Name	**History and Physical:** **Chief complaint:** Abdominal pain **History of present illness:** Patient presents with extensive history of bowel surgeries who presents with abdominal pain. CT shows findings suggestive of small bowel obstruction. Dr. Patel with surgery was consulted and felt the patient might resolve with medical management. An NG tube was placed to the emergency room which improved patient's symptomatology. The patient has had multiple bowel movements at home and in the emergency department. She describes the bowel as liquid. Upon my evaluation of the patient she stated that she felt better and wanted to go home. She decided to sign out against medical advice. She currently only complains of discomfort of the NG tube and is requesting that can be taken out. Of note the patient did have a syncope episode at home which I did not obtain history about as patient had already made a decision to leave against medical advice. **Physical examination:** **Abdomen:** Distended and non-tender to palpation. **Assessment/plan:** 1. Small bowel obstruction: Patient treated with NG tube in the emergency room with resolution of symptoms. Patient is having liquid stools. She is requesting to leave against medical advice. 2. Syncope: Etiology unclear. 3. Leukocytosis: Most likely reactive. No indication of infection. 4. Hypotension: Patient's blood pressure was initially elevated and had subsequent drop. Suspect some dehydration. Concerned about orthostasis. Unfortunately this will not be able to be worked up. **Clinical information:** Patient left against medical advice.	354-358, 363, 399-402
11/15/YYYY	Hospital/ Provider Name	**X-ray of chest:** **Clinical**: Weakness; chest and abdomen pain. **Impression**: Mild linear atelectasis of the left lower lung zone.	358-359

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
11/15/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis without contrast:** **Clinical indication:** Abdominal pain, history of ovarian cancer. **Impression**: Dilated, fecalized small bowel loops without a clear transition point to collapsed small bowel loops are noted distally and findings are concerning for bowel obstruction. This likely involves the distal jejunum or proximal ileum. No bowel perforation, pneumatosis or drainable fluid collection.	360-361
11/15/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 11/15/YYYY **Discharge diagnosis:** Small bowel resection **Hospital course:** Patient presented with small bowel obstruction however decided to leave against medical advice.	354
11/22/YYYY	Hospital/ Provider Name	**General Surgery Follow-up Visit:** **History of present illness:** Patient was last seen in May 2017. She has had no issues with her abdominal wall and no evidence of recurrence of her ventral hernia. She does reports having an episode of nausea and vomiting a week ago for which she was seen in the St. Joe's ED on 11/14 but was discharged to home. She then came back on 11/15 after passing out at home with persistent nausea and vomiting. She had an NG placed and underwent a CT with contrast. During this evaluation, she started having BMs (after contrast load) and elected to go AMA from the ED when it was recommended that she be evaluated by a surgeon. She reports no further emesis since Friday night. She is having small BMs and flatus. No fevers and is tolerating liquids and some chicken. Her last SBO was just after Thanksgiving in 2016. Regarding her constipation, she takes Miralax, Senna, 2 "stool softeners", suppositories, and Fleets enemas. **Physical examination:** **Abdomen**: Well-healed midline laparotomy incision with area of some soft tissue bulge and pain at superior incision but no fascia I defect or hernia. **Assessment/ Plan:** 1. History of ventral hernia: - We had a long discussion regarding her prior abdominal surgeries and likely presence of intra-abdominal adhesive disease that makes her at risk for developing small bowel obstructions in the future, but that given her surgical history and adhesive disease, would try to manage conservatively before considering surgical intervention. - Discussed early obstructive management strategies and when to go to ED and indications for surgery (non-resolving SBO, concern for bowel ischemia, perforation). - Will obtain a routine 1 yr follow up MRE in 3 months.	672-675, 671

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		2. Small bowel obstruction: - At this time, there is no evidence of acute obstructive symptoms or oral intolerance. 3. Nausea and vomiting 4. Pelvic floor dysfunction - The patient does have a significant component of constipation which is confounding some of her abdominal complaints. - Other non-pharmacological therapies can include: total colonic lavage, Pelvic floor therapy - Provided referral to local DPT who does pelvic floor dysfunction, and CALM tea - RTC in 3 month with MRE	
	Hospital/ Provider Name	***AB University Hospital (01/08/YYYY)***	
01/08/YYYY	Hospital/ Provider Name	**@0103 hours: History and physical:** **Chief Complaint:** Gastroesophageal reflux. **History of Present Illness:** Patient was last seen in clinic on 12/30, where her GER symptoms were noted causing her to have poor PO intake and feel dehydrated. Plan at that time was to restart Reglan, add a PPI for GER, continue abdominal binder, and focus on staying hydrated. Since this clinic visit, patient says that her reflux continues to be a major problem. She is not able to keep food or liquids down easily secondary to the pain in her esophagus. She was taking a nutritional shake regularly, but says that it has become increasingly difficult to take this as well. She is making approximately "3-4 cups" of urine daily. She has had no emesis recently, but did have an episode of non-bloody, non-bilious emesis 4 days ago. Over the last couple of days she has had good bowel function, although she says it is runny like diarrhea. **Impression and plan:** Admit to General Surgery, Dr. Galloway attending Plan for EGD tomorrow NPO, mIVF Labs ordered Reglan, Protonix for GER and GI motility Phenergan for nausea control	2-5
01/08/YYYY	Hospital/ Provider Name	**Discharge summary:** **Admission Information:** Patient admitted on the morning on 1/8/16 with symptoms of reflux, a recent episode of small volume emesis, and concern for dehydration. **Hospital Course:** Patient was admitted, underwent EGD with the below findings, and was stabilized with improved symptoms on Carafate. She tolerated a regular diet and was deemed appropriate for discharge home on the same day, 1/8/16	1-2, 5-11

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Significant findings: Findings: Z-line at 36cm, small to moderate hiatal hernia, bilious content in the stomach, mild edema of duodenal mucosa **Impressions:** Small to moderate Hiatal hernia and bile reflux into stomach **Discharge condition:** Good **Disposition:** Home with family	
02/04/YYYY	Hospital/ Provider Name	**ER Record for left arm pain:** **Chief complaint:** Left arm pain. **History of present illness:** Patient who had an infusion of vitamin C via a catheter in her left antecubital area on Thursday, 3 days ago. Beginning Friday there was some mild discomfort and yesterday the discomfort was worse. Today she is quite uncomfortable if she touches the area on the medial aspect of the arm and she was concerned she had a blood clot. She had a central line associated DVT in the right upper extremity in 2014 treated with removal of the line and anticoagulation. The pain does not extend to the forearm, hand, or digits. She has had no pain with use of the hand other than right where there is the area of localized tenderness. **Impression**: Superficial phlebitis. **Plan**: Follow up tomorrow in the vascular lab to exclude deep venous thrombosis, which is unlikely. Vascular Surgery follow-up for treatment of her superficial phlebitis. Two Advil 4 times a day along with warm compresses to treat the phlebitis. Return criteria discussed.	379-380, 381-382
02/05/YYYY	Hospital/ Provider Name	**Ultrasound of Upper extremity venous duplex left VASC:** **Diagnosis:** Pain and swelling. **Right upper extremity findings:** The right subclavian vein is patient and reveals no evidence of deep venous thrombosis. **Left upper extremity findings:** Color duplex evaluation of the left upper extremity shows no evidence of acute deep vein thrombosis. There is acute superficial venous noted in the basilic vein.	383
02/05/YYYY	Hospital/ Provider Name	**ER Record for UE pain:** **Chief complaint:** Left upper extremity pain and swelling. **History of present illness:** Patient was seen in the emergency department yesterday evening, diagnosed with incapsula superficial thrombophlebitis and was sent for DVT study this morning as we do not do venous ultrasound in the evening at this emergency department.	392-394

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient returns today after DVT study was done and she brings the study back with her and it shows acute superficial thrombophlebitis with no evidence of deep vein thrombosis. Patient is well appearing, in no acute distress. She states that she has been putting heat to the area which seems to be helping. **Impression and plan**: Patient presents today after DVT ultrasound that was done this morning. I reviewed the study Results. I did not notice that there was no evidence of deep venous thrombosis, but there is acute superficial venous thrombosis noted in the basilic vein. I advised her to apply warm compresses to the area and follow up with her primary care physician in 5-7 days for re-evaluation. Return precautions were given and discussed. There is no other evidence of cellulitic changes on exam. Discussed case with Dr. Farabaugh. He agrees with plan of care. **Diagnosis**: Acute superficial thrombophlebitis. **Disposition**: Patient was discharged home. Return precautions were given and discussed.	
	Hospital/ Provider Name	***St. Joseph's Hospital (02/09/YYYY-02/10/YYYY)***	
02/09/YYYY	Hospital/ Provider Name	**@2347 hours: ER visit for abdomen pain:** **History of present illness:** Patient presents to ED complaining of diffuse abdominal pain worse on the left side since this evening. She states she was starting to feel nauseous around 4:30 pm and passed out. EMS arrived and she refused transport to the hospital. She started having severe abdominal pain around 7 pm with nausea/vomiting, which prompted her to come to the ED. She has history of multiple abdominal surgeries and states she has chronic partial bowel obstruction. **Physical exam:** **Gastrointestinal:** Moderate tenderness. **Rationale:** Patient presents with abdominal pain that's worse on the left side with history of bowel obstructions. Lab work shows mild leukocytosis. Patient care transitioned to Dr. George for final disposition pending CT of abdomen results. **Impression and plan:** Generalized abdominal pain. **Plan:** **Condition**: Stable. **Disposition**: Patient care transitioned to Sheba George	330-335, 3329
02/10/YYYY	Hospital/ Provider Name	**@0218 hours: CT of abdomen and pelvis with IV contrast:** **Clinical indication:** Abdominal pain unspecified history of melanoma, history of ovarian cancer, bowel resection x4.	335-337

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: High grade proximal small bowel obstruction with transition point along the anterior abdominal wall. There is a possible second transition point involving the proximal jejunum. Associated mesenteric edema is concerning for early ischemic change. No pneumatosis or free air. Stable post-surgical changes from anterior abdominal wall hernia repair with trace persistent fluid associated with the mesh. **Recommendation:** Surgical consultation.	
02/10/YYYY	Hospital/ Provider Name	**@0455 hours: ER addendum:** **Reexamination' Reevaluation** **Course**: Progressing as expected. Pain status: Decreased. **Impression and Plan:** SBO (small bowel obstruction). **Calls-Consults:** Emory Transfer center contacted. Dr. Galloway's partner (Dr. Yheulon) has accepted patient as a direct admit. NGT placed. **Plan:** **Condition**: Stable. **Disposition**: Patient care transitioned to: Time: 02/10/YYYY 04:55:00	329-330, 395-398, 3256-3259
	Hospital/ Provider Name	***AB University Hospital (02/10/YYYY-02/15/YYYY)***	
02/10/YYYY	Hospital/ Provider Name	**@0834 hours: History and Physical:** **Chief Complaint:** Abdominal pain, nausea, and vomiting **History of present illness:** Patient was transferred to EUH from Emory St. Joseph's hospital on 2/10/18 for small bowel obstruction. She reports having a syncopal type episode while at the Social Security office yesterday. She did not fall or hit her head. She was sitting. She then had acute onset of abdominal pain. When she was home, she tried to take Miralax, Bisacodyl, Baking soda, and enema per her usual regimen when she gets partial obstructions. However, she did not get relief and she had high volume bilious emesis. She and her daughter then went to the ED at St Joe's and found to have dilated loops of small bowel on imaging. She got an NG placed which bilious output. She now reports some relief in her abdominal pain but having pain and initiation in her nose and throat after NG. **Physical exam:** **Abdomen**: Tenderness in left lower quadrant. Well healed previous midline	3322-3327

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		surgical scar. **Assessment and plan:** Small bowel obstruction: - Admit to floor; Dr. Yheulon - NPO with NG - mIVF with DS 1/2NS - IV pain and anti-emetic meds - Replete electrolytes - Patient has no evidence of diffuse peritonitis, with normal vitals, and no pneumatosis or fluid on imaging -> will manage conservatively for now given her complex abdominal wall reconstruction and multiple prior surgeries with recurrent ventral hernias. - Follow-up repeat labs and serial abdomen exams.	
02/10/YYYY	Hospital/ Provider Name	**@2140 hours: X-ray of thracoabdomen high KUB:** **Reason for exam:** Significant throat and left ear pain from NGT placement; history of malposed NGT needing specialist intervention; Aftercare following nasogastric tube placement. **Clinical indication:** Aftercare following nasogastric tube placement. **Impression**: NG colitis in the mid stomach.	4734-4735
02/13/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with IV contrast:** **Clinical indication:** Multiple prior surgeries for small bowel obstruction and ventral, presenting with proximal small bowel obstruction, study ordered to evaluate for interval change **Impression**: Resolved small bowel obstruction	4733-4734
02/15/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 02/10/YYYY **Hospital Course:** Patient was admitted to EUH on 2/10/YYYY with small bowel obstruction, acute on chronic. She remained hemodynamically stable and had minimal abdominal discomfort. She was observed with NPO, NGT, IVF, and on hospital day #2 in the evening her NGT was removed by RN due to patient discomfort. On hospital day 3. she passed flatus spontaneously, and a CT with IV and PO contrast was performed which demonstrated contrast passing all the way through her GI tract and a resolution of the obstruction. She underwent enema which produced large BM. Her diet was slowly advanced and her abdominal exam remained benign. On hospital day 6 she was discharged on a regular diet, tolerating PO pain meds, having bowel movements, and ambulating well. **Physical exam:**	3293-3295

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Gastrointestinal: Minimally tenderness to palpation in left lower quadrant, improving. **Discharge condition:** Good. **Discharge disposition:** Home. Follow-up in clinic in 2-3 weeks.	
02/10/YYYY-02/15/YYYY	Hospital/ Provider Name	**Other records:** Vaccination/Immunization, Medication Sheets, Social Service Records, Input / Output Record, Patient Education, Orders, Discharge Instructions, Progress Notes, Nursing Notes/Records, Plan of Care, Assessment **PDF-Ref:** 3282-3292, 4394-4398, 4474-4479, 4412-4414, 4462-4473, 4390-4391, 4399, 4385, 4402-4403, 4415-4451, 4460-4462, 4480-4732, 4736-4922, 4924-4982, 6359-6364	
02/21/YYYY	Hospital/ Provider Name	**General Surgery Follow-up Visit:** **Chief complaint:** 3 month follow-up. **History of present illness:** Patient presents today for both post-hospitalization and routine follow up. Patient was transferred to EUH from St. Joe's on 2/10 with SBO, acute on chronic. During her stay, she remained hemodynamically stable with minimal abdominal discomfort, received multiple enemas that produced BMs, and had a CT prior to discharge that showed SBO resolution. She has been improving over the last week since her discharge. Reports BMs once per day that are loose and non-bloody. She remains on an aggressive bowel regimen of daily Senna, Colace, and Miralax and weekly Fleet enemas. She is still experiencing nausea most days. PO intake is "not quite back at baseline" but is tolerating all food she eats. Of note, she also has reflux disease for which she takes Dexlansoprazole 60mg daily which can contribute to some nausea and epigastric pain. At previous clinic visit, was supposed to undergo MRE for routine annual imaging, but was hospitalized during appointment and did not do MRI. **Impression**: 1. Recent hospitalization for SBO; resolving - Continue bowel regimen as per HPI - Discussed dietary habits (low fiber/residue) to minimize future recurrences 2. Status post multiple abdominal surgeries - MRI abdomen and pelvis with small bowel protocol - RTC in next couple months after above MRI	668-670, 667
03/02/YYYY	Hospital/ Provider Name	**Cardiology Follow-up Visit:** **Chief complaint:**	645-648

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Follow-up visit, patient reports continued palpitation, SOB and swelling. **History of Present Illness:** Patient had multiple bowel surgery and abdominal wall reconstruction with recent admission for small bowel obstruction associate with some sepsis and anemia. She was in the hospital for 6 days and finally had relief of this but in the meantime was getting IV TPN. She was on bowel rest for that time. She just comes in now following that for her routine cardiac follow-up. During these episode, her heart attack she did extremely well. They did do multiple EKGs they were all normal. She did not have any significant arrhythmias on telemetry. She continues to have her palpitation shortness breath but her main thing is that she has more swelling in her hands and feet since her hospitalization. She has not passed out. She has not had chest pain. She has had some intermittent sharp pains but is not really associated with any activities or cardiac distress. **Review of system:** **Respiratory**: Shortness of breath. **Cardiovascular**: Palpitations fluttering in your chest. **Assessment/plan:** 1. DVT (deep venous thrombosis): Stable, leg looks good, IVC filter has been removed 2. Heart palpitations: Stable no significant events. I think IV iron would help her especially if she can get her hemoglobin up this will help with some of her palpitation or shortness of breath. 3. Syncope No further events for now, has mild edema due to IVF and TPN in hospital, hold Fludrocortisone for another month and take as needed. 4. Small bowel obstruction: Per surgery. 5. Mild mitral regurgitation: 6. Hypotension.	
03/28/YYYY	Hospital/ Provider Name	**MRI of pelvis with and without contrast:** **Reason for exam:** Small bowel obstruction, Abdominal pain, Nausea/vomiting. **Impression**: 1. Short segment narrowing of a small bowel loop in the mid pelvis, concerning for a fixed small bowel stricture. No bowel obstruction. 2. Postsurgical changes from small bowel and colonic resections with two clusters of matted/tethered loops of small bowel in the mid abdomen and right lower quadrant of the pelvis.	731-732
04/18/YYYY	Hospital/ Provider Name	**General Surgery Follow-up Visit:** **Chief complaint:** 3 month follow-up for SBO. **History of present illness:** Patient remains on aggressive BM regimen of daily Senna, Colace, and Miralax	664-666, 663

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		as well as weekly enemas. However, she reports she has had several days of loose stool and has decreased the amount of Senna she is taking during the episodes. She is tolerating PO but states she still has decreased appetite (it is closer to baseline). Denies any abdominal pain but does state that she has had 2 episodes of severe constipation but denies similar abdominal pain to what she felt prior to her SBO in February. Patient does have intermittent nausea. **Assessment/ Plan:** - MRI reviewed: Matted small bowel with narrowing concerning for fibrotic structure. Discussed with patient low fiber diet and continued aggressive bowel regiment to prevent future occurrences of SBO. Discussed with patient concerning symptoms of obstruction and to call/come to ED if these arise. - Rec RTC in 4 months with flat/upright abdominal series.	
05/02/YYYY	Hospital/ Provider Name	**Hematology Visit for anemia:** **History of present illness:** Patient presents with multiple medical issues. Had a right and left arm clot after PICC line placement for IV antibiotics. The patient has had to have abdominal wall reconstruction after a cholecystectomy in 2014 caused abdominal complications. The patient has had persistent anemia as well. She feels tired. **Assessment/ Plan:** 1. Anemia: Patient with persistent anemia. I suspect that patient has malabsorption due to her bowel surgery - Get serum chemistries to evaluate for deficiency states. - Get Ig levels to see if she has increased risk of bacterial infections.	710-711, 899-908
05/09/YYYY	Hospital/ Provider Name	**Hematology Follow up Visit for anemia:** **History of present illness:** The patient feels well. **Assessment/ Plan:** Anemia: Patient with iron deficiency anemia Plan on parenteral iron.	707-709
06/06/YYYY	Hospital/ Provider Name	**Hematology Follow up Visit for anemia:** **History of present illness:** The patient feels tired, still with abdominal pain. **Assessment/ Plan:** Anemia: Anemia improved with parenteral iron. Will see surgery about bowel issues.	704-706
	Hospital/ Provider Name	***AB University Hospital (06/06/YYYY-06/10/YYYY)***	
06/06/YYYY	Hospital/ Provider Name	**@2115 hours: ER Record:**	5011-5018

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chief Complaint: Patient presenting with feels like "blockage" again x 1 week, no nausea/vomiting yet. Last BM minimal 2 days ago, minimal flatus. **History of present illness:** The onset was 2 days ago. The character of symptoms is crampy and pressure. The degree at onset was moderate. The Location of pain at onset was diffuse. The degree at present is moderate. The Location of pain at present is diffuse. Radiating pain: Abdomen. There are exacerbating factors including eating and changing position. The relieving factor is none. Therapy today: prescription medications. Risk factors consist of multiple surgeries and SBO history- followed by Dr. Galloway/Hack. Associated symptoms: Nausea, vomiting and headache. **Reexamination/ Reevaluation** Notes: Patient stable got IVFR- Abdomen soft but still complains of pain and feeling like she might get sick. Spoke with General Surgery. Abdomen X-ray not typical for SBO but with her protracted history, feel General Surgery should see and dispo. Patient has had multiple CT and prefers not to just get another- no active vomiting. Will await general surgery. **Impression and plan:** Abdominal pain Nausea and vomiting	
06/06/YYYY	Hospital/ Provider Name	**@2226 hours: ER addendum:** **Reexamination/ Reevaluation:** Notes: General surgery resident, Dr. Mueller, has seen patient and recommends enema, Zofran, and IV fluids. If there is no defecation after 2 hours, will admit inpatient to the hospital. Notes: General surgery resident says to just admit the patient to their service. **Impression and Plan:** Constipation Abdominal pain **Plan:** **Condition**: Stable. **Disposition**: Admit	5005-5011
06/07/YYYY	Hospital/ Provider Name	**@0220 hours: History and Physical:** **Chief Complaint:** GI obstruction. **History of present illness:** Patient presents with five days of crampy abdominal pain. She says she feels like she is getting a bowel obstruction and wanted to be seen before it got worse. Last BM 2 days ago, passing flatus. Recently had some dental work done and was taking Dilaudid PO afterwards. Has been taking daily Miralax/ Senna/ Colace. KUB obtained in the ED shows normal bowel gas pattern with stool and gas in	5071-5074

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		colon. **Physical exam:** **Abdomen**: Moderately distended, mild tenderness. **Assessment and plan:** Patient presents presents with likely a very early partial SBO. - Admit to ACS (Srinivasan) for observation - Soap suds enemas - Bolus 1L LR - PRN pain control with Toradol - Repeat AXR tomorrow morning if no improvement - If feeling better alter a BM can likely discharge home	
06/10/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 06/06/YYYY **Hospital course:** Her hospital course was uncomplicated. She underwent a period of bowel rest then her diet was advanced slowly. On day of discharge she was alert, afebrile, breathing comfortably on room air, and tolerating a low residue diet with return of bowel function. She will follow up with Dr. Galloway as previously scheduled to discuss additional surgery. **Discharge plan:** To home with family. Follow-up with Dr. Galloway as previously scheduled. **Discharge condition:** Stable. **Discharge disposition:** To home with family.	5056
06/06/YYYY-06/10/YYYY	Hospital/ Provider Name	**Other records:** Labs, Vaccination/Immunization, Medication Sheets, Input / Output Record, Patient Education, Assessment, Orders, Plan of Care, Progress Notes, Discharge Instructions, Nursing Notes/Records, Plan of Care, X-Ray Reports, EKG **PDF-Ref:** 5206-5320, 4988-4993, 4999-5004, 5019-5055, 5080, 5076-5205, 5057-5070, 5322-5340, 6365-6369	
07/03/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief complaint:** Bowel blockage. **History of present illness:** Patient presents today for scheduled follow-up of recurrent clostridium difficile diarrhea and IgG subclass deficiency, and multiple episodes of sepsis, after a last appointment on 07/28/YYYY. She is experiencing fatigue. She reports the symptoms are moderate-severe. She reports the problem is aggravated by activity and eating. She reports that the process has been unchanged by time. She is not taking therapy with any antibiotics. She feels that overall she is without change.	261-263

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		She expects to have surgery at Emory soon for partial small bowel obstruction/stricture. Concerned she may face sepsis again. **Assessment:** 1. Fibromyalgia 2. Hypogammaglobulinemia: Watch closely over time. Check level today and every 6-12 months. 3. Resolved Gram-negative sepsis: No active infectious problems. 4. Clostridium difficile colitis: No current symptoms consistent with recurrence. **Plan:** Call or Return If symptoms worsen or persist.	
08/15/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** **Clinical indication:** Small bowel obstruction, constipation. **Impression**: Moderate fecal burden, correlate for constipation.	5377
09/20/YYYY	Hospital/ Provider Name	**MRI of abdomen with and without contrast:** **Reason for exam:** Small bowel obstruction **Impression:** Previously noted small bowel stricture is not seen on this examination. No other strictures identified. No bowel obstructions.	6190-6191
11/15/YYYY	Hospital/ Provider Name	**Follow-up Visit:** **History of present illness:** Patient is referred by Dr. Kara Pepper and who presents for follow up of GERD and chronic constipation. *History reviewed* Patient uses Senakot, Colace, Miralax, and fleet once a week. Patient moves her bowels with hard stools every few days. She can't push or uses her muscles very effectively as she has generalized weakness from the post op and recovery and hospitalizations. She is working with water physical therapy. She is on Dexilant and Carafate for GERD and states she is doing ok with that. She is seeing a psychologist fur PTSD and anxiety and working on this everyday. She was very depressed last year but getting slowly better day by day. Patient taking Mylanta liquid and PRN Lidocaine. She complaint abdomen burning and cough and abdomen pain. Her last colon was 1/31/14 - normal sigmoid anastomosis, no polyps. Patient here for follow-up, accompanied by her son. Has seen Emory physicians had an MRI of abdomen 9/20/18 - negative. Colonoscopy by Dr. Virginia Shaffer 8/27/18 - (Emory GI) Patient anastomosis in rectum. I did and EGD on 1/23/18 - grossly normal biospy: reactive gastropathy and fundic gland polyp esophageal biopsy: reflux changes.	6198-6202

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		Patient still having issues with her bowels and thinking of going to Mayo clinic as she said feels no one knows how to help sepsis pts. She says her Dr's are also supportive of this and will discuss with Dr. Galloway next mouth. Patient had a partial obstruction in Feb and in July and both times this resolved with NGT decompression. Patient has BM and sometimes has round hard stools, She worries about traveling out of town and chance of obstruction. Patient is on Colace and Senna and Miralax. Patient uses Carafate liquid and dexilant 60 mg otherwise she has "burning", she still complaint of dysphagia and burning. She has not been able to tolerate Carafate pills due to her dysphagia but liquid helps her burning sensation and she uses Zofran as well. **Assessment:** 1. Abdominal pain: Improving but patient may have adhesions given number of surgeries. 2. Constipation: With history of complicated surgeries 3. Heartburn: GERD history with small-mod hiatal hernia by notes of recent EGD done at Emory main campus by a surgeon, regurgitation/heartburn despite PPI then. 4. GERD (Gastroesophageal reflux disease) 5. Family history of colon cancer. **Plan:** Labs ordered **Medication:** - Carafate 100 mg/ml. - Dexilant 60 mg.	
11/30/YYYY	Hospital/ Provider Name	**UGI/Small bowel follow through:** **Clinical indication:** Patient presents with recurrent ventral hernia and multiple abdominal surgeries. Assess for abdominal stricture. **Impression**: Negative upper GI and small bowel series.	5421-5422
01/17/YYYY	Hospital/ Provider Name	**Follow-up Visit:** Patient here for add on visit here with her son, due to nausea and pain and she is worried about a partial blockage. Sat morning she was constipated and she doubled her Miralax and Senna - she went to the bathroom. **Assessment:** 1. Abdominal pain: Improving but patient may have adhesions given number of surgeries. Has had partial SOB since received medically. 2. Constipation: With history of complicated surgeries, so risk of adhesions limits use of stronger meds like Linzess/Brulance/Amilize. We will get a CT scan. Patient feels she is starting to have another obstruction and was told to go to ER by her other physician and prefers to have an outpatient CT so will order at Emory so that her Emory surgeon has access to it	6177-6182

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/18/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with IV contrast:** **Clinical indication:** Abdomen pain, bowel obstruction, possible surgery next week. **Impression**: No bowel obstruction.	6184-6185
	Hospital/ Provider Name	***AB University Hospital (01/28/YYYY-02/05/YYYY)***	
01/28/YYYY	Hospital/ Provider Name	**History and Physical:** **History of Present Illness:** *History reviewed* Patient presents today with continued complaints of chronic abdominal issues. She is constantly nauseous. She has approximately 1 bowel movement per week. She intermittently takes her bowel regimen (she takes it when she has not had a bowel movement however stops that shortly after having a bowel movement). Patient became acutely ill in the clinic with nausea, vomiting, lethargy. **Physical exam:** **Abdomen:** Well healed incisions. Abdomen is soft, minimal diffuse tenderness non-distended. **Assessment and plan:** Presents to clinic today with chronic abdominal complaints and negative imaging studies - Admit to floor, Dr. Galloway - CT scan abdomen and pelvis with IV and PO contrast - Stat labs - IV hydration - PRN antiemetics - Bowel regimen	5498-5500
01/29/YYYY	Hospital/ Provider Name	**Consultation for EGD:** **History of Present Illness:** GI consulted for utility of EGD. **Assessment/Plan** GI consulted for persistent nausea. Appears symptoms correlate with constipation - likely secondary to gastrocolic reflex. Normal UGI transit. EGD likely to be low yield in clinical context, however, will assist to rule out upper GI pathology. **Recommendations**: - Aggressive bowel regimen. Would hold home Colace, consider adding Psyllium and giving Golytely, titrate to bowel movement daily. - Would discontinue Zofran given constipating effect. - Agree with treatment of abdominal pain with non-opioid medicaitons.	5501-5504

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		- Will plan for EGD tomorrow; please make NPO at MN and obtain AM labs.	
01/29/YYYY	Hospital/ Provider Name	**CT of abdomen and pelvis with IV contrast:** **Clinical indication:** Nausea/vomiting. **Impression**: No evidence of GI tract inflammation or obstruction nor evidence of inflammatory change elsewhere within the abdomen or pelvis to explain nausea/vomiting symptoms. Re-demonstrated uncomplicated surgical changes.	5855-5857
01/30/YYYY	Hospital/ Provider Name	**Upper GI endoscopy Procedure Report:** **Indication**: Persistent vomiting of unknown cause. **Impression**: - Normal esophagus. - Z-line regular, 35 cm from the incisors. - A large amount of food (residue) in the stomach. Suspect element of gastroparesis. **Recommendation**: - Return patient to hospital ward for ongoing care. - Would recommend low fiber, low fat, gastroparetic diet - Continue to work on constipation with aggressive bowel regimen.	5509-5511
01/31/YYYY	Hospital/ Provider Name	**Gastric emptying study:** **Clinical indication:** History of recurrent ventral hernias and multiple abdominal surgeries presents with chronic abdominal pain, nausea, constipation. EGD with solid food in stomach concerning for gastroparesis. **Impression**: Normal gastric emptying study with retention percentage as above.	5854-5855
02/04/YYYY	Hospital/ Provider Name	**Water soluble contrast enema:** **Clinical indication:** Abdominal pain unspecified. **Findings**: Preliminary scout: scattered stool is noted throughout the rectum, sigmoid and descending colon. Non obstructive bowel gas pattern. Numerous surgical clips throughout the abdomen and pelvis. **Impression**: Negative water soluble contrast enema.	5853-5854
02/05/YYYY	Hospital/ Provider Name	**Discharge Summary:** **Date of admission:** 01/28/YYYY. **Hospital Course:** On 1/28, patient presented to clinic with continued complaints of chronic abdominal issues, constant nausea, and approximately 1 bowel movement per week (and is non-adherent to bowel regimen). Patient became acutely ill in the	5477-5478

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		clinic with nausea, vomiting, lethargy and was admitted to the hospital. On 1/29, she underwent a CT abdomen/pelvis with PO/IV contrast and there was no evidence of GI tract inflammation, obstruction nor evidence of inflammatory change elsewhere within the abdomen or pelvis to explain nausea/vomiting. Due to prior EGD showing food in stomach (despite being NPO), she underwent gastric emptying study, which was within normal limits. During her stay pain and nausea were controlled with oral and IV medications and appropriate DVT prophylaxis was given. Finally, she underwent a gastrograffin enema on 2/4 which was negative for a leak. On 2/5, the patient was afebrile, with stable vital signs, tolerating PO diet with minimal nausea, having BMs, ambulating appropriately, and determined to be stable for discharge home with follow up outpatient with a Sitz marker study prior to her appt. The patient verbalized understanding and comfort with this plan. In addition, the patient was given detailed instructions for a bowel regimen, with emphasis on the importance of adherence. **Discharge Medications:** - Reglan 5 mg. - Colace 100 mg. - Miralax oral powder for reconstitution: 17 gm. - Senna 8.6 mg. **Diet**: General **Follow-up**: 4 week with Dr. Galloway **Disposition**: Home with family. **Condition at discharge:** Stable	
01/28/YYYY-02/05/YYYY	Hospital/ Provider Name	**Other records:** Medication Sheets, Input / Output Record, Patient Education, Discharge Instructions, Labs, Nutritional Assessments, Social Service Records, Anesthesia Record, Orders, Rhythm Strips, Prescription Record, Pathology Report, Nursing Notes/Records, Progress Notes, EKG, Assessment, Plan of Care, Labs **PDF-Ref:** 6186-6187, 5451-5452, 5467-5476, 6580-6581, 6593-6594, 5442-5566, 5459-5466, 5512-5527, 5529-5546, 5427-5437, 235-238, 245, 5505-5507, 5479-5497, 5858-6119, 6133-6174, 6370-6381	
02/25/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** **Clinical indication:** Recurrent ventral hernia pain. **Impression**: 24 Sitz marks, normal progression for presumed day 1 image. Follow up on day 3 and if needed on day 5.	6238
02/27/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** **Clinical indication:** Recurrent abdomen pain**.** **Impression:** Interval progression of Sitz marks with most of the markers now projecting over the left colon and sigmoid colon.	6275

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
03/01/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** **Clinical indication:** Sitz marker study**.** **Impression:** Grossly normal colonic transit, with one Sitz mark remaining in the sigmoid colon on day 5.	6313
04/15/YYYY	Hospital/ Provider Name	**Office Visit for chronic pain:** **History of present illness:** Patient who presents to the Department of Pain Medicine, Pain Psychology to address chronic pain. Patient notes onset of pain was August 2014. Precipitating cause of pain was sepsis following surgery. Patient's pain is impacting functioning in the following domains: ability to perform household chores, participate in hobbies/leisure, family functions, errands and employment. The patient noted that pain interferes with her daily functioning. The patient noted that pain interferes with his/her daily functioning (self-care, eating, sleep, school/work attendance, extra-curricular activities, chores). The patient has been prone to over activity followed by prolonged recovery. The patient endorses decrease in physical capacity. **Assessment/plan:** Patient is an excellent candidate for pain rehab. This is 3 weeks of day treatment with physical and occupational therapy for physical reconditioning and improved activity tolerance. In addition, we would address the functional and behavioral morbidities she is currently experiencing. Appreciate the referral.	8200-8201
04/15/YYYY	Hospital/ Provider Name	**Consultation Report:** At this time, patient has complaints of chronic nausea. She takes Zofran 1 to 3 times a day which does help. She rarely vomits. She does have epigastric burning which has worsened over the past few months. She takes Dexilant 60 mg daily. She will occasionally have solid food, liquid and pill dysphagia. She has had weight gain. She currently manages her constipation with 1 serving of MiraLax daily and sent to daily. With this regimen, she can have a bowel movement every 2-3 days. She does admit to incomplete evacuation and tries to avoid straining. She does use enemas and suppositories to help with lower evacuation. She denies rectal digitation. She does note that prior to any of her episodes of her obstructions, she does feel constipated, and abdominal X-rays and CTs of always mention large stool burden. She does feel her constipation has been far worse since she had her gallbladder surgery with complications. Patient is on multiple medications that can impact her GI tract including Pristiq, Zofran, Tramadol, Lexapro and Lyrica. Patient is a nonsmoker. **Impression:** 1. Chronic constipation. 2. Status post laparoscopic cholecystectomy with inguinal hernia repair August 2014. Small-bowel perforation and sepsis postop. History of multiple abdominal surgeries and small-bowel obstructions. 3. Outside diagnosis of gastroparesis per EGD February 2019.	8202-8204

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		4. Central sensitization syndrome with fibromyalgia features. 5. Polypharmacy. **Plan:** 1. Abdominal X-ray today to assess stool burden. 2. Anorectal manometry. 3. CT enterography in light of history of small-bowel obstruction. Multiple abdominal surgeries. 4. EGD with anesthesia assistance. Possible dilation pending evidence of small bowel stricture per GTE. 5. We did discuss patient's chronic constipation probable pelvic floor dysfunction. I did provide her materials on pelvic floor dysfunction as well. 6. Return visit with me when the above has been complete.	
04/15/YYYY	Hospital/ Provider Name	**X-ray of abdomen:** **Impression**: Non obstructive bowel gas pattern. Moderate stool burden seen throughout the colon. No residual Sitz markers identified. Incidental surgical clips and phleboliths throughout the abdomen and pelvis.	8199
04/16/YYYY	Hospital/ Provider Name	**Anorectal manometry Procedure Report:** **Indication**: Constipation. **Pre and post procedure diagnosis:** Bloating Abdominal. **Impressions**: 1. Normal anal canal resting pressure. 2. Low normal anal canal squeeze pressures. 3. The patient was not able to maintain more than 3 sec of sustained contraction of the anal canal muscles. 4. Normal rectoanal inhibitory reflex. 5. Evidence of rectal hypersensitivity given reduced threshold for discomfort during balloon inflation. 6. The patient was unable to expel a 50 cc rectal balloon in under 1 min. 7. During simulated evacuation, the patient did not relax the external anal sphincter muscle nor the internal anal sphincter muscle. In combination with the inability to expel a 50 cc rectal balloon this is consistent with pelvic floor dyssynergia assuming that mechanical obstruction has been ruled out. This condition is generally best treated with a pelvic floor retraining program.	8194-8196
04/17/YYYY	Hospital/ Provider Name	**CT of abdomen pelvis enterography with IV contrast:** **Indication**: Abdominal bloating and distension. **Impression**: 1. No small bowel dilation/caliber change to point toward a site of obstruction. 2. Small bowel closely opposed to the anterior abdominal wall in the lower abdomen/upper pelvis, such as typical of adhesions.	8189-8190

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		3. Contrast enhancement of the vaginal soft tissues. Finding is nonspecific, but can be seen with vaginitis.	
04/18/YYYY	Hospital/ Provider Name	**Upper GI endoscopy Procedure Report:** **Pre-operative diagnosis:** Dysphagia, EGD with anesthesia assistance. **Post-op Diagnoses:** - Esophageal mucosa changes suspicious for eosinophilic esophagitis. Biopsied. - Nodule found in the esophagus. Biopsied. - 1 cm hiatal hernia. - Z-line regular 38 cm from the incisors. Dilated. - Gastritis. Biopsied. - Flattened mucosa was found in the duodenum, rule out celiac disease. Biopsied. - The examination was otherwise normal. **Recommendation**: Discharge patient to home (ambulatory). Resume previous diet. Continue present medications. Return to referring physician as previously scheduled. Return to nurse practitioner as previously scheduled. Await pathology results.	8175-8177
10/25/YYYY	Hospital/ Provider Name	**History and Physical:** **History of present illness:** The patient presents today for clearance prior to planned endoscopic procedure. There have been no new issues since their last evaluation at the clinic. **Impression/Plan:** Pre endoscopic evaluation patient presents prior to undergoing surveillance endoscopy scheduled for later today. She is accompanied by her daughter who will be her driver. She will be following up with Ms. Avens APRN for test results and further plan of care. If there are any questions I am happy to help until the return of Ms. Avens. She has undergone laboratory testing this is reviewed and is within normal limits. The patient is in adequate condition to proceed to the planned endoscopic procedure.	8154-8157
10/25/YYYY	Hospital/ Provider Name	**Upper GI endoscopy Procedure Report:** **Pre-operative diagnosis:** Dysphagia. **Recommendation**: Discharge patient to home (ambulatory). Resume previous diet. Continue present medications. Return to referring physician as previously scheduled. **Impression:** **Post-op Diagnoses:** - Z-line regular 38 cm from the incisors. Dilated. - Small hiatal hernia. No evidence of residual papilloma.	8158-8159

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		- The examination was otherwise normal. - No specimens collected.	
10/25/YYYY	Hospital/ Provider Name	**ER visit for facial droop:** **Chief complaint/reason for visit:** Facial Droop (patient complains of R eye droop that started today. Noticed weakness in her face yesterday evening) **History of present illness:** Patient to ED with CC R facial droop. Patient was sent from GI due to right facial droop that was noticed after patient had EGD. Per GI did not have right facial droop prior to the procedure. Patient was given Propofol for procedural sedation. Per family member patient reported right-sided face feeling unusual yesterday evening but did not have any obvious abnormalities. Patient states she cannot open her right eye. States she feels weak all over but does not have any focal weakness. Daughter reports multiple episodes of sepsis in the past and patient describes herself as fragile. States she feels okay. **Physical examination:** **Neurological:** She is alert and oriented to person, place, and time. She is not disoriented. No cranial nerve deficit (does not open R eye but resists active opening). She exhibits normal muscle tone. Coordination normal. Distal strength and sensation intact all 4 extremities, has giveway weakness RLE that is not consistent on repeat exams. **Final diagnosis:** Facial weakness	8146-8149
10/25/YYYY	Hospital/ Provider Name	**Neurology consult:** Patient was scheduled for an upper endoscopy to follow up on a esophageal papilloma today. She was last seen well at 10:00 am prior to the procedure. It was documented by anesthesia at 10:51 am, that the patient was noted to have ptosis OD, with tongue deviation to the right. She was examined, and the changes were thought to be chronic. She subsequently returned to Davis 6 East following her procedure. On exam, she was noted to have anisocoria, ptosis OD, with right facial droop. Her EOM were thought to be restricted, with OD deviated to the right; it is unclear if it was down and out, as seen with a third nerve palsy. Code 250 was called and the patient was taken to the ED for evaluation. At 13:46, the neurology team was paged by the ED physician for ptosis OD. She was evaluated at the bedside, and the daughter reported that her symptoms were improving. She reports a history of a TIA in 2009, during which she had transient right sided weakness of her face. **Assessment and Plan:** Patient presented to the ED at MCJ on 10/25/19 with a one day history of ptosis. Exam is notable for ptosis OD, mild anisocoria of 1 mm, sluggish pupils bilaterally, evidence of Hering's law phenomenon, with full EOM, mild right facial droop, with midline tongue, and diffuse bilateral weakness, the latter finding is noted to be chronic according to the patient's daughter. The patient has had many hospitalizations 2/2 sepsis from a perforated bowel, and has been	8143-8146

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		chronically ill during this time. The patient's exam is concerning for new focal neurologic deficits. At the time of evaluation her symptoms were improving, and she was out of the window for IV tPA. Her symptoms may reflect a complex migraine, as the localization for the patient's symptoms is not clear. Brainstem ischemic stroke is also a consideration. However, to affect the third cranial nerve in the midbrain, would suggest ischemia in the paramedian branches of the basilar bifurcation. However, one would anticipate involvement of the corticospinal tract, as it traverses the cerebral peduncles, and there was no asymmetry to her extremity weakness. To explicate a seventh cranial nerve palsy, would suggest ischemia in the long circumferential branches of the basilar or AIGA affecting the pons. This would also explicate her diminished pinprick of the right hemibody, as it would also involve the anterolateral system as well as the spinal trigeminal tract and nucleus, explicating diminished pinprick of the right face. However, one would also anticipate vestibular involvement, as the vestibular nuclei are also in this territory. Her transient tongue deviation to the right, which was not appreciated on my exam, would suggest medulla involvement, affecting the hypoglossal nucleus or hypoglossal nerve, which would suggest anterior spinal artery involvement. - MRI brain without contrast	
10/25/YYYY	Hospital/ Provider Name	**MR brain without contrast:** **Impression**: No evidence of recent infarction, intracranial mass, positive mass effect or shift of midline structures. Ventricles and cortical sulci are age-appropriate.	8149-8150
10/25/YYYY	Hospital/ Provider Name	**CT head without contrast:** **Clinical indication**: Altered mental status. **Impression**: No acute intracranial abnormally.	8149-8150
12/10/YYYY	Hospital/ Provider Name	**Office Visit for multiple complaints:** **Medical problem:** Diarrhea. Increased BMI greater than or equal to 25. Influenza vaccination given Dyshidrosis. Vitamin B12 deficiency.	325-328
02/11/YYYY	Hospital/ Provider Name	**Office Visit:** **Chief complaint:** Patient presenting for neurovascular evaluation of multiple TIAs. She was referred by Dr. Wolfsen. They drove last night from Atlanta, GA for this week's Clinic encounters and testing. She is accompanied today by her daughter, Whipney, who provided collateral history throughout our clinic encounter. **Assessment and plan:** 1. Transient Ischemic Attack.	8135-8142

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		2. Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side 3. Paresthesia. 4. Pain in right lower leg. **Plan:** - CTA head and neck for vascular imaging. - Transthoracic echocardiogram with shunt study. - 12-lead EKG. - Continue Aspirin 81 mg daily for stroke prevention. - Peripheral Nerve Clinic referral for suspected small fiber neuropathy. Outside EMG and biopsy results to be uploaded to EMR prior to the visit. - Mediterranean diet, moderate intensity exercise at least 3 hours per week, gradual weight loss with goal of normal BMI. Will obtain fasting lipid panel. - Questionable MTFHR mutation at Emory. Will order homocysteine level.	
02/11/YYYY	Hospital/ Provider Name	**Echocardiogram:** **Final Impressions:** 1. Normal left ventricular chamber size and wall thickness 2. Calculated 2-D biplane volumetric left ventricular ejection fraction 61 %. 3. No regional wall motion abnormalities. 4. Normal left ventricular diastolic function. 5. Normal right ventricular chamber size and systolic function 6. Mild mitral valve regurgitation. 7. Agitated saline injection was performed and showed no shunt. 8. No pericardial effusion.	8129-8134
02/12/YYYY	Hospital/ Provider Name	**Office Visit:** Patient returns today due to 3-4 week history fecal urgency, mushy stools, and episodes of fecal incontinence. Patient was sick most of the month of January and in the hospital for about a week due to bronchitis at her pneumonia. She was treated with multiple courses of antibiotics as well as high-dose steroids. Patient does have a history of C diff x4 over 3 years ago. Patient does report foul-smelling, loose stools. She has had nighttime episodes as well. Patient's most recent colonoscopy was about 4 years ago. She does have a history of colon polyps, histology unknown. Patient's mother died of colon cancer at the age of 65. Patient does have obstructive sleep apnea. She does have a history of TIA as being followed by Neurology. Patient has a history of fibromyalgia, migraines, anxiety and depression, melanoma, neuropathy. **Impression** 1. Fecal urgency and fecal incontinence x1 month. 2. Bowel change, loose stools and diarrhea x1 month. 3. History of C diff. 4. Family history of colon cancer, mother. 5. Personal history of tubular adenomas.	8122-8123, 8117-8121, 8124-8125, 8127-8128

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		Plan: 1. We will update labs today. 2. Stool for C diff. 3. Colonoscopy with anesthesia assistance. Note to endoscopist please intubate the terminal ileum and do random biopsies throughout the colon to rule out microscopic colitis. I reviewed the sedation procedure with patient in detail and she verbalized understanding. I provided patient prescription for Golytely sent to the Mayo Pharmacy and she will do the split prep for her procedure. Patient's daughter is here and will be the driver. 4. Referral for pelvic floor physical therapy given to patient. 5. We may consider a referral to Urogynecology to discuss a possible eclipse if fecal incontinence continues.	
02/12/YYYY	Hospital/ Provider Name	**CT head neck angiogram with IV contrast:** **Impression:** Normal examination without evidence of significant carotid artery atherosclerosis or intracranial vessel stenosis, occlusion, or vascular malformation.	8126-8127