ejournal

Date: 23-May-2013
Location: RIGSHOSPITALET
Department: SURGICAL GASTROENTEROLOGY CLINIC C. AMB., HELDØGN
Diagnosis: Pancreatic cancer

01-July-2013 Note

Plan, diagnostics and care as indicated in visit. v/———————.
Chief Physician ———————
Medical Secretary ———————

Created by:
Name:
Title:
Department: MED. ENDOCRINE CLINIC PE, AMB.
Institution: RIGSHOSPITALET

01-July-2013 Note

according to the EWS > 9 must take the values at 1/2 hour and with score over 12, contact watch.
1. Resident ———————

Created by:
Name:
Title:
Department: SURGICAL GASTROENTEROLOGY CLINIC C. AMB., HELDØGN
Institution: RIGSHOSPITALET

01-July-2013 Note

Summoned due to resp aggravation
Heavy resp aggravation approximately at 24:00. Hyper Ventilating. Deset without oxygen at 85% is directed to 96% with 15 liters of oxygen. Cold and clammy sweating, low pressure. Exhausted 500 ml pleural exudate earlier today.
Abdominal no problems.
TP: 38
ITA supervision, see this note.
rp A gas
rp Showing SR 110
rp thoracic
Showing right central infiltrate.
rp Meropenem
rp Cipro
rp Duovent
rp 2000 ml NaCl
according to opus. after about 1-1.5 hours rightly falls tp 37 and calmer resp frequency. Agreed re ITA assessment if the above does not inform the PT's revamped **pneumonia with sepsis**
1. Resident ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC.C,HELDØGN
Institution: RIGSHOSPITALET

30-June-2013 Note

Hyperventilate and takes O2 glasses off. Monitoring Pulse 119 SatO2 96% at 5 L O2. He believes he is anxious because of this.

rp. inj. Stesolid 5 mg pn.

A-gas. pH 7.49, p02 7.83, pCO2 3,77, HE -1,7, HCO3 23.4

rp. inh. Duovent 4 mL pn.
rp. fixed guard due to poor compliance,
taking nasal cannula to and desaturate, restless in bed

Resident ——————————

Created by:
Name:
Title:
Department: RADIOLOGY DEPARTMENT X
Institution: RIGSHOSPITALET

30-June-2013 Note

The ul-guided pleural drainage ordered. Pt informed and agreed.
Chief Physician ———————

Created by:
Name:

Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

30-June-2013 Note

Pt ews 4 prime resp rate of 26 tp 37.3 set 96%
Review of CT scan shows pleural effusion on the right side.
Rp Ul guided drainage
Pt is in Ab handling after culture result.
Is informed of the findings and plan.
Resident Karen Oline Larsen Langballegård
A puncture shows lactate pH 7.5 2.2 S02 0.96

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

29-June-2013 Note

Pt starting febrile, have chills tp 38.4
Rp venules
Rp inf numbers
Rp urine to D + R
Rp rgtof the thorax
Pig tail does not work, on suspicion of unclean accumulation and
after conf with radiological assistant,
Rp CT scan of the abdomen obs
for buildup.

Resident ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

28-June-2013 Note

Slightly better compared to yesterday. Eating continues and that is good once in the stomach.
PTC drain produces 400cc gal abd drain + / - 100 cc
The wound was split in 3 sides. The iv has vancomycine. He has had lx
packed cells (Hb 4.6)
Obj: In recovery
Abd: soft and sore.
cicatrice with intact fascia at the bottom. Can be kept dry with AQUACEL.
Lab Hb 5.5 (lx PC), leuk 10
amy sinks (25/6): 31700
program for the day + weekend.
conversation with the cardiologist with respect to atrial flutter.
Pores analgesia with fentanyl 50
mobilize, control laboratory research in morning + amylase in drainage
Clinic physician ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

27-June-2013 Note

Anesthesia for ptc. have rapid atrial fibrillation with hr 125 on arrival.
given 500 micrograms digoxin iv. suggests that the department asks based on
Using preceded by 12-straight ECG.

Chief physician ——————

Created by:
Name:
Title:
Department: ANÆSTESI-/OPERATIONSKLINIK, AB
Institution: RIGSHOSPITALET

27-June-2013 Note

Preoperative today atrial fibrillation, intra-operatively digitized, a total of 500 ug.
Postoperative f 90-100, MAP 70, no shortness of breath or chest pain.
Afebrile, Hgb 4.9, not tormented by pain.

PA scope still sacrificed rp ECG
By continuing sacrificed in the department proposed switch to
heart medicines, MHP frequency regulation and any anticoagulant treatment.

Resident ——————

Created by:
Name:
Title:
Department: ANÆSTESI-/OPERATION CLINIC, AB
Institution: RIGSHOSPITALET

27-June-2013 Note

FTC drainage construction.
General and local anesthesia
Plug-in on the right side. No dilatation to biliary system. The assessment is 8.5 fr. internal / external drainage for relief. Suturing the skin.
Chief Physician ————————-

Created by:
Name:
Title:
Department: RADIOLOGY DEPT X
Institution: RIGSHOSPITALET

26-June-2013 Note

FTC drainage construction.
General and local anesthesia
Plug-in on the right side. No dilatation to biliary system. The assessment is 8.5 fr. internal / external drainage for relief. Suturing the skin.

Temperature 38.2. 31000 in amylase in drain secretions, and it comes out through the suction drain resembles small intestinal secretions! Still throwing up a little bit, and the last day 700 ml, bile-colored. However, once in the stomach.
There has been growing response, and there may be a slight difference, and these bacteria are sensitive to Lineiolid and Vanco.
Therefore,
September Zinacef and Metronidaxol.
Runs on with Linezolid and so
rp. Vancomycin 1 g x 2
Pt. must have leak, so there is an indication FTC - This has now ordered via RIS and Radiology Department is aware and pt. are booked in Orbit - Hopefully we can make this FTC tomorrow.

————————-, Chief physician/ngr

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

25-June-2013 Note

Have thrown bile colored up about 400 ml in total the last day. Is somewhat discouraged this morning. Eating continues and that is good once in the stomach. Drain put in accumulation that has seen 100 yellow clear liquid.
The second drain abd brought per operatively has produced nothing in 4 full days. The wound was split into left side. In the iv cinazef and metronidazole. Blood samples are pending.
Obj. / recovery
Abd. soft and not sore. Night bowel sounds
cicatrice with intact fascia in bundles. Can be kept dry with AQUACEL.
rp drain fluid to DR and Amylase / bili rp fj not producing drainage
We are keep an eye on any additional vomiting. Does not activate the sensor at present time.

—————————- Resident

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

24-June-2013 Note

Tel handover to reply to dagense CT abdomen. Continued accumulation, no new. Accumulation of 4.5 x 5 cm. Contact is made to watch radiologist with a view on rp. 131 guided drainage
if possible.
The patient was provided information about intervention and risks and accepts this.

Resident ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

24-June-2013 Note

The patient well-being afebrile, has continued epigastric pain.
Staples are removed and completely out laterally on the left side, cleaved area due to old hematoma, which washed away. It's a bit hard to decide if upper fascia sheet is intact, but there is certainly an intact fascia sheet on the bottom to the wound. There used aqua-gel m dry comp. above.
The patient has continued leukocytes of 9.4 and CRP at 84
Discontinued fallen his pigtail cath. Thu weekend and then there is agreement on the morning conf., if new rp. CT-scan, the abdomen, obs
ansaml. (not req. in RIS) to be carried out
(this was ordered by telephone from the radiologists and it is agreed that it is to be done today, alternatively tomorrow.)
The patient is unaffected.
There must be new liquid/electrolite/ inf. tal tomorrow and coag. figures
if to be performed ultrasound-guided drainage.
The wound should be changed daily
————————1. Resident Physician/vg

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

23-June-2013 Note

The patient feels a little queasy. There are stools and he has a good appetite, but has thrown up a few times after food intake. After consuming smaller portions things are however better.
He has mild abdominal pain, upon closer examination it turns out to be related to suture around the drain and in relation to clips in the skin.

Obj:
Pt is alert and ready.
Skin hot and dry, nice colors, sclera remains easy icterus. Abdomen: Flat and soft, are not sore apart from at the clip and drain. The drain in the right side with yellow tinged output. Drain-amylase 9, bilirubin 36

Biochemistry:
Bilirubin decreased to 65 Alkaline phosphatase: unchanged high for 1000.

Plan:
We await CT tomorrow for the last drain discontinued.
Resident ————————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

21-June-2013 Note

After accidental SEP pigtail catheter suspected bile mixed with some drain. Feeling good though cases of upper colic pain.
It takes rp drain fluid for bil & amy
If elevated to consider for advance and acute CT abd tomorrow instead of Monday as planned MHP if necessary undrained / restored accumulations.

Resident ————————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, AMB
Institution: RIGSHOSPITALET

21-June-2013 Note

The patient has pulled his pigtail catheter out. In the bag was a lot of pus. It is hardly possible to bring new catheter now. One must wait until there is an accumulation restored.
Therefore, patients must undergo a new CT scan of the abdomen Monday, 24/June/13 MHP.
drain just accumulations
If the patient is poor during the weekend emergency CT scan should be performed
Rp. Control the infection counts
Rp. Base samples
The patient has so far been covered with antibiotics according to susceptibility testing.
Chief Physician. ————————/ah

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, AMB
Institution: RIGSHOSPITALET

19-June-2013 Note

Temperature 37.6, but otherwise things are moving forward. Some drainage is serous, about 200ml. There is no amylase increase, but the second drain is slightly purulent - Both the drains to remain in situ.
————————, Chief Physician /ngr

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

18-June-2013 Note

Waning icterus That is 140 ml in some drainage and 140 ml in the left-side pigtail Cath., Still a little murky.
Should be taken from the amylase base of both drains.
————————Chief Physician /vg

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

17-June-2013 Note

Note Cause
Whipple surgery. Nutritional counseling.

Energy-ag protein needs
Weight: 95.9 kg (habitual weight approx. 100 kg) Height: 188 cm
BMI: 27
For weight maintenance 9850 kJ and 103 g of protein

Instructions / recommendations
Pt. guided in energy and protein diet, with a focus on small frequent meals.
Pt. is informed of the dumping symptoms.
Pt. has been provided with written material effect as well as the cookbook "Less is more".
Pt. recommended weight control home x 1 week MHP. weight stability.
Pt. recommended 1 x multivitamin-mineral tablet daily.
Pt. is informed of vitamin B12 injection and monitoring of iron status every 3 months at e.l.
Clinical dietician————————

Created by:
Name:
Title:
Department: HEPITOLOGICAL CLINIC. A, AMB
Institution: RIGSHOSPITALET

17-June-2013 Note

There is now about 100 ml slightly murky discharge from the pigtail drainage. Serous in the right-side, c. 200ml. cont. both drain
Pt. have had bowel movements rp. diet for to aid
A small hematoma depleted on the left side of cicatrice, which incidentally holds fast. There is no suspect fascia rupture.
rp. dry dressing
————————, Chief Physician /gp

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

16-June-2013 Note

Drain amylase is 5900. Is well and afebrile.

Rp. Daily inf. numbers
1. Resident ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

15-June-2013 Note

15/6 2013
Continued icterus, blood test showing bilirubin 14 may be error measurement. Muddied secretions from the pigtail catheter, serous from suction drainage. Abd. soft and mild pain. Still no bowel movement. Clin. Biochemistry: continued leukocytosis and amylase from the drain in 6000. Suspected leak.
Rp: secretions from the suction drainage and the pigtail catheter for determining amylase secretion from dwn to D + R
blood to D + R
If amylase> 20,000 must pt be in container octreotide 300 mcg sc x 3 and pt be fixed (with water pr. os ad libitum) and TPN.
Rp. control the infection counts and base samples
Chief physician ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

14-June-2013 Note

CT abdomen showing a large accumulation of 7x7cm in relation to pancreatic and galdean astomoser. There is evidence of UL guided drainage. Pt. be informed of this.
1. Resident ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

14-June-2013 Note

4 days after the whipple operation. By day increasing abdominal pain. Have unchanged high infection counts. Temp. 37.9. GI function of flatus and the guide.
Abdomen. Soft, diffuse sore in the lower right abdomen. reciprocal predominance, non peritoneal. Seros angvin east of drained without evidence of bile. You will normally hear tinkling bowel sounds.
There is indication for CT to the abdomen. Be informed of this. The radiologist contacted.
Physician ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

14-June-2013 Note

4th day after whipple.
There's still a little blood in the drain and amylase content is 150, so the drain must remain in situ. Have a little bit of fever, 37.9 but appears otherwise quite pristine, some chronic included and continued icteric. Must continue with antibiotics.
———————Chief Physician /vg

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

13-June-2013 Note

Quiet process. Waning bilirubin. Leukocytosis of 23.4.
Abdomen: soft and without pain. Not peripheral edema.
rp. rtg. of the thorax mhp. pneumonia rp. drain secretion measurement of amylase rp. control to inf.tal
and base samples
The patient has had a bowel movement yesterday, rp. thin per os
———————Chief Physician /vg

Created by:

Created by:
Name:

Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

13-June-2013 Note

Descriptive Memo
Functioning of illness / hospitalization: Independent, decrease risk, aids, KRAMS:
The intervention during hospitalization
Diagnosis and referral reason: C. pancreas. Postoperative respiratory physiotherapy
Treatment Contents: losing assessment, positioning, respiratory physiotherapy including PEP, guidance
Duration: Physiotherapy started on 11/June-13 and completed dd
Frequency: x 3
Current feature mention of marked time
Cognition: VKO
Pain: /
Respiration: SAT: 94-95 * sitting on the edge of the bed without oxygen supplementation, sufficient coughing power and secretions present.

Test:
CAS-test (Cumulated Ambulation Score)
Out and up to bed - 2 points
Travel sit in the chair - 2 points time indoors - 1 point
Overall score - 5 points
Possibly. time tool: Easy personal support,
Basic Mobility: In the up in bed (0-2) + Travel / sit in chair (0-2) + time with current mobility device (0-2) provides a daily score for basic mobility from 0-6.

Activity and participation: Pt. moves independently from bed to standing and walk around. 10m with easy person support.
Treatment Result: Repealed respiratory complications
Conclusion: Respiratory physiotherapy discontinued
Plan: Cont. mobilization and functioning of department. Pt. continue self-administration to PEP flute during hospitalization. Devices used / distributed to hospital: Rostrum used.

Consent
The patient is informed of the above and has given consent.
Physiotherapist ————————

Created by:
Name:
Title:
Department: CLINIC FOR ERGO AND PHYSIOTHEREPY
Institution: RIGSHOSPITALET

12-June-2013 Note

Called because pt. has an irregular heartbeat and pulse rate is around 150
Is not known with atrial fibrillation but according to pt. he has had an irregular rhythm after a previous operation. Is currently not affected by it.

rp. ECG

It shows atrial fibrillation. In another examination, the heart rate was down to 60 and the subsequent swing great. After cardiology result vague pt. to be saturated with digoxin if he seems to maintain a high frequency.

rp. new ECG tomorrow
rp. new ECG when the pulse is normal in between time
rp. cardiological supervision tomorrow if pt. constant is in atrial

presentations:
pt. with postoperative atrial fibrillation after Whipple-OP. Not available with atrial fibrillation. There asked to consider possible drug treatment.
Resident ————————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

12-June-2013 Note

Pt, check in using the PEP flute. Instruction in bed exercises. Sgpl. mobilizes pt. after washing.

Physiotheripist ————————

Created by:
Name:
Title:
Department: CLINIC FOR ERGO AND PHYSIOTHEREPY
Institution: RIGSHOSPITALET

01-July-2013 Note

Quiet process. Neg net asp. A little flatus. Still icterus with pruritus.
rp tf
monitoring of liver bile numbers and basic tests.
Chief physician ————————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

11-June-2013 Note

PEP:
Indication: Preventing respiratory complications.
PEP whistle with resistance: 3 - Omm
Duration of the treatment: 3-5 minutes
Frequency: Every 2 waking hour
Starting position: The camp high in bed, sitting on the edge of the bed or sitting in the chair.
Conventional treatment: The booklet Treatment with PEP flute is distributed and reviewed for self-administration.
Pt. have good understanding and self-managed.

Physiotherapist ————————

Created by:
Name:
Title:
Department: CLINIC FOR ERGO AND PHYSIOTHEREPY
Institution: RIGSHOSPITALET

11-June-2013 Note

Respiratory assessment
Date of referral: d.d.
Diagnosis and referral reason: C. pancreas. Postoperative respiratory physiotherapy
Treatment according to treatment guidelines: Laparotomy Assessment and treatment started: dd
Functioning of illness / hospitalization: Independent, KRAMS: / Restrictions / Special notes: Pt. using home CPAP due to sleep Apnea.

Current functionality:
Cognition: VKO
Cardiovascular:
Respiration: SAT: 97% sitting on the edge of the bed without oxygen supplementation Cough Power: Sufficient
Secretions: /
Pain: /

Test:
CAS-test (Cumulated Ambulation Score)
In and out of bed - 1 point
Travel sit in the chair - 1 point
Time indoors - 2 points
Overall score - 4 points
Possibly. walking aid: Rostrum

Basic Mobility:
From up in bed (0-2) + Travel / sit in chair (0-2) + Gang with current mobility device (0-2) provides a daily score for basic mobility from 0-6.

Activity / participation: Pt. mobilized to the bedside / lectern with easy person support and go approx. 10-12m.

Conclusion: There is a need for respiratory physiotherapy incl. PEP, mobilization and position changes
Short-term goals by therapist: prevent postoperative pulmonary complications.
Long-term goals by therapist: Follow the route marked Plan: mobilization and self-administered PEP.

Consent:
The patient is informed of the above plan and has given consent.
Physiotherapist ————————

Created by:
Name:
Title:
Department: CLINIC FOR ERGO AND PHYSIOTHEREPY
Institution: RIGSHOSPITALET

11-June-2013 Note

Quiet postoperative course now. Withdrawn to noradrenaline, blood pressure acceptable, pane diuresis and numbers, pain c well covered by the given treatment.
Rp. Described on stam.afd.
Department Physician ———————

Created by:
Name:
Title:
Department: ANÆSTE51-/OPERATIONSKLINIK, AB
Institution: RIGSHOSPITALET

10-June-2013 Note

POTA Postoperative note

Formerly known to have asthma that is well controlled.
2001, Frederiksberg hosp. Right hip replacement, osteoarthritis
2008, RH surgery for breast cancer treatment ended, no more controller.
In therapy with the anti-asthmatic bra. and lower dose of slow-release morphine 10mg x 2

Pt. has a tumor located in the caput pancreatic extending into the processus uncinatus compressing the biliary tract. No ingrowth of vessels and no evidence of metastasis. Is called in mhp on Anesthesia for Whipple surgery.
Preoperative construction of Epi sv. to Th 9-10, LOR 7.5cm. 13 cm in Hud.glat.

Anesthesia with Sevo-Ultiva - Cisatracurium
CVE in v. jug. int. dx, a catheter in a row.
Uncomplicated intra-operatively process is, with foreseeable hypo
Losses: blood, 750 mL, diuresis: 450 ml
Administration: Ringer 2000 ml, Voluven 1000 Medicine: 500 ml. Beretgnet VB + 2300 ml.
End Mb: 5.0

Plan
The observation of FOTO until tomorrow.
Cont epidural pain
Transfusion threshold: Hb 4.5
CPAP for an usual.
Strive MAP> 65 SV02> 75 TD a 75 SAT a 92

Resident ———————

Created by:
Name:
Title:
Department: ANÆSTE51-/OPERATIONSKLINIK, AB
Institution: RIGSHOSPITALET

10-June-2013 Note

Operation: KJLC30 pancreaticoduodenectomy

Operator: ———————
Anesthesia: universal anesthesia

Pathology
Large tumor in the pancreas Processus Uncinatus . No ingrowth into the vein. No carcinosis or liver metastases.
FREEZE : common bile duct and pancreatic resection rim without malignancy.

Procedures:
Curved incision during curvaturer. Kochers maneuver. Access to the pancreas following the demolition of the omentum majus from the transverse colon. A. and V. superior mesenteric Sup isolated. Clivage between the superior mesenteric v. / v. vein and femoral pancreatic formed . It performed a cholecystectomy . All dissection of the ductus choledocus , portal vein and a hepatica propria , each of which is held by sling. A. gastro duodenalis shared. A gas rica dexter and a gastroduodenalis dexter shared in line with the antrum ventriculi. Ventricle shared by antrum with staples . Treitz ligament is divided and shared jejunum 10 cm from the Treitz ligament. Jejunum proximal to the division released to flexura duo denojejunalis . The ductus hepaticus shared right across the ductus cysticus. Pancreatic mobilized from vein, uncinate first, tying vævspladen during caput pancreatic shared and pancreatic shared. The preparation (antrum gastric, pancreatic caput, duodenum and proximal jejunum) removed.

Reconstruction a.m. Whipple
All anastomoses constructed in the same jejunum legs. Jejunum is pulled through the transverse mesocolon. Pancreatitis cojenunostomi am Blumgart with PDS 4-0 and 5-0. Hepatico jejunostomy in one layer with 4-0 PDS. Gastro jejunostomy in two layers with continuous POE 3-0. Suction drainage behind hepaticoj ejunostomi and pancreatico jenunostomi. Closing the abdomen in two layers with continuous PDS.

Plan:
Antibiotic treatment Zinacef 1.5 gx 3 Metronidazole 1.5 gx 1 in
at least 3 days
Pantoprazole 40 mg x 2 iv.

until further
duodenals pain by slight suction
as long as the gastric retention.
1000 ml of water per os
as long as there is gastric retention,
then increasing diet
suction drainage removed 7
postoperative day
if no secretion. drain from the ductus pancreaticus removed after 3 weeks.
———————, Department Physician./vw

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

07-June-2013 Note

The patient is afebrile. Well-being. Normal kidney counts, but as
indicated elevated bilirubin. ERCP failed yesterday.
However, the patient was moved forward for the operating
treatment
Monday, 10/June/13
So we will make no further interventions. JF. MJs note of gd. The patient can go on leave
And continues cont. Antibiotics as he receives currently.
Chief Physician ———————/ah

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. AMB.
Institution: RIGSHOSPITALET

06-June-2013 Note

050836-0193

ERCP
Rigshospitalet - Surgery Clinic C

Patient: 050836-0193 ERIK LARSEN Date: 6. June 2013
Used sedation
INDICATIONS
Affected liver enzymes + jaundice

PROCEDURES UJKO2 ERCP

DIAGNOSTICS
DC250 cancer capitis pancreatic

COMMENTS FOR INVESTIGATION
Tentamen ERCP. Coming in good position papilla, but it is impossible to insert syringe needle. Chief
physician MJ also trying but it fails.

According to reports from the department, the patient operating date was brought forward about 4 days.
Therefore, there must not be ordered PTC
There is 1 in the Endoscopy database

Examiner
———————. Serving secretary ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. AMB.
Institution: RIGSHOSPITALET

06-June-2013 Note

76-year-old man hospitalized MHP. ERCP with stenting and Whipple's operation due to tumor in caput
pancreaticus

Allergies:
Possible allergy to plaster. Getting some red bumps which disappear within 24 hours as the only symptom. No
known drug reactions. Resistant to iodine and latex.

Measures:
cancer in the right breast, 2008. No sequelae

Exposures: Not MRSA
Former diseases / admissions

Known with asthma that is well controlled.
Have sleep dyspnoea, and uses C-PAP
2001 Frederiksberg hosp. Right hip replacement, osteoarthritis
2008. RH surgery for breast cancer treatment ended, no more controller.
2010 BBH Op. for complaining
2013 Frederiksberg Hosp. foot OP., Bunion.

Current:
Feel at the moment bloated, and have felt like this for a while. Have no pain, but experience a tightness in the epigastric when swallowing food. Pt. says that there is little appetite. Have lost a 4-5kg since Pentecost. Pt. has at times slightly acidic state, but it does not feel like a real problem. Stool has been quite whitish, but is now more normalized. Described as gray-brown. The consistency is described as a bit tough, but pattern and the amount is normal for pt.
Pt. also complained about some itching on the body but is also icterus. This also occurred in connection with Pentecost

Other organ systems:
CNS: no headaches, dizziness, or syncope. Does not experience visual or hearing disorders.
CF: No heartbeat, pain or kurale edema. Can be due to his asthma very occasionally experiences a little shortness of breath, but that's not as troublesome. Is known to sleep dyspnoea and use C-PAP.
GI; as specified under current.
UG: Experiencing easy hesitancy and lumber muligis not the bladder completely. The urine is described as dark golden, but the more normal than before.
B A: No pain or force reductions. Discloses itchy skin over most of the body.

Alcohol:
15 drinks / week. Most red wine and a beer.

Tobacco:
Ex-smokers. Termination in 72 Before that approx. 20 years.

Medicine:
inhl. Asmanex twisthaler. 400 mikrogram 1 inhalationinhl. Omis turbuhaler 9 mikrogram, 2 inhalation
tabl. Zolpidem 10 mg, 1 tab / day
tabl doltard 10 mg, 2 times daily
tabl Toilax 5 mg, 1 tabl daily
tabl Paracetamol 500 mg, 2 times daily tabl 2
tabl Ciprofloxacin 500 mg, 1 tabl 2 times daily empty 08:June:13 PH Omeprazole 20 mg, if necessary, against acid

Tells of additional use of viagra 1-2 times a week. However, this has not been relevant for 14 days.

Social
Living with wife in house with 1st floor and basement, and has no
problems to move around there. Is very active, especially in the garden. Does no house cleaning.

Objective
Pt. appears VKO. Warm and dry. Traces icterus. Not included. Very good general condition.

BT: 134/92 P: 68 SAT: 96%

Eyes; round, equal pupils with normal light reflection.
Cavum ors. No loose teeth or dentures
Collura , no jugular vein congestion or palpable lymph nodes. No goiter St.P : vesicular breathing bilaterally , without murmurs
st.c : regular rhythm = perifmr pulse, without murmurs .
Abdomen : flat and no pain . Sufficiente cicatricer left, the umbilicus and left flank corresponding to the hernia. Normal bowel sounds. No organomegaly. Small filling in left, flank old hernia. Slidable and a few centimeters in diameter.
Exploratio rectalis: no hemorrhoids or fistulas by inspection. Normal sphincter tone. Prostatic feels smooth at surface. No blood on the glove.
Extremities : Sleek and not sore. Right slimmer than the left due to bunion surgery in January. No ulcer or ordem. palpable am . dorsalis pedis.

Plan
76- year-old man hospitalized MHP. ERCP and Whipple up due to the tumor in the caput pancreaticus. Have lost an est. 4- 5kg since Pentecost. Traces icterus , and pts. describes gray dark stools and also mark golden urine, but also that this has improved in the last Lid . Ind.journal 04/June/2013 describes uregl terms hjerterytme. After consultation with PM we disagree on this point but:
rp . ECG
rp . ERCP samples
rp . Type and BAS
rp . Standard package in the EPM for ERCP
cont usual medication.
Medical student ————————, supervised by ————————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. C, HELDØGN
Institution: RIGSHOSPITALET

04-June-2013 Note

Pt. to be informed that we have values. His scan at LPK, we agree that it is a tumor of the pancreatic caput

extending into the processus uncinatus which causes cholestasis.
Provided information about the offer of whipple OP. Is informed about the risk of leakage from the three anastomoses, especially pancreatic anastomosis, informed risk of total pancreatectomi. Informed about the risk of endocrine and exocrine insufficiency.
Is also informed that if we find evidence of spread, that surgery will not carry out as the best treatment at such a stage will be chemotherapy.
Pt. biliary tract is not relieved, appears clinically difficult icterus and bilirubin date 1.6 is 245
Ordered time in this house to rp. ERCP on 6.6
Is informed about the procedure and the risk of pancreatitis in the grand ERCP procedure.
Is also informed that we have three weeks of waiting for the OP that therefore we cannot maintain the guaranteed two-week waiting period. Is offered ref. to ODE, which currently has two weeks of waiting, but wants to maintain OP at RB.
———————, Department Physician / jk

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. AMB.
Institution: RIGSHOSPITALET

04-June-2013 Note

2013

Allergies
None known. Possible allergy to plaster, but no problems with it at last hospitalization. No allergy to eggs, peanuts or soy.
Stud. med. ———————

Created by:
Name:
Title:
Department: SURG. GASTROENT. CLINIC. AMB
Institution: RIGSHOSPITALET

04-June-2013 Note

Preliminary study

Allergy
None known. Possible allergy to plaster, but no problems with it at last hospitalization. No allergy to eggs, peanuts or soy.

Cause:
Pt. has a tumor located in the caput pancreatic extending into the processus uncinatus compressing the biliary tract. No ingrowth of vessels and no evidence of metastasis. MHP is Whipple operation.

Previously:
Known with asthma that is well controlled.
2001 Frederiksberg hosp. Right hip replacement, osteoarthritis
2008 RH surgery for breast cancer treatment ended, no more controller.
2010 BBH Op. for complaining
2013 Frederiksberg hosp. foot OP Bunion.

Current:
Previously healthy. Whitish stools and dark urine since the end of May. Was thereby also icterus. Have itchy skin, but not particularly bothered by that. Feces were more normal in color at present, and urine have been a little brighter again. No loose stools or change in consistency. No pain, but treated with opiates prevention. No more weight loss, possibly 2-3 kg. No loathing of food or nausea. Feeling slightly bloated.

Other organ systems:
CNS: No headaches, dizziness or visual disturbances.
CP: No cough, sputum, shortness of breath or chest pain. Suffering from asthma, but no problems right now.
G-I: as specified under current. In addition, regular bowel movements without blood or mucus. No nausea or vomiting.
UG: Not clear when urinating, no blood in the urine, dark colored urine. No difficulty urinating or frequent micturitions.
BA: No pain or muscle weakness, no sensory disturbances or tendency to swollen legs.

Medicine:
Asmanex twist tails, 400 mcg 1 puff daily for asthma
Oxis Turbohaler 9 micrograms, 2 puffs daily for asthma.
Zolpidem 10 mg, 1 tabl daily for insomnia
doltard 10 mg, 2 times daily for pain
Toilax 5 mg, 1 tabl daily to prevent constipation
Paracetamol 500 mg, 2 times daily tabl 2
Ciprofloxacin 500 mg, 1 tabl 2 times daily empty 08:June:13
Omeprazole 20 mg, if necessary, against acidic occurred

Tobacco:
No, stopped in 1972. smoked 15 years, about 20 a day.

Alcohol:
Two items daily.

Social:

Retired, former engineer. Married. 2 adult children.

Screening for MESA Not performed

Objective:

General Condition: Good.
Nutritional status: Medium.
Skin: icterus
BT: 115/90 HR: 85 (irregular) SAT: 94
Weight: 98 kg Height: 188 cm
ASA score: ASA-score:

St.c.: Irregular action not equal to pp, no audible noise. St.p.: Vesicular breathing bilaterally, no murmurs. Normal lung borders.
Abdomen: Soft, no pain. No swelling perceived. No hepatosplenomegaly.
Natural bowel sounds. No hernias. Old cicatrices form bridge cup. Exoloratio rectalis: Not performed.
Extremities: Normal movement and sensibility. Normal capillary, can not feel foot pulses.
Sleep apnea: answered yes since 6-7 years, sleeping with the mask
Plan and ordination:
MHP is set for Whipple operation.
Pt. has an irregular heartbeat that box 'investigated further with ECG.
Main Diagnosis: DZ031F
Secondary diagnosis: DJ 459
Cancer Registry: AZCD19, AZCD39, AZCD49, AZCK2, AZCL9

Medical Student ———————

Created by:
Name:
Title:
Department: KIR. GASTROENT. CLINIC C. AMB.
Institution: RIGSHOSPITALET