Ramapo Radiology Associates, P.C.

RAMAPO DIAGNOSTIC IMAGING
11 NORTH AIRMONT ROAD
SUFFERN, NY 10901
Phone (845) 357-7245
Fax (845) 357-7907

Orange Radiology Associates, P.C.

NEWBURGH
320 ROBINSON AVENUE
NEWBURGH, NY 12550
Phone (845) 565-3664
Fax (845) 565-3617

MONROE
505 ROUTE 208
MONROE, NY 10950
Phone (845) 783-3444
Fax (845) 783-9561

PET/CT Imaging of Ramapo Radiology

PET/CT IMAGING OF RAMAPO RADIOLOGY
POMONA PROFESSIONAL PLAZA, 972 ROUTE 45
POMONA, NY 10970
Phone (845) 354-8909
Fax (845) 354-8910

August 15, 2019

Richard Anthony Pucci D.O.
2 Executive Blvd
Suite 404
Suffern, NY 10901
Tel# (845) 368-1500
Fax# 201/447-2809

RE: OLGA HERNANDEZ
DOB: 01/11/1956
PT TEL# 845/281-9765
ACCT#: 429056
STUDY DATE: 08/15/2019

Dear Richard Anthony Pucci D.O.:

UPPER GI SERIES WITH KUB

INDICATION.: Evaluate lap band placement.

COMPARISON.: No prior studies are available for comparison.

FINDINGS.:
The initial scout image demonstrates a lap band in expected position and orientation. The phi angle measures 35 degrees. The LAP-BAND catheter tubing appears intact.

There is a nonobstructed bowel gas pattern. Moderate stool is noted in the imaged colon.

Ingested oral barium demonstrates a normal esophageal contour. There is prompt passage of contrast across the lap band into the stomach.

IMPRESSION.: Normal appearance of the LAP-BAND without evidence of slipped for stenosis.

The total fluoroscopic time was under 1 minute. No additional fluoroscopic images were saved.

PS Electronically Signed: Sibin Thachet, MD 8/15/2019 10:13 AM

ST:PS
RAMAPO RAD/RAMAP DIAG IM
Electronically Signed - THACHET, SIBIN MD 08/15/19 10:14

RP

NAME Olga Hernandez **Age** 52 **Height** 5'3 **Weight**

Laparoscopic Lap-Band
Date of Surgery May 12 2008
Referring MD

COMORBIDITIES: (DM) (HTN) SAS CAD DVA LIPIDS GERD (OSTEO) ASTHM DEPRESSION

DATE	BP	WEIGHT	BMI	WT Loss (last visit)	WT Loss (since surg)	% EWL	Wast/Hip (cm)	WHR	Lap Band Adjustment (cc added/removed)
2-7-08	150/97	207.2	36.6	PREOP	PREOP				
5-8-08	140/85	202	35.7	-5.2					#38032
5-22-08	121/75	197.2	34.8	-4.8	-10				
7-17-08	118/81	179	31.8	-23					
7/31/08	114/71	177.4	31.3	-1.6	-24.6				
8/28/08	132/80	175.8	31.1	-1.6	-26.2				
9/11/08	110/71	168.6	29.9	-7.2	-33.4			⊕	1cc
10-9-08	103/69	168.6	29.9	—	/			⊕	1cc
12-11-08	136/91	171.8	30.4	+3.2	-30.2			⊕	1cc
1-22-09	122/73	178.4	31.5	+6.6	-23.6			⊕	3cc
5-26-09	124/84	193.6	34.3						
7-7-09	151/97	192.8	34.1	-.8					⊕ 3cc (4 total)
8-18-09	131/82	190.4	33.8	+3.6					D-5
3-16-10	133/86	207	36.7	+10.6					2.0
4-29-10	152/90	190.2	34.8	-10.8					
6/1/10	129/80	197.6	35	+1.4					1.0
2-5-11	139/84	199.8	35.2						.5

GOOD SAMARITAN HOSPITAL
OPERATIVE REPORT

Name: HERNANDEZ,OLGA
MR#: 124-347
Account #: 10942886
Location:
Room:
Date of Adm: 07/05/2008

Physician: Richard Anthony Pucci, DO

Date of Surgery: 07/07/2008

PREOPERATIVE DIAGNOSIS: PARTIAL SMALL-BOWEL OBSTRUCTION.

POSTOPERATIVE DIAGNOSIS: PARTIAL SMALL-BOWEL OBSTRUCTION.

PROCEDURE: Diagnostic laparoscopy, exploratory laparotomy, extensive lysis of adhesions, repair of small intestinal enterotomy, repair of large intestine/rectal enterotomy.

SURGEON: Dr. Richard Pucci

ASSISTANT: Dr. Edward Pucci and Dr. Anthony Pucci

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Less than 300 mL.

URINE OUTPUT: 350 mL.

FLUIDS: 4 liters.

INDICATIONS FOR PROCEDURE: Olga Hernandez is a 52-year-old female who has an extensive surgical past medical history including sigmoid colectomy for diverticulitis as well as a hysterectomy and a previous laparoscopic adjustable gastric band approximately 7 weeks ago who has had chronic abdominal pain over the last 4-5 years, increasing after her numerous surgeries, including her hysterectomy as well as a colon resection. The patient indicates that she had previous colicky abdominal pain that spontaneously resolved. However, was admitted approximately 48 hours prior with partial small-bowel obstruction. Upon conservative management including IV hydration as well as NG tube decompression, her small bowel obstruction persisted with an elevated white count and increasing abdominal tenderness which prompted us to take her to the operating room for diagnostic laparoscopy and

GOOD SAMARITAN HOSPITAL
OPERATIVE REPORT

Name: HERNANDEZ,OLGA
MR#: 124-347
Account #: 10942886

exploratory laparotomy.

OPERATIVE REPORT: The patient was identified as Olga Hernandez and brought back to the operating room, placed on the operating table in the supine position. General endotracheal anesthesia was induced. The patient's abdomen was then prepped and draped in the usual sterile fashion. An 11-blade scalpel was used to make an incision in the infraumbilical region. The Hasson port was then placed in this infraumbilical incision site after entrance into the abdomen. The 10-mm, 45-degrees scope was then used to inspect the intra-abdominal compartment and upon placement of the scope intra-abdominally there appeared to be large amounts of adhesions with extremely dilated small intestine. Once it was clear that the operation could not continue laparoscopically and our diagnosis of a high-grade small bowel obstruction was correct, we then converted to an open procedure. A 10-blade scalpel was then used to make an incision from approximately 3 cm below the xiphoid process all the way to the suprapubic region. Incision was then carried down through the epidermis into the dermis and subcutaneous tissue was dissected and the fascia was then entered. The intra-abdominal compartment was entered after entering posterior to the fascia. The Bookwalter retractor was then used for retraction. Four right-angle retractors were then placed without difficulty. Upon entering the intra-abdominal compartment there appeared to be large amounts of mid- to distal small bowel loops with dense adhesions. These loops were matted together with these dense adhesions and the first group of adhesions which were lysed included the distal jejunum. Sharp dissection was then used with the Metzenbaum scissors to dissect and lyse these extensive adhesions in the mid- to distal jejunum. There also appeared to distal jejunum loops that were matted to her area of rectum/sigmoid remnant from her previous sigmoid colectomy. These loops of bowel were completely freed with sharp dissection from the area of sigmoid colon. Upon lysing the small intestinal contents there appeared to be a small enterotomy in the sigmoid colon remnant that was repaired in two layers consisting of the first layer 2-0 Vicryl and the second layer 3-0 silk. This enterotomy was repaired without difficulty. There also appeared to be a small enterotomy in the small intestine after lysing these adhesions that was repaired in two layers as above. Next the terminal ileum was inspected and the bowel was then run from the terminal ileum in a retrograde manner to the ligament of Treitz. There were numerous areas in the distal small intestine that were freed without difficulty. This was done using sharp dissection with the Metzenbaum scissors. There was also an area

GOOD SAMARITAN HOSPITAL
OPERATIVE REPORT

Name: HERNANDEZ,OLGA
MR#: 124-347
Account #: 10757003
Location:
Room:
Date of Adm: 05/12/2008

Physician: Richard Anthony Pucci, DO

Date of Surgery: 05/12/2008

PREOPERATIVE DIAGNOSIS:
1. Morbid obesity.
2. Hypertension.
3. Diabetes.
4. Back pain.
5. Arthritis.

POSTOPERATIVE DIAGNOSIS:
1. Morbid obesity.
2. Hypertension.
3. Diabetes.
4. Back pain.
5. Arthritis.

PROCEDURE: Laparoscopic adjustable gastric band with AP standard band.

SURGEON: Dr. R Pucci

ASSISTANT: Dr. E Pucci

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

DESCRIPTION OF PROCEDURE: The patient was identified as Olga Hernandez and brought back to the operating room, placed on the operating room table in the supine position. General endotracheal anesthesia was induced. The patient's abdomen was then prepped and draped in the usual sterile fashion. An 11-blade scalpel was used to make an incision in the left subcostal region. A Veress needle was

GOOD SAMARITAN HOSPITAL
OPERATIVE REPORT

Name: HERNANDEZ, OLGA
MR#: 124-347
Account #: 10757003

inserted. Pneumoperitoneum was then created. Once adequate pneumoperitoneum was created, a 5 mm laparoscopic port was placed in the periumbilical region. Next under direct visualization, a left lateral laparoscopic port was placed, a 15 mm left upper quadrant port, a 5 mm left lateral as well as a 5 mm subxiphoid and a right upper quadrant port. Once all ports were in place, surgery was commenced by identifying the angle of His. The Prestige grasper was used to dissect at the angle of His. Next, the lesser curvature of the stomach was identified and a retrogastric pathway from the lesser curve to the angle of His was then created with the Prestige grasper. The AP standard band was then prepared and introduced into the intra-abdominal compartment through the 15 mm left upper quadrant port. The tail of the band was then grasped at the angle of His and then threaded in the retrogastric pathway encircling the stomach and thereby creating a proximal gastric pouch. The band was then clasped into place without difficulty. Three tacking sutures imbricated the fundus of the stomach on top of the proximal gastric pouch without difficulty. After this was done, the band was then grasped. The band was then brought out through the 15 mm port. The band port was brought into the field, attached to the band tubing and the port was then anchored to the underlying fascia with 4 tacking sutures without difficulty. The tubing was then reintroduced into the intra-abdominal compartment without difficulty. Next once it was clear that the operation was complete and there was no evidence any bleeding, the Nathanson retractor was removed. The ports were removed from each individual port site. The skin edges were then reapproximated with 4-0 Monocryl suture in a subcuticular stitch pattern. Bandages as well as Dermabond were applied over each individual incision site.

_____

RICHARD ANTHONY PUCCI, DO

DICTATED BY: Richard Anthony Pucci, DO

MedQ 7416248/47709
DD:05/12/2008 11:18:08
DT:05/12/2008 17:03:46

Dictated By=PUCCI,RICHARD ANTHONY (DO) D/T=05/12/2008 1118
Text Status=**FINAL**
To Be Elec Signed=( ) D/T=( )
PUCCI,RICHARD ANTHONY (DO)
Transcribed By=THOMAS,MOLLY D/T=05/12/2008 1703

GOOD SAMARITAN HOSPITAL
HISTORY & PHYSICAL REPORT

Name: HERNANDEZ,OLGA
MR#: 124-347
Account #: NO VISIT
Location:
Room:
Date of Adm:

cc: Deborah Shapiro, MD
Fax: 8453535668

Physician: Benjamin Gee Chang, MD

CHIEF COMPLAINT: Preop clearance for lap band surgery.

HISTORY OF PRESENT ILLNESS: The patient is a 52-year-old female with a history of type 2 diabetes and hypertension and elevated cholesterol who was referred for possible laparoscopic band surgery for weight loss. The patient is status post a sleep study on 03/01/2008 which revealed mild obstructive sleep apnea with an overall index of 6.9 events per hour and a low O2 saturation of 88%. The events were primarily present in the supine position. The patient reports no significant shortness of breath or dyspnea on exertion. The patient is able climb 2 flights of stairs without significant difficulty.

PAST MEDICAL HISTORY: Hypertension, type 2 diabetes, elevated cholesterol, mild obstructive sleep apnea.

MEDICATIONS: Avapro 150 mg daily, Norvasc 5 mg daily, Glucophage 1000 mg b.i.d., glyburide 5 mg daily, Zocor 10 mg daily.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: She is a former smoker, quit 30 years ago. She is an LPN.

PHYSICAL EXAMINATION: Weight 205 pounds, blood pressure 145/80, respiratory rate 12, pulse 118, O2 saturation 96% on room air. GENERAL: She is an overweight woman in no acute distress. HEENT: Pupils equal, round, react to light. Anicteric sclerae. Mucous membranes are moist. She has braces. She has a Mallampati class III airway. LUNGS: Clear to auscultation bilaterally without wheezes or rhonchi. CARDIAC: Regular rate and rhythm. No murmurs, rubs or gallops. ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds. EXTREMITIES: No clubbing, cyanosis or edema. NEUROLOGICALLY:

GOOD SAMARITAN HOSPITAL
HISTORY & PHYSICAL REPORT

Name: HERNANDEZ,OLGA
MR#: 124-347
Account #: NO VISIT

Alert and oriented x3.

ASSESSMENT/PLAN: MS. OLGA HERNANDEZ IS A 52-YEAR-OLD FEMALE WITH A HISTORY OF TYPE 2 DIABETES, HYPERTENSION, ELEVATED CHOLESTEROL, MILD OBSTRUCTIVE SLEEP APNEA PURSUING LAP BAND SURGERY. FROM A SLEEP PERSPECTIVE SHE IS AN ACCEPTABLE RISK FOR GENERAL ANESTHESIA. SHE SHOULD POSE NO DIFFICULTIES FROM AN AIRWAY PERSPECTIVE. IF DESATURATIONS AND OBSTRUCTIVE EVENTS ARE NOTED IN THE POSTOPERATIVE STATE WOULD RECOMMEND EMPIRIC USE OF CPAP AT 10 CM H2O OF PRESSURE. FROM A PULMONARY PERSPECTIVE SHE IS ALSO AN ACCEPTABLE RISK FOR GENERAL ANESTHESIA. I WOULD RECOMMEND EARLY OUT OF BED AND INCENTIVE SPIROMETRY AS NEEDED.

Thank you for the courtesy of this consultation and allowing us to participate in this patient's care. If you have any questions please feel free to give me a call.

BENJAMIN GEE CHANG, MD

DICTATED BY: Benjamin Gee Chang, MD

MedQ 7416261/485915
DD:04/23/2008 12:22:57
DT:04/23/2008 13:04:10

Dictated By=CHANG,BENJAMIN GEE (MD)	D/T=04/23/2008 1222
Text Status=FINAL	
Elec Signed By= (Electronic Signature) CHANG,BENJAMIN GEE (MD)	D/T=04/25/2008 0855
Transcribed By=THOMAS,MOLLY	D/T=04/23/2008 1304