In [41]:
```
import pandas as pd

pd.set_option('display.max_colwidth', None)
df = pd.read_csv('mtsamples.csv')

def clean_text(text):
    if not isinstance(text, str):
        return ""

    # Lowercase for consistency
    text = text.lower()

    # Remove non-sentential artifacts
    text = re.sub(r'\[.*?\]', '', text)  # Remove things in brackets [like t
    text = re.sub(r'\(.*?\)', '', text)  # Remove things in parentheses
    text = re.sub(r'[^a-z0-9.,;:!?\'\"\\s-]', '', text)  # Remove weird char

    # Replace multiple punctuation or dashes
    text = re.sub(r'[-]{2,}', '-', text)
    text = re.sub(r'[.]{2,}', '.', text)

    # Normalize whitespace
    text = re.sub(r'\s+', ' ', text).strip()

    # Optional: Capitalize first letter of each sentence (basic)
    sentences = re.split(r'(?<=[.!?]) +', text)
    text = ' '.join(s.capitalize() for s in sentences)

    return text
```

In [37]:
```
df['transcription'] = df['transcription'].apply(clean_text)
```

In [35]:
```

```

Out[35]:

0	
1	
2	Historyofpresentillness:,ihaveseenabctoday.heisaverypleasantgentlemanwhois42yearsold,344
3	
4	

In [18]:
```
import re
import pandas as pd

def clean_text(text):
    if not isinstance(text, str):
        return ""
```

```
    # Lowercase for consistency
    text = text.lower()

    # Remove non-sentential artifacts
    text = re.sub(r'\[.*?\]', '', text)  # Remove things in brackets [like t
    text = re.sub(r'\(.*?\)', '', text)  # Remove things in parentheses
    text = re.sub(r'[^a-z0-9.,;:!?\'\"\\s-]', '', text)  # Remove weird char

    # Replace multiple punctuation or dashes
    text = re.sub(r'[-]{2,}', '-', text)
    text = re.sub(r'[.]{2,}', '.', text)

    # Normalize whitespace
    text = re.sub(r'\s+', ' ', text).strip()

    # Optional: Capitalize first letter of each sentence (basic)
    sentences = re.split(r'(?<=[.!?]) +', text)
    text = ' '.join(s.capitalize() for s in sentences)

    return text
```

In [19]:
```
df['transcription_clean'] = df['transcription'].apply(clean_text)
```

In [21]:
```
df[['description', 'transcription']].head()
```

Out[21]:

	description	transcription
0	a 23-year-old white female presents with complaint of allergies.	subjective:, this 23-year-old white female presents with complaint of allergies. she used to have allergies when she lived in seattle but she thinks they are worse here. in the past, she has tried claritin, and zyrtec. both worked for short time but then seemed to lose effectiveness. she has used allegra also. she used that last summer and she began using it again two weeks ago. it does not appear to be working very well. she has used over-the-counter sprays but no prescription nasal sprays. she does have asthma but doest not require daily medication for this and does not think it is flaring up.,medications: , her only medication currently is ortho tri-cyclen and the allegra.,allergies: , she has no known medicine allergies.,objective:,vitals: weight was 130 pounds and blood pressure 124/78.,heent: her throat was mildly erythematous without exudate. nasal mucosa was erythematous and swollen. only clear drainage was seen. tms were clear.,neck: supple without adenopathy.,lungs: clear.,assessment:, allergic rhinitis.,plan:,1. she will try zyrtec instead of allegra again. another option will be to use loratadine. she does not think she has prescription coverage so that might be cheaper.,2. samples of nasonex two sprays in each nostril given for three weeks. a prescription was written as well.
1	consult for laparoscopic gastric bypass.	past medical history:, he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, and lifting objects off the floor. he exercises three times a week at home and does cardio. he has difficulty walking two blocks or five flights of stairs. difficulty with snoring. he has muscle and joint pains including knee pain, back pain, foot and ankle pain, and swelling. he has gastroesophageal reflux disease.,past surgical history:, includes reconstructive surgery on his right hand 13 years ago. ,social history:, he is currently single. he has about ten drinks a year. he had smoked significantly up until several months ago. he now smokes less than three cigarettes a day.,family history:, heart disease in both grandfathers, grandmother with stroke, and a grandmother with diabetes. denies obesity and hypertension in other family members.,current medications:, none.,allergies:, he is allergic to penicillin.,miscellaneous/eating history:, he has been going to support groups for seven months with lynn holmberg in greenwich and he is from eastchester, new york and he feels that we are the appropriate program. he had a poor experience with the greenwich program. eating history, he is not an emotional eater. does not like sweets. he likes big portions and carbohydrates. he likes chicken and not steak. he currently weighs 312 pounds. ideal body weight would be 170 pounds. he is 142 pounds overweight. if ,he lost 60% of his excess body weight that would be 84 pounds and he should weigh about 228.,review of systems: ,negative for head, neck, heart, lungs, gi, gu, orthopedic, and skin. specifically denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, high cholesterol, pulmonary embolism, high blood pressure, cva, venous insufficiency, thrombophlebitis, asthma, shortness of breath, copd, emphysema, sleep apnea, diabetes, leg and foot swelling, osteoarthritis, rheumatoid arthritis, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, hemorrhoids, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,physical examination:, he is alert and oriented x 3. cranial nerves ii-xii are intact. afebrile. vital signs are stable.

	description	transcription
2	consult for laparoscopic gastric bypass.	history of present illness: , i have seen abc today. he is a very pleasant gentleman who is 42 years old, 344 pounds. he is 5'9". he has a bmi of 51. he has been overweight for ten years since the age of 33, at his highest he was 358 pounds, at his lowest 260. he is pursuing surgical attempts of weight loss to feel good, get healthy, and begin to exercise again. he wants to be able to exercise and play volleyball. physically, he is sluggish. he gets tired quickly. he does not go out often. when he loses weight he always regains it and he gains back more than he lost. his biggest weight loss is 25 pounds and it was three months before he gained it back. he did six months of not drinking alcohol and not taking in many calories. he has been on multiple commercial weight loss programs including slim fast for one month one year ago and atkin's diet for one month two years ago.,past medical history: , he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, difficulty walking, high cholesterol, and high blood pressure. he has asthma and difficulty walking two blocks or going eight to ten steps. he has sleep apnea and snoring. he is a diabetic, on medication. he has joint pain, knee pain, back pain, foot and ankle pain, leg and foot swelling. he has hemorrhoids.,past surgical history: , includes orthopedic or knee surgery.,social history: , he is currently single. he drinks alcohol ten to twelve drinks a week, but does not drink five days a week and then will binge drink. he smokes one and a half pack a day for 15 years, but he has recently stopped smoking for the past two weeks.,family history: , obesity, heart disease, and diabetes. family history is negative for hypertension and stroke.,current medications:, include diovan, crestor, and tricor.,miscellaneous/eating history: ,he says a couple of friends of his have had heart attacks and have had died. he used to drink everyday, but stopped two years ago. he now only drinks on weekends. he is on his second week of chantix, which is a medication to come off smoking completely. eating, he eats bad food. he is single. he eats things like bacon, eggs, and cheese, cheeseburgers, fast food, eats four times a day, seven in the morning, at noon, 9 p.m., and 2 a.m. he currently weighs 344 pounds and 5'9". his ideal body weight is 160 pounds. he is 184 pounds overweight. if he lost 70% of his excess body weight that would be 129 pounds and that would get him down to 215.,review of systems: , negative for head, neck, heart, lungs, gi, gu, orthopedic, or skin. he also is positive for gout. he denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, pulmonary embolism, or cva. he denies venous insufficiency or thrombophlebitis. denies shortness of breath, copd, or emphysema. denies thyroid problems, hip pain, osteoarthritis, rheumatoid arthritis, gerd, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. he denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,physical examination: ,he is alert and oriented x 3. cranial nerves ii-xii are intact. neck is soft and supple. lungs: he has positive wheezing bilaterally. heart is regular rhythm and rate. his abdomen is soft. extremities: he has 1+ pitting edema.,impression/plan:, i have explained to him the risks and potential complications of laparoscopic gastric bypass in detail and these include bleeding, infection, deep venous thrombosis, pulmonary embolism, leakage from the gastrojejuno-anastomosis, jejunojejuno-anastomosis, and possible bowel obstruction among other potential complications. he understands. he wants to proceed with workup and evaluation for laparoscopic roux-en-y gastric bypass. he will need to

	description	transcription
		get a letter of approval from dr. xyz. he will need to see a nutritionist and mental health worker. he will need an upper endoscopy by either dr. xyz. he will need to go to dr. xyz as he previously had a sleep study. we will need another sleep study. he will need h. pylori testing, thyroid function tests, lfts, glycosylated hemoglobin, and fasting blood sugar. after this is performed, we will submit him for insurance approval.
3	2-d m-mode. doppler.	2-d m-mode: , ,1. left atrial enlargement with left atrial diameter of 4.7 cm.,2. normal size right and left ventricle.,3. normal lv systolic function with left ventricular ejection fraction of 51%.,4. normal lv diastolic function.,5. no pericardial effusion.,6. normal morphology of aortic valve, mitral valve, tricuspid valve, and pulmonary valve.,7. pa systolic pressure is 36 mmhg.,doppler: , ,1. mild mitral and tricuspid regurgitation.,2. trace aortic and pulmonary regurgitation.
4	2-d echocardiogram	1. the left ventricular cavity size and wall thickness appear normal. the wall motion and left ventricular systolic function appears hyperdynamic with estimated ejection fraction of 70% to 75%. there is near-cavity obliteration seen. there also appears to be increased left ventricular outflow tract gradient at the mid cavity level consistent with hyperdynamic left ventricular systolic function. there is abnormal left ventricular relaxation pattern seen as well as elevated left atrial pressures seen by doppler examination.,2. the left atrium appears mildly dilated.,3. the right atrium and right ventricle appear normal.,4. the aortic root appears normal.,5. the aortic valve appears calcified with mild aortic valve stenosis, calculated aortic valve area is 1.3 cm square with a maximum instantaneous gradient of 34 and a mean gradient of 19 mm.,6. there is mitral annular calcification extending to leaflets and supportive structures with thickening of mitral valve leaflets with mild mitral regurgitation.,7. the tricuspid valve appears normal with trace tricuspid regurgitation with moderate pulmonary artery hypertension. estimated pulmonary artery systolic pressure is 49 mmhg. estimated right atrial pressure of 10 mmhg.,8. the pulmonary valve appears normal with trace pulmonary insufficiency.,9. there is no pericardial effusion or intracardiac mass seen.,10. there is a color doppler suggestive of a patent foramen ovale with lipomatous hypertrophy of the interatrial septum.,11. the study was somewhat technically limited and hence subtle abnormalities could be missed from the study.,

In [30]:
```
df['medical_specialty'] = df['medical_specialty'].astype(str).str.strip().st
```

In [31]:
```
df['medical_specialty'].head()
```

Out[31]:
```
0          allergyimmunology
1                 bariatrics
2                 bariatrics
3    cardiovascularpulmonary
4    cardiovascularpulmonary
Name: medical_specialty, dtype: object
```

In [42]:
```
df['keywords'].head()
```

Out[42]:
```
0
allergy / immunology, allergic rhinitis, allergies, asthma, nasal sprays, r
hinitis, nasal, erythematous, allegra, sprays, allergic,
1
bariatrics, laparoscopic gastric bypass, weight loss programs, gastric bypa
ss, atkin's diet, weight watcher's, body weight, laparoscopic gastric, weig
ht loss, pounds, months, weight, laparoscopic, band, loss, diets, overweigh
t, lost
2
bariatrics, laparoscopic gastric bypass, heart attacks, body weight, pulmon
ary embolism, potential complications, sleep study, weight loss, gastric by
pass, anastomosis, loss, sleep, laparoscopic, gastric, bypass, heart, pound
s, weight,
3
cardiovascular / pulmonary, 2-d m-mode, doppler, aortic valve, atrial enlar
gement, diastolic function, ejection fraction, mitral, mitral valve, perica
rdial effusion, pulmonary valve, regurgitation, systolic function, tricuspi
d, tricuspid valve, normal lv
4    cardiovascular / pulmonary, 2-d, doppler, echocardiogram, annular, aor
tic root, aortic valve, atrial, atrium, calcification, cavity, ejection fra
ction, mitral, obliteration, outflow, regurgitation, relaxation pattern, st
enosis, systolic function, tricuspid, valve, ventricular, ventricular cavit
y, wall motion, pulmonary artery
Name: keywords, dtype: object
```

In [43]:
```
import re

def clean_keywords(text):
    if pd.isnull(text):
        return ""
    text = str(text).lower()
    text = re.sub(r'\s+', ' ', text)                # collapse extra spaces
    text = re.sub(r'[^a-z0-9,\s]', '', text)        # remove all except a-z
    text = re.sub(r',\s*', ', ', text)              # consistent comma+spac
    return text.strip()

df['keywords_clean'] = df['keywords'].apply(clean_keywords)
```

In [46]:
```
df['keywords_clean'].head()
```

Out[46]:
```
0
allergy  immunology, allergic rhinitis, allergies, asthma, nasal sprays, rh
initis, nasal, erythematous, allegra, sprays, allergic,
1
bariatrics, laparoscopic gastric bypass, weight loss programs, gastric bypa
ss, atkins diet, weight watchers, body weight, laparoscopic gastric, weight
loss, pounds, months, weight, laparoscopic, band, loss, diets, overweight,
lost
2
bariatrics, laparoscopic gastric bypass, heart attacks, body weight, pulmon
ary embolism, potential complications, sleep study, weight loss, gastric by
pass, anastomosis, loss, sleep, laparoscopic, gastric, bypass, heart, pound
s, weight,
3
cardiovascular  pulmonary, 2d mmode, doppler, aortic valve, atrial enlargem
ent, diastolic function, ejection fraction, mitral, mitral valve, pericardi
al effusion, pulmonary valve, regurgitation, systolic function, tricuspid,
tricuspid valve, normal lv
4    cardiovascular  pulmonary, 2d, doppler, echocardiogram, annular, aorti
c root, aortic valve, atrial, atrium, calcification, cavity, ejection fract
ion, mitral, obliteration, outflow, regurgitation, relaxation pattern, sten
osis, systolic function, tricuspid, valve, ventricular, ventricular cavity,
wall motion, pulmonary artery
Name: keywords_clean, dtype: object
```

In [45]:
```
import re

def clean_description(text):
    if pd.isnull(text):
        return ""
    text = str(text).lower()
    text = re.sub(r'(\d+)([a-zA-Z])', r'\1 \2', text)  # add space between r
    text = re.sub(r'[^a-z0-9\s.,!?-]', '', text)       # keep essential punc
    text = re.sub(r'\s+', ' ', text)                   # normalize whitespac
    return text.strip()

df['description_clean'] = df['description'].apply(clean_description)
```

In [48]:
```
df['description_clean'].head(20)
```

Out[48]:
```
0
a 23-year-old white female presents with complaint of allergies.
1
consult for laparoscopic gastric bypass.
2
consult for laparoscopic gastric bypass.
3
2-d m-mode. doppler.
4
2-d echocardiogram
5     morbid obesity. laparoscopic antecolic antegastric roux-en-y gastric
bypass with eea anastomosis. this is a 30-year-old female, who has been ove
rweight for many years. she has tried many different diets, but is unsucces
sful.
6
liposuction of the supraumbilical abdomen, revision of right breast reconst
ruction, excision of soft tissue fullness of the lateral abdomen and flank.
7
2-d echocardiogram
8
suction-assisted lipectomy - lipodystrophy of the abdomen and thighs.
9
echocardiogram and doppler
10
morbid obesity. laparoscopic roux-en-y gastric bypass, antecolic, antegastr
ic with 25-mm eea anastamosis, esophagogastroduodenoscopy.
11
normal left ventricle, moderate biatrial enlargement, and mild tricuspid re
gurgitation, but only mild increase in right heart pressures.
12
cerebral angiogram - moyamoya disease.
13
patient presented to the bariatric surgery service for consideration of lap
aroscopic roux en y gastric bypass surgery.
14
surgical removal of completely bony impacted teeth 1, 16, 17, and 32. compl
etely bony impacted teeth 1, 16, 17, and 32.
15
preoperative visit for weight management with laparoscopic gastric banding
16          neck exploration tracheostomy urgent flexible bronchoscopy via
tracheostomy site removal of foreign body, tracheal metallic stent material
dilation distal trachea placement of 8 shiley single cannula tracheostomy t
ube.
17
patient status post lap band placement.
18
fertile male with completed family. elective male sterilization via bilater
al vasectomy.
19                                                 the patient is a 17-year-
old female, who presents to the emergency room with foreign body and airway
compromise and was taken to the operating room. she was intubated and fishb
one.
Name: description_clean, dtype: object
```

In [49]:
```
df[['description', 'description_clean']].head(10)
```

Out[49]:

	description	description_clean
0	A 23-year-old white female presents with complaint of allergies.	a 23-year-old white female presents with complaint of allergies.
1	Consult for laparoscopic gastric bypass.	consult for laparoscopic gastric bypass.
2	Consult for laparoscopic gastric bypass.	consult for laparoscopic gastric bypass.
3	2-D M-Mode. Doppler.	2-d m-mode. doppler.
4	2-D Echocardiogram	2-d echocardiogram
5	Morbid obesity. Laparoscopic antecolic antegastric Roux-en-Y gastric bypass with EEA anastomosis. This is a 30-year-old female, who has been overweight for many years. She has tried many different diets, but is unsuccessful.	morbid obesity. laparoscopic antecolic antegastric roux-en-y gastric bypass with eea anastomosis. this is a 30-year-old female, who has been overweight for many years. she has tried many different diets, but is unsuccessful.
6	Liposuction of the supraumbilical abdomen, revision of right breast reconstruction, excision of soft tissue fullness of the lateral abdomen and flank.\r\n	liposuction of the supraumbilical abdomen, revision of right breast reconstruction, excision of soft tissue fullness of the lateral abdomen and flank.
7	2-D Echocardiogram	2-d echocardiogram
8	Suction-assisted lipectomy - lipodystrophy of the abdomen and thighs.	suction-assisted lipectomy - lipodystrophy of the abdomen and thighs.
9	Echocardiogram and Doppler	echocardiogram and doppler

In [51]:
```
def clean_sample_name(text):
    if pd.isnull(text):
        return ""
    text = str(text).lower()
    text = re.sub(r'[^a-z0-9\s-]', '', text)  # keep only a-z, numbers, spac
    text = re.sub(r'\s+', ' ', text)          # normalize whitespace
    return text.strip()

df['sample_name_clean'] = df['sample_name'].apply(clean_sample_name)
```

In [52]:
```
df[['sample_name', 'sample_name_clean']].head(10)
```

Out[52]:

	sample_name	sample_name_clean
0	Allergic Rhinitis	allergic rhinitis
1	Laparoscopic Gastric Bypass Consult - 2	laparoscopic gastric bypass consult - 2
2	Laparoscopic Gastric Bypass Consult - 1	laparoscopic gastric bypass consult - 1
3	2-D Echocardiogram - 1	2-d echocardiogram - 1
4	2-D Echocardiogram - 2	2-d echocardiogram - 2
5	Laparoscopic Gastric Bypass	laparoscopic gastric bypass
6	Liposuction	liposuction
7	2-D Echocardiogram - 3	2-d echocardiogram - 3
8	Lipectomy - Abdomen/Thighs	lipectomy - abdomenthighs
9	2-D Echocardiogram - 4	2-d echocardiogram - 4

In [53]:
```
def clean_medical_specialty(text):
    if pd.isnull(text):
        return ""
    text = str(text).lower()
    text = text.replace('/', '_').replace('&', 'and')
    text = re.sub(r'\s+', '_', text)          # replace spaces with underscor
    text = re.sub(r'[^a-z0-9_]', '', text)    # remove remaining punctuation
    return text.strip('_')

df['medical_specialty_clean'] = df['medical_specialty'].apply(clean_medical_
```

In [54]:
```
df[['medical_specialty', 'medical_specialty_clean']].head(10)
```

Out[54]:

	medical_specialty	medical_specialty_clean
0	Allergy / Immunology	allergy___immunology
1	Bariatrics	bariatrics
2	Bariatrics	bariatrics
3	Cardiovascular / Pulmonary	cardiovascular___pulmonary
4	Cardiovascular / Pulmonary	cardiovascular___pulmonary
5	Bariatrics	bariatrics
6	Bariatrics	bariatrics
7	Cardiovascular / Pulmonary	cardiovascular___pulmonary
8	Bariatrics	bariatrics
9	Cardiovascular / Pulmonary	cardiovascular___pulmonary

In [60]:
```
import re
```

```
def clean_transcription(text):
    if pd.isnull(text):
        return ""
    text = str(text).lower()

    # Fix period-comma
    text = re.sub(r'\.,', '.', text)

    # Add space between number and letter
    text = re.sub(r'(\d+)([a-zA-Z])', r'\1 \2', text)

    # Fix spacing after list numbers only at beginning of line or after whit
    text = re.sub(r'(\d+)\.(?=[a-zA-Z])', r'\1. ', text)

    # Replace section headers followed by comma with colon and newline
    text = re.sub(r'\b(description|doppler|impression|procedure|findings|dia

    # Optional: Put each list item on a new line
    text = re.sub(r'(\d+\.\s)', r'\n\1', text)

    # Remove unwanted characters but keep essential punctuation
    text = re.sub(r'[^a-z0-9\s.,!?/-]', '', text)

    # Normalize whitespace
    text = re.sub(r'\s+', ' ', text)

    return text.strip()

df['transcription_clean'] = df['transcription'].apply(clean_transcription)
```

In [61]:
```
df[['transcription', 'transcription_clean']].head(10)
```

Out[61]:

	transcription	transcription_clean
0	SUBJECTIVE:, This 23-year-old white female presents with complaint of allergies. She used to have allergies when she lived in Seattle but she thinks they are worse here. In the past, she has tried Claritin, and Zyrtec. Both worked for short time but then seemed to lose effectiveness. She has used Allegra also. She used that last summer and she began using it again two weeks ago. It does not appear to be working very well. She has used over-the-counter sprays but no prescription nasal sprays. She does have asthma but doest not require daily medication for this and does not think it is flaring up.,MEDICATIONS: , Her only medication currently is Ortho Tri-Cyclen and the Allegra.,ALLERGIES: , She has no known medicine allergies.,OBJECTIVE:,Vitals: Weight was 130 pounds and blood pressure 124/78.,HEENT: Her throat was mildly erythematous without exudate. Nasal mucosa was erythematous and swollen. Only clear drainage was seen. TMs were clear.,Neck: Supple without adenopathy.,Lungs: Clear.,ASSESSMENT:, Allergic rhinitis.,PLAN:,1. She will try Zyrtec instead of Allegra again. Another option will be to use loratadine. She does not think she has prescription coverage so that might be cheaper.,2. Samples of Nasonex two sprays in each nostril given for three weeks. A prescription was written as well.	subjective, this 23-year-old white female presents with complaint of allergies. she used to have allergies when she lived in seattle but she thinks they are worse here. in the past, she has tried claritin, and zyrtec. both worked for short time but then seemed to lose effectiveness. she has used allegra also. she used that last summer and she began using it again two weeks ago. it does not appear to be working very well. she has used over-the-counter sprays but no prescription nasal sprays. she does have asthma but doest not require daily medication for this and does not think it is flaring up.medications , her only medication currently is ortho tri-cyclen and the allegra.allergies , she has no known medicine allergies.objective,vitals weight was 130 pounds and blood pressure 124/ 78. heent her throat was mildly erythematous without exudate. nasal mucosa was erythematous and swollen. only clear drainage was seen. tms were clear.neck supple without adenopathy.lungs clear.assessment, allergic rhinitis.plan, 1. she will try zyrtec instead of allegra again. another option will be to use loratadine. she does not think she has prescription coverage so that might be cheaper. 2. samples of nasonex two sprays in each nostril given for three weeks. a prescription was written as well.
1	PAST MEDICAL HISTORY:, He has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, and lifting objects off the floor. He exercises three times a week at home and does cardio. He has difficulty walking two blocks or five flights of stairs. Difficulty with snoring. He has muscle and joint pains including knee pain, back pain, foot and ankle pain, and swelling. He has gastroesophageal reflux disease.,PAST SURGICAL HISTORY:, Includes reconstructive surgery on his right hand 13 years ago. ,SOCIAL HISTORY:, He is currently single. He has about ten drinks a year. He had smoked significantly up until several months ago. He now smokes less than three cigarettes a day.,FAMILY HISTORY:, Heart disease in both grandfathers, grandmother with stroke, and a grandmother with diabetes. Denies obesity and hypertension in other family members.,CURRENT MEDICATIONS:,	past medical history, he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, and lifting objects off the floor. he exercises three times a week at home and does cardio. he has difficulty walking two blocks or five flights of stairs. difficulty with snoring. he has muscle and joint pains including knee pain, back pain, foot and ankle pain, and swelling. he has gastroesophageal reflux disease.past surgical history, includes reconstructive surgery on his right hand 13 years ago. ,social history, he is currently single. he has about ten drinks a year. he had smoked significantly up until several months ago. he now smokes less than three cigarettes a day.family history, heart disease in both grandfathers, grandmother with stroke, and a grandmother with diabetes.

	transcription	transcription_clean
	None.,ALLERGIES:, He is allergic to Penicillin.,MISCELLANEOUS/EATING HISTORY:, He has been going to support groups for seven months with Lynn Holmberg in Greenwich and he is from Eastchester, New York and he feels that we are the appropriate program. He had a poor experience with the Greenwich program. Eating history, he is not an emotional eater. Does not like sweets. He likes big portions and carbohydrates. He likes chicken and not steak. He currently weighs 312 pounds. Ideal body weight would be 170 pounds. He is 142 pounds overweight. If ,he lost 60% of his excess body weight that would be 84 pounds and he should weigh about 228.,REVIEW OF SYSTEMS: ,Negative for head, neck, heart, lungs, GI, GU, orthopedic, and skin. Specifically denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, high cholesterol, pulmonary embolism, high blood pressure, CVA, venous insufficiency, thrombophlebitis, asthma, shortness of breath, COPD, emphysema, sleep apnea, diabetes, leg and foot swelling, osteoarthritis, rheumatoid arthritis, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, hemorrhoids, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. Denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,PHYSICAL EXAMINATION:, He is alert and oriented x 3. Cranial nerves II-XII are intact. Afebrile. Vital Signs are stable.	denies obesity and hypertension in other family members.current medications, none.allergies, he is allergic to penicillin.miscellaneous/eating history, he has been going to support groups for seven months with lynn holmberg in greenwich and he is from eastchester, new york and he feels that we are the appropriate program. he had a poor experience with the greenwich program. eating history, he is not an emotional eater. does not like sweets. he likes big portions and carbohydrates. he likes chicken and not steak. he currently weighs 312 pounds. ideal body weight would be 170 pounds. he is 142 pounds overweight. if ,he lost 60 of his excess body weight that would be 84 pounds and he should weigh about 228. review of systems ,negative for head, neck, heart, lungs, gi, gu, orthopedic, and skin. specifically denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, high cholesterol, pulmonary embolism, high blood pressure, cva, venous insufficiency, thrombophlebitis, asthma, shortness of breath, copd, emphysema, sleep apnea, diabetes, leg and foot swelling, osteoarthritis, rheumatoid arthritis, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, hemorrhoids, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.physical examination, he is alert and oriented x 3. cranial nerves ii-xii are intact. afebrile. vital signs are stable.
2	HISTORY OF PRESENT ILLNESS: , I have seen ABC today. He is a very pleasant gentleman who is 42 years old, 344 pounds. He is 5'9". He has a BMI of 51. He has been overweight for ten years since the age of 33, at his highest he was 358 pounds, at his lowest 260. He is pursuing surgical attempts of weight loss to feel good, get healthy, and begin to exercise again. He wants to be able to exercise and play volleyball. Physically, he is sluggish. He gets tired quickly. He does not go out often. When he loses weight he always regains it and he gains back more than he lost. His biggest weight loss is 25 pounds and it was three months before he gained it back. He did	history of present illness , i have seen abc today. he is a very pleasant gentleman who is 42 years old, 344 pounds. he is 59. he has a bmi of 51. he has been overweight for ten years since the age of 33, at his highest he was 358 pounds, at his lowest 260. he is pursuing surgical attempts of weight loss to feel good, get healthy, and begin to exercise again. he wants to be able to exercise and play volleyball. physically, he is sluggish. he gets tired quickly. he does not go out often. when he loses weight he always regains it and he gains back more than he lost. his biggest

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six months of not drinking alcohol and not taking in many calories. He has been on multiple commercial weight loss programs including Slim Fast for one month one year ago and Atkin's Diet for one month two years ago.,PAST MEDICAL HISTORY: , He has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, difficulty walking, high cholesterol, and high blood pressure. He has asthma and difficulty walking two blocks or going eight to ten steps. He has sleep apnea and snoring. He is a diabetic, on medication. He has joint pain, knee pain, back pain, foot and ankle pain, leg and foot swelling. He has hemorrhoids.,PAST SURGICAL HISTORY: , Includes orthopedic or knee surgery.,SOCIAL HISTORY: , He is currently single. He drinks alcohol ten to twelve drinks a week, but does not drink five days a week and then will binge drink. He smokes one and a half pack a day for 15 years, but he has recently stopped smoking for the past two weeks.,FAMILY HISTORY: , Obesity, heart disease, and diabetes. Family history is negative for hypertension and stroke.,CURRENT MEDICATIONS:, Include Diovan, Crestor, and Tricor.,MISCELLANEOUS/EATING HISTORY: ,He says a couple of friends of his have had heart attacks and have had died. He used to drink everyday, but stopped two years ago. He now only drinks on weekends. He is on his second week of Chantix, which is a medication to come off smoking completely. Eating, he eats bad food. He is single. He eats things like bacon, eggs, and cheese, cheeseburgers, fast food, eats four times a day, seven in the morning, at noon, 9 p.m., and 2 a.m. He currently weighs 344 pounds and 5'9". His ideal body weight is 160 pounds. He is 184 pounds overweight. If he lost 70% of his excess body weight that would be 129 pounds and that would get him down to 215.,REVIEW OF SYSTEMS: , Negative for head, neck, heart, lungs, GI, GU, orthopedic, or skin. He also is positive for gout. He denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, pulmonary embolism, or CVA. He denies venous insufficiency or thrombophlebitis. Denies shortness of breath, COPD, or emphysema. Denies thyroid problems, hip pain, osteoarthritis, rheumatoid arthritis, GERD, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. He	weight loss is 25 pounds and it was three months before he gained it back. he did six months of not drinking alcohol and not taking in many calories. he has been on multiple commercial weight loss programs including slim fast for one month one year ago and atkins diet for one month two years ago.past medical history , he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, difficulty walking, high cholesterol, and high blood pressure. he has asthma and difficulty walking two blocks or going eight to ten steps. he has sleep apnea and snoring. he is a diabetic, on medication. he has joint pain, knee pain, back pain, foot and ankle pain, leg and foot swelling. he has hemorrhoids.past surgical history , includes orthopedic or knee surgery.social history , he is currently single. he drinks alcohol ten to twelve drinks a week, but does not drink five days a week and then will binge drink. he smokes one and a half pack a day for 15 years, but he has recently stopped smoking for the past two weeks.family history , obesity, heart disease, and diabetes. family history is negative for hypertension and stroke.current medications, include diovan, crestor, and tricor.miscellaneous/eating history ,he says a couple of friends of his have had heart attacks and have had died. he used to drink everyday, but stopped two years ago. he now only drinks on weekends. he is on his second week of chantix, which is a medication to come off smoking completely. eating, he eats bad food. he is single. he eats things like bacon, eggs, and cheese, cheeseburgers, fast food, eats four times a day, seven in the morning, at noon, 9 p.m. and 2 a.m. he currently weighs 344 pounds and 59. his ideal body weight is 160 pounds. he is 184 pounds overweight. if he lost 70 of his excess body weight that would be 129 pounds and that would get him down to 215. review of systems , negative for head, neck, heart, lungs, gi, gu, orthopedic, or skin. he also is positive for gout. he denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, pulmonary embolism, or cva. he denies venous insufficiency or thrombophlebitis. denies

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	denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,PHYSICAL EXAMINATION: ,He is alert and oriented x 3. Cranial nerves II-XII are intact. Neck is soft and supple. Lungs: He has positive wheezing bilaterally. Heart is regular rhythm and rate. His abdomen is soft. Extremities: He has 1+ pitting edema.,IMPRESSION/PLAN:, I have explained to him the risks and potential complications of laparoscopic gastric bypass in detail and these include bleeding, infection, deep venous thrombosis, pulmonary embolism, leakage from the gastrojejuno-anastomosis, jejunojejuno-anastomosis, and possible bowel obstruction among other potential complications. He understands. He wants to proceed with workup and evaluation for laparoscopic Roux-en-Y gastric bypass. He will need to get a letter of approval from Dr. XYZ. He will need to see a nutritionist and mental health worker. He will need an upper endoscopy by either Dr. XYZ. He will need to go to Dr. XYZ as he previously had a sleep study. We will need another sleep study. He will need H. pylori testing, thyroid function tests, LFTs, glycosylated hemoglobin, and fasting blood sugar. After this is performed, we will submit him for insurance approval.	shortness of breath, copd, or emphysema. denies thyroid problems, hip pain, osteoarthritis, rheumatoid arthritis, gerd, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. he denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.physical examination ,he is alert and oriented x 3. cranial nerves ii-xii are intact. neck is soft and supple. lungs he has positive wheezing bilaterally. heart is regular rhythm and rate. his abdomen is soft. extremities he has 1 pitting edema.impression/plan, i have explained to him the risks and potential complications of laparoscopic gastric bypass in detail and these include bleeding, infection, deep venous thrombosis, pulmonary embolism, leakage from the gastrojejuno-anastomosis, jejunojejuno-anastomosis, and possible bowel obstruction among other potential complications. he understands. he wants to proceed with workup and evaluation for laparoscopic roux-en-y gastric bypass. he will need to get a letter of approval from dr. xyz. he will need to see a nutritionist and mental health worker. he will need an upper endoscopy by either dr. xyz. he will need to go to dr. xyz as he previously had a sleep study. we will need another sleep study. he will need h. pylori testing, thyroid function tests, lfts, glycosylated hemoglobin, and fasting blood sugar. after this is performed, we will submit him for insurance approval.
3	2-D M-MODE: , ,1. Left atrial enlargement with left atrial diameter of 4.7 cm.,2. Normal size right and left ventricle.,3. Normal LV systolic function with left ventricular ejection fraction of 51%.,4. Normal LV diastolic function.,5. No pericardial effusion.,6. Normal morphology of aortic valve, mitral valve, tricuspid valve, and pulmonary valve.,7. PA systolic pressure is 36 mmHg.,DOPPLER: , ,1. Mild mitral and tricuspid regurgitation.,2. Trace aortic and pulmonary regurgitation.	2-d m-mode , , 1. left atrial enlargement with left atrial diameter of 4.7 cm. 2. normal size right and left ventricle. 3. normal lv systolic function with left ventricular ejection fraction of 51. 4. normal lv diastolic function. 5. no pericardial effusion. 6. normal morphology of aortic valve, mitral valve, tricuspid valve, and pulmonary valve. 7. pa systolic pressure is 36 mmhg.doppler , , 1. mild mitral and tricuspid regurgitation. 2. trace aortic and pulmonary regurgitation.
4	1. The left ventricular cavity size and wall thickness appear normal. The wall motion and left ventricular systolic function appears	1. the left ventricular cavity size and wall thickness appear normal. the wall motion and left ventricular systolic

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	hyperdynamic with estimated ejection fraction of 70% to 75%. There is near-cavity obliteration seen. There also appears to be increased left ventricular outflow tract gradient at the mid cavity level consistent with hyperdynamic left ventricular systolic function. There is abnormal left ventricular relaxation pattern seen as well as elevated left atrial pressures seen by Doppler examination.,2. The left atrium appears mildly dilated.,3. The right atrium and right ventricle appear normal.,4. The aortic root appears normal.,5. The aortic valve appears calcified with mild aortic valve stenosis, calculated aortic valve area is 1.3 cm square with a maximum instantaneous gradient of 34 and a mean gradient of 19 mm.,6. There is mitral annular calcification extending to leaflets and supportive structures with thickening of mitral valve leaflets with mild mitral regurgitation.,7. The tricuspid valve appears normal with trace tricuspid regurgitation with moderate pulmonary artery hypertension. Estimated pulmonary artery systolic pressure is 49 mmHg. Estimated right atrial pressure of 10 mmHg.,8. The pulmonary valve appears normal with trace pulmonary insufficiency.,9. There is no pericardial effusion or intracardiac mass seen.,10. There is a color Doppler suggestive of a patent foramen ovale with lipomatous hypertrophy of the interatrial septum.,11. The study was somewhat technically limited and hence subtle abnormalities could be missed from the study.,	function appears hyperdynamic with estimated ejection fraction of 70 to 75. there is near-cavity obliteration seen. there also appears to be increased left ventricular outflow tract gradient at the mid cavity level consistent with hyperdynamic left ventricular systolic function. there is abnormal left ventricular relaxation pattern seen as well as elevated left atrial pressures seen by doppler examination. 2. the left atrium appears mildly dilated. 3. the right atrium and right ventricle appear normal. 4. the aortic root appears normal. 5. the aortic valve appears calcified with mild aortic valve stenosis, calculated aortic valve area is 1.3 cm square with a maximum instantaneous gradient of 34 and a mean gradient of 19 mm. 6. there is mitral annular calcification extending to leaflets and supportive structures with thickening of mitral valve leaflets with mild mitral regurgitation. 7. the tricuspid valve appears normal with trace tricuspid regurgitation with moderate pulmonary artery hypertension. estimated pulmonary artery systolic pressure is 49 mmhg. estimated right atrial pressure of 10 mmhg. 8. the pulmonary valve appears normal with trace pulmonary insufficiency. 9. there is no pericardial effusion or intracardiac mass seen. 10. there is a color doppler suggestive of a patent foramen ovale with lipomatous hypertrophy of the interatrial septum. 11. the study was somewhat technically limited and hence subtle abnormalities could be missed from the study.
5	PREOPERATIVE DIAGNOSIS: , Morbid obesity.,POSTOPERATIVE DIAGNOSIS: ,Morbid obesity.,PROCEDURE: , Laparoscopic antecolic antegastric Roux-en-Y gastric bypass with EEA anastomosis.,ANESTHESIA: , General with endotracheal intubation.,INDICATION FOR PROCEDURE: , This is a 30-year-old female, who has been overweight for many years. She has tried many different diets, but is unsuccessful. She has been to our Bariatric Surgery Seminar, received some handouts, and signed the consent. The risks and benefits of the procedure have been explained to the patient.,PROCEDURE IN DETAIL: ,The patient was taken to the operating room and placed supine on the operating room table. All pressure points were carefully padded. She	preoperative diagnosis , morbid obesity.postoperative diagnosis ,morbid obesity.procedure , laparoscopic antecolic antegastric roux-en-y gastric bypass with eea anastomosis.anesthesia , general with endotracheal intubation.indication for procedure , this is a 30-year-old female, who has been overweight for many years. she has tried many different diets, but is unsuccessful. she has been to our bariatric surgery seminar, received some handouts, and signed the consent. the risks and benefits of the procedure have been explained to the patient.procedure in detail ,the patient was taken to the operating room and placed supine on the operating room table. all pressure

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was given general anesthesia with endotracheal intubation. SCD stockings were placed on both legs. Foley catheter was placed for bladder decompression. The abdomen was then prepped and draped in standard sterile surgical fashion. Marcaine was then injected through umbilicus. A small incision was made. A Veress needle was introduced into the abdomen. CO2 insufflation was done to a maximum pressure of 15 mmHg. A 12-mm VersaStep port was placed through the umbilicus. I then placed a 5-mm port just anterior to the midaxillary line and just subcostal on the right side. I placed another 5-mm port in the midclavicular line just subcostal on the right side, a few centimeters below and medial to that, I placed a 12-mm VersaStep port. On the left side, just anterior to the midaxillary line and just subcostal, I placed a 5-mm port. A few centimeters below and medial to that, I placed a 15-mm port. I began by lifting up the omentum and identifying the transverse colon and lifting that up and thereby identifying my ligament of Treitz. I ran the small bowel down approximately 40 cm and divided the small bowel with a white load GIA stapler. I then divided the mesentery all the way down to the base of the mesentery with a LigaSure device. I then ran the distal bowel down, approximately 100 cm, and at 100 cm, I made a hole at the antimesenteric portion of the Roux limb and a hole in the antimesenteric portion of the duodenogastric limb, and I passed a 45 white load stapler and fired a stapler creating a side-to-side anastomosis. I reapproximated the edges of the defect. I lifted it up and stapled across it with another white load stapler. I then closed the mesenteric defect with interrupted Surgidac sutures. I divided the omentum all the way down to the colon in order to create a passageway for my small bowel to go antecolic. I then put the patient in reverse Trendelenburg. I placed a liver retractor, identified, and dissected the angle of His. I then dissected on the lesser curve, approximately 2.5 cm below the gastroesophageal junction, and got into a lesser space. I fired transversely across the stomach with a 45 blue load stapler. I then used two fires of the 60 blue load with SeamGuard to go up into my angle of His, thereby creating my gastric pouch. I then made a hole at the base of the gastric pouch and had Anesthesia remove the bougie and place the OG tube connected to the anvil. I pulled the anvil into place, and I then opened	points were carefully padded. she was given general anesthesia with endotracheal intubation. scd stockings were placed on both legs. foley catheter was placed for bladder decompression. the abdomen was then prepped and draped in standard sterile surgical fashion. marcaine was then injected through umbilicus. a small incision was made. a veress needle was introduced into the abdomen. co2 insufflation was done to a maximum pressure of 15 mmhg. a 12-mm versastep port was placed through the umbilicus. i then placed a 5-mm port just anterior to the midaxillary line and just subcostal on the right side. i placed another 5-mm port in the midclavicular line just subcostal on the right side, a few centimeters below and medial to that, i placed a 12-mm versastep port. on the left side, just anterior to the midaxillary line and just subcostal, i placed a 5-mm port. a few centimeters below and medial to that, i placed a 15-mm port. i began by lifting up the omentum and identifying the transverse colon and lifting that up and thereby identifying my ligament of treitz. i ran the small bowel down approximately 40 cm and divided the small bowel with a white load gia stapler. i then divided the mesentery all the way down to the base of the mesentery with a ligasure device. i then ran the distal bowel down, approximately 100 cm, and at 100 cm, i made a hole at the antimesenteric portion of the roux limb and a hole in the antimesenteric portion of the duodenogastric limb, and i passed a 45 white load stapler and fired a stapler creating a side-to-side anastomosis. i reapproximated the edges of the defect. i lifted it up and stapled across it with another white load stapler. i then closed the mesenteric defect with interrupted surgidac sutures. i divided the omentum all the way down to the colon in order to create a passageway for my small bowel to go antecolic. i then put the patient in reverse trendelenburg. i placed a liver retractor, identified, and dissected the angle of his. i then dissected on the lesser curve, approximately 2.5 cm below the gastroesophageal junction, and got into a lesser space. i fired transversely across the stomach with a 45 blue load stapler. i then used two

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	up my 15-mm port site and passed my EEA stapler. I passed that in the end of my Roux limb and had the spike come out antimesenteric. I joined the spike with the anvil and fired a stapler creating an end-to-side anastomosis, then divided across the redundant portion of my Roux limb with a white load GI stapler, and removed it with an Endocatch bag. I put some additional 2-0 Vicryl sutures in the anastomosis for further security. I then placed a bowel clamp across the bowel. I went above and passed an EGD scope into the mouth down to the esophagus and into the gastric pouch. I distended gastric pouch with air. There was no air leak seen. I could pass the scope easily through the anastomosis. There was no bleeding seen through the scope. We closed the 15-mm port site with interrupted 0 Vicryl suture utilizing Carter-Thomason. I copiously irrigated out that incision with about 2 L of saline. I then closed the skin of all incisions with running Monocryl. Sponge, instrument, and needle counts were correct at the end of the case. The patient tolerated the procedure well without any complications.	fires of the 60 blue load with seamguard to go up into my angle of his, thereby creating my gastric pouch. i then made a hole at the base of the gastric pouch and had anesthesia remove the bougie and place the og tube connected to the anvil. i pulled the anvil into place, and i then opened up my 15-mm port site and passed my eea stapler. i passed that in the end of my roux limb and had the spike come out antimesenteric. i joined the spike with the anvil and fired a stapler creating an end-to-side anastomosis, then divided across the redundant portion of my roux limb with a white load gi stapler, and removed it with an endocatch bag. i put some additional 2-0 vicryl sutures in the anastomosis for further security. i then placed a bowel clamp across the bowel. i went above and passed an egd scope into the mouth down to the esophagus and into the gastric pouch. i distended gastric pouch with air. there was no air leak seen. i could pass the scope easily through the anastomosis. there was no bleeding seen through the scope. we closed the 15-mm port site with interrupted 0 vicryl suture utilizing carter-thomason. i copiously irrigated out that incision with about 2 l of saline. i then closed the skin of all incisions with running monocryl. sponge, instrument, and needle counts were correct at the end of the case. the patient tolerated the procedure well without any complications.
6	PREOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,POSTOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,PROCEDURES:,1. Revision, right breast reconstruction.,2. Excision, soft tissue fullness of the lateral abdomen and flank.,3. Liposuction of the supraumbilical abdomen.,ANESTHESIA: , General.,INDICATION FOR OPERATION:, The patient is a 31-year-old white female who previously has undergone latissimus dorsi flap and implant, breast reconstruction. She now had lateralization of the implant with loss of medial fullness for which she desired correction. It was felt that mobilization of the	preoperative diagnoses, 1. deformity, right breast reconstruction. 2. excess soft tissue, anterior abdomen and flank. 3. lipodystrophy of the abdomen.postoperative diagnoses, 1. deformity, right breast reconstruction. 2. excess soft tissue, anterior abdomen and flank. 3. lipodystrophy of the abdomen.procedures, 1. revision, right breast reconstruction. 2. excision, soft tissue fullness of the lateral abdomen and flank. 3. liposuction of the supraumbilical abdomen.anesthesia , general.indication for operation, the patient is a 31-year-old white female who previously has undergone latissimus dorsi flap and implant, breast reconstruction. she now had lateralization of the implant with loss of medial fullness for which she desired

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implant medially would provide the patient significant improvement and this was discussed with the patient at length. The patient also had a small dog ear in the flank area on the right from the latissimus flap harvest, which was to be corrected. She had also had liposuction of the periumbilical and infraumbilical abdomen with desire to have great improvement superiorly, was felt to be a candidate for such. The above-noted procedure was discussed with the patient in detail. The risks, benefits and potential complications were discussed. She was marked in the upright position and then taken to the operating room for the above-noted procedure.,OPERATIVE PROCEDURE: , The patient was taken to the operating room and placed in the supine position. Following adequate induction of general LMA anesthesia, the chest and abdomen was prepped and draped in the usual sterile fashion. The supraumbilical abdomen was then injected with a solution of 5% lidocaine with epinephrine, as was the dog ear. At this time, the superior central scar was then excised, dissection continued through the subcutaneous tissue, the underlying latissimus muscle until the capsule of the implant was reached. This was then opened. The implant was removed and placed on the back table in antibiotic solution. Using Bovie cautery, the medial capsule was released and undermining was then performed with release of the muscle to the level of the proposed medial projection of the breast. The inframammary fold medially was secured with 2-0 PDS suture to create greater takeoff point at this level which in the upright position and using a sizer produced a good form. The lateral pocket was diminished by series of 2-0 PDS suture to provide medialization of the implant. The implant was then placed back into the submuscular pocket with much improved positioning and medial fullness. With this completed, the implant was again removed, antibiotic irrigation was performed. A drain was placed and brought out through a separate inferior stab wound incision and hemostasis was confirmed. The implant was then replaced and the wound was then closed in layers using 2-0 PDS running suture on the muscle and 3-0 Monocryl Dermabond subcuticular sutures. The 2.5 cm dog ear was then excised into and including the subcutaneous tissue, even contouring was achieved and this was closed with two layers using 3-0 Monocryl suture. Using a #3 cannula, a superior umbilical incision,	correction. it was felt that mobilization of the implant medially would provide the patient significant improvement and this was discussed with the patient at length. the patient also had a small dog ear in the flank area on the right from the latissimus flap harvest, which was to be corrected. she had also had liposuction of the periumbilical and infraumbilical abdomen with desire to have great improvement superiorly, was felt to be a candidate for such. the above-noted procedure was discussed with the patient in detail. the risks, benefits and potential complications were discussed. she was marked in the upright position and then taken to the operating room for the above-noted procedure.operative procedure , the patient was taken to the operating room and placed in the supine position. following adequate induction of general lma anesthesia, the chest and abdomen was prepped and draped in the usual sterile fashion. the supraumbilical abdomen was then injected with a solution of 5 lidocaine with epinephrine, as was the dog ear. at this time, the superior central scar was then excised, dissection continued through the subcutaneous tissue, the underlying latissimus muscle until the capsule of the implant was reached. this was then opened. the implant was removed and placed on the back table in antibiotic solution. using bovie cautery, the medial capsule was released and undermining was then performed with release of the muscle to the level of the proposed medial projection of the breast. the inframammary fold medially was secured with 2-0 pds suture to create greater takeoff point at this level which in the upright position and using a sizer produced a good form. the lateral pocket was diminished by series of 2-0 pds suture to provide medialization of the implant. the implant was then placed back into the submuscular pocket with much improved positioning and medial fullness. with this completed, the implant was again removed, antibiotic irrigation was performed. a drain was placed and brought out through a separate inferior stab wound incision and hemostasis was confirmed. the implant was then replaced and the wound was then closed in layers using

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	liposuction was carried out into the supraumbilical abdomen, removing approximately 40 to 50 mL of fat with improved supraumbilical contours. This was closed with 6-0 Prolene suture. The patient was placed in a compressive garment after treating the incision with Dermabond, Steri-Strips and antibiotic ointment around the drain site and umbilicus. A Kerlix dressing and a surgical bra was placed to the chest area. A compressive garment was placed. The patient was then aroused from anesthesia, extubated, and taken to the recovery room in stable condition. Sponge, needle, lap, instrument counts were all correct. The patient tolerated the procedure well. There were no complications. The estimated blood loss was approximately 25 mL.	2-0 pds running suture on the muscle and 3-0 monocryl dermabond subcuticular sutures. the 2.5 cm dog ear was then excised into and including the subcutaneous tissue, even contouring was achieved and this was closed with two layers using 3-0 monocryl suture. using a 3 cannula, a superior umbilical incision, liposuction was carried out into the supraumbilical abdomen, removing approximately 40 to 50 ml of fat with improved supraumbilical contours. this was closed with 6-0 prolene suture. the patient was placed in a compressive garment after treating the incision with dermabond, steri-strips and antibiotic ointment around the drain site and umbilicus. a kerlix dressing and a surgical bra was placed to the chest area. a compressive garment was placed. the patient was then aroused from anesthesia, extubated, and taken to the recovery room in stable condition. sponge, needle, lap, instrument counts were all correct. the patient tolerated the procedure well. there were no complications. the estimated blood loss was approximately 25 ml.
7	2-D ECHOCARDIOGRAM,Multiple views of the heart and great vessels reveal normal intracardiac and great vessel relationships. Cardiac function is normal. There is no significant chamber enlargement or hypertrophy. There is no pericardial effusion or vegetations seen. Doppler interrogation, including color flow imaging, reveals systemic venous return to the right atrium with normal tricuspid inflow. Pulmonary outflow is normal at the valve. Pulmonary venous return is to the left atrium. The interatrial septum is intact. Mitral inflow and ascending aorta flow are normal. The aortic valve is trileaflet. The coronary arteries appear to be normal in their origins. The aortic arch is left-sided and patent with normal descending aorta pulsatility.	2-d echocardiogram,multiple views of the heart and great vessels reveal normal intracardiac and great vessel relationships. cardiac function is normal. there is no significant chamber enlargement or hypertrophy. there is no pericardial effusion or vegetations seen. doppler interrogation, including color flow imaging, reveals systemic venous return to the right atrium with normal tricuspid inflow. pulmonary outflow is normal at the valve. pulmonary venous return is to the left atrium. the interatrial septum is intact. mitral inflow and ascending aorta flow are normal. the aortic valve is trileaflet. the coronary arteries appear to be normal in their origins. the aortic arch is left-sided and patent with normal descending aorta pulsatility.
8	PREOPERATIVE DIAGNOSIS: , Lipodystrophy of the abdomen and thighs.,POSTOPERATIVE DIAGNOSIS:, Lipodystrophy of the abdomen and thighs.,OPERATION: , Suction-assisted lipectomy.,ANESTHESIA:, General.,FINDINGS AND PROCEDURE:, With the patient under satisfactory general endotracheal anesthesia, the entire abdomen, flanks, perineum, and	preoperative diagnosis , lipodystrophy of the abdomen and thighs.postoperative diagnosis, lipodystrophy of the abdomen and thighs.operation , suction-assisted lipectomy.anesthesia, general.findings and procedure, with the patient under satisfactory general endotracheal anesthesia, the entire abdomen, flanks,

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	thighs to the knees were prepped and draped circumferentially in sterile fashion. After this had been completed, a #15 blade was used to make small stab wounds in the lateral hips, the pubic area, and upper edge of the umbilicus. Through these small incisions, a cannula was used to infiltrate lactated Ringers with 1000 cc was infiltrated initially into the abdomen. A 3 and 4-mm cannulas were then used to carry out the liposuction of the abdomen removing a total of 1100 cc of aspirate, which was mostly fat, little fluid, and blood. Attention was then directed to the thighs both inner and outer. A total of 1000 cc was infiltrated in both lateral thighs only about 50 cc in the medial thighs. After this had been completed, 3 and 4-mm cannulas were used to suction 650 cc from each side, approximately 50 cc in the inner thigh and 600 on each lateral thigh. The patient tolerated the procedure very well. All of this aspirate was mostly fat with little fluid and very little blood. Wounds were cleaned and steri-stripped and dressing of ABD pads and ***** was then applied. The patient tolerated the procedure very well and was sent to the recovery room in good condition.	perineum, and thighs to the knees were prepped and draped circumferentially in sterile fashion. after this had been completed, a 15 blade was used to make small stab wounds in the lateral hips, the pubic area, and upper edge of the umbilicus. through these small incisions, a cannula was used to infiltrate lactated ringers with 1000 cc was infiltrated initially into the abdomen. a 3 and 4-mm cannulas were then used to carry out the liposuction of the abdomen removing a total of 1100 cc of aspirate, which was mostly fat, little fluid, and blood. attention was then directed to the thighs both inner and outer. a total of 1000 cc was infiltrated in both lateral thighs only about 50 cc in the medial thighs. after this had been completed, 3 and 4-mm cannulas were used to suction 650 cc from each side, approximately 50 cc in the inner thigh and 600 on each lateral thigh. the patient tolerated the procedure very well. all of this aspirate was mostly fat with little fluid and very little blood. wounds were cleaned and steri-stripped and dressing of abd pads and was then applied. the patient tolerated the procedure very well and was sent to the recovery room in good condition.
9	DESCRIPTION:,1. Normal cardiac chambers size.,2. Normal left ventricular size.,3. Normal LV systolic function. Ejection fraction estimated around 60%.,4. Aortic valve seen with good motion.,5. Mitral valve seen with good motion.,6. Tricuspid valve seen with good motion.,7. No pericardial effusion or intracardiac masses.,DOPPLER:,1. Trace mitral regurgitation.,2. Trace tricuspid regurgitation.,IMPRESSION:,1. Normal LV systolic function.,2. Ejection fraction estimated around 60%.,	description, 1. normal cardiac chambers size. 2. normal left ventricular size. 3. normal lv systolic function. ejection fraction estimated around 60. 4. aortic valve seen with good motion. 5. mitral valve seen with good motion. 6. tricuspid valve seen with good motion. 7. no pericardial effusion or intracardiac masses.doppler, 1. trace mitral regurgitation. 2. trace tricuspid regurgitation.impression, 1. normal lv systolic function. 2. ejection fraction estimated around 60.

In [ ]:
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df[['medical_specialty_clean','transcription', 'transcription_clean']].head(
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In [65]:
```
import re

def format_transcription_sections(text, add_newlines=True):
    if pd.isnull(text):
        return ""

    text = str(text).lower()
```

```
    # Fix things like ".," or "%," or "60%."
    text = re.sub(r'\.,', '.', text)
    text = re.sub(r'%,', '%', text)
    text = re.sub(r'([0-9])\s*%\s*\.', r'\1 percent.', text)  # replace 60%.

    # Ensure space between sentences if missing
    text = re.sub(r'([a-z])\.(?=[a-z])', r'\1. ', text)

    # Normalize section headers (with or without colon)
    section_headers = [
        "description", "doppler", "impression", "procedure", "findings",
        "diagnosis", "assessment", "plan", "subjective", "objective"
    ]
    for header in section_headers:
        text = re.sub(rf'\b{header}[:,]?', f'\n{header}:', text)

    # Fix spacing after numbered list items
    text = re.sub(r'(\d+)\.\s*', r'\1. ', text)

    # Optional: Put list items on new lines
    if add_newlines:
        text = re.sub(r'(?<!\n)(\d+\.\s)', r'\n\1', text)

    # Remove extra whitespace
    text = re.sub(r'\s+', ' ', text).strip()

    return text
```

In [66]:
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df['transcription_formatted'] = df['transcription'].apply(format_transcripti
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In [68]:
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df[['transcription', 'transcription_formatted']].head(20)
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Out[68]:

	transcription	transcription_formatted
0	SUBJECTIVE:, This 23-year-old white female presents with complaint of allergies. She used to have allergies when she lived in Seattle but she thinks they are worse here. In the past, she has tried Claritin, and Zyrtec. Both worked for short time but then seemed to lose effectiveness. She has used Allegra also. She used that last summer and she began using it again two weeks ago. It does not appear to be working very well. She has used over-the-counter sprays but no prescription nasal sprays. She does have asthma but doest not require daily medication for this and does not think it is flaring up.,MEDICATIONS: , Her only medication currently is Ortho Tri-Cyclen and the Allegra.,ALLERGIES: , She has no known medicine allergies.,OBJECTIVE:,Vitals: Weight was 130 pounds and blood pressure 124/78.,HEENT: Her throat was mildly erythematous without exudate. Nasal mucosa was erythematous and swollen. Only clear drainage was seen. TMs were clear.,Neck: Supple without adenopathy.,Lungs: Clear.,ASSESSMENT:, Allergic rhinitis.,PLAN:,1. She will try Zyrtec instead of Allegra again. Another option will be to use loratadine. She does not think she has prescription coverage so that might be cheaper.,2. Samples of Nasonex two sprays in each nostril given for three weeks. A prescription was written as well.	subjective:, this 23-year-old white female presents with complaint of allergies. she used to have allergies when she lived in seattle but she thinks they are worse here. in the past, she has tried claritin, and zyrtec. both worked for short time but then seemed to lose effectiveness. she has used allegra also. she used that last summer and she began using it again two weeks ago. it does not appear to be working very well. she has used over-the-counter sprays but no prescription nasal sprays. she does have asthma but doest not require daily medication for this and does not think it is flaring up. medications: , her only medication currently is ortho tri-cyclen and the allegra. allergies: , she has no known medicine allergies. objective:,vitals: weight was 130 pounds and blood pressure 124/ 78. heent: her throat was mildly erythematous without exudate. nasal mucosa was erythematous and swollen. only clear drainage was seen. tms were clear. neck: supple without adenopathy. lungs: clear. assessment:, allergic rhinitis. plan:, 1. she will try zyrtec instead of allegra again. another option will be to use loratadine. she does not think she has prescription coverage so that might be cheaper. 2. samples of nasonex two sprays in each nostril given for three weeks. a prescription was written as well.
1	PAST MEDICAL HISTORY:, He has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, and lifting objects off the floor. He exercises three times a week at home and does cardio. He has difficulty walking two blocks or five flights of stairs. Difficulty with snoring. He has muscle and joint pains including knee pain, back pain, foot and ankle pain, and swelling. He has gastroesophageal reflux disease.,PAST SURGICAL HISTORY:, Includes reconstructive surgery on his right hand 13 years ago. ,SOCIAL HISTORY:, He is currently single. He has about ten drinks a year. He had smoked significantly up until several months ago. He now smokes less than three cigarettes a day.,FAMILY HISTORY:, Heart disease in both grandfathers, grandmother with stroke, and a grandmother with diabetes. Denies obesity and hypertension in other family members.,CURRENT	past medical history:, he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, and lifting objects off the floor. he exercises three times a week at home and does cardio. he has difficulty walking two blocks or five flights of stairs. difficulty with snoring. he has muscle and joint pains including knee pain, back pain, foot and ankle pain, and swelling. he has gastroesophageal reflux disease. past surgical history:, includes reconstructive surgery on his right hand 13 years ago. ,social history:, he is currently single. he has about ten drinks a year. he had smoked significantly up until several months ago. he now smokes less than three cigarettes a day. family history:, heart disease in both grandfathers, grandmother with stroke, and a grandmother with diabetes. denies

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	MEDICATIONS:, None.,ALLERGIES:, He is allergic to Penicillin.,MISCELLANEOUS/EATING HISTORY:, He has been going to support groups for seven months with Lynn Holmberg in Greenwich and he is from Eastchester, New York and he feels that we are the appropriate program. He had a poor experience with the Greenwich program. Eating history, he is not an emotional eater. Does not like sweets. He likes big portions and carbohydrates. He likes chicken and not steak. He currently weighs 312 pounds. Ideal body weight would be 170 pounds. He is 142 pounds overweight. If ,he lost 60% of his excess body weight that would be 84 pounds and he should weigh about 228.,REVIEW OF SYSTEMS: ,Negative for head, neck, heart, lungs, GI, GU, orthopedic, and skin. Specifically denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, high cholesterol, pulmonary embolism, high blood pressure, CVA, venous insufficiency, thrombophlebitis, asthma, shortness of breath, COPD, emphysema, sleep apnea, diabetes, leg and foot swelling, osteoarthritis, rheumatoid arthritis, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, hemorrhoids, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. Denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,PHYSICAL EXAMINATION:, He is alert and oriented x 3. Cranial nerves II-XII are intact. Afebrile. Vital Signs are stable.	obesity and hypertension in other family members. current medications:, none. allergies:, he is allergic to penicillin. miscellaneous/eating history:, he has been going to support groups for seven months with lynn holmberg in greenwich and he is from eastchester, new york and he feels that we are the appropriate program. he had a poor experience with the greenwich program. eating history, he is not an emotional eater. does not like sweets. he likes big portions and carbohydrates. he likes chicken and not steak. he currently weighs 312 pounds. ideal body weight would be 170 pounds. he is 142 pounds overweight. if ,he lost 60% of his excess body weight that would be 84 pounds and he should weigh about 228. review of systems: ,negative for head, neck, heart, lungs, gi, gu, orthopedic, and skin. specifically denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, high cholesterol, pulmonary embolism, high blood pressure, cva, venous insufficiency, thrombophlebitis, asthma, shortness of breath, copd, emphysema, sleep apnea, diabetes, leg and foot swelling, osteoarthritis, rheumatoid arthritis, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, hemorrhoids, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis. physical examination:, he is alert and oriented x 3. cranial nerves ii-xii are intact. afebrile. vital signs are stable.
2	HISTORY OF PRESENT ILLNESS: , I have seen ABC today. He is a very pleasant gentleman who is 42 years old, 344 pounds. He is 5'9". He has a BMI of 51. He has been overweight for ten years since the age of 33, at his highest he was 358 pounds, at his lowest 260. He is pursuing surgical attempts of weight loss to feel good, get healthy, and begin to exercise again. He wants to be able to exercise and play volleyball. Physically, he is sluggish. He gets tired quickly. He does not go out often. When he loses weight he always regains it and he gains back more than he lost. His biggest weight loss is 25 pounds and it was three months before he	history of present illness: , i have seen abc today. he is a very pleasant gentleman who is 42 years old, 344 pounds. he is 5'9". he has a bmi of 51. he has been overweight for ten years since the age of 33, at his highest he was 358 pounds, at his lowest 260. he is pursuing surgical attempts of weight loss to feel good, get healthy, and begin to exercise again. he wants to be able to exercise and play volleyball. physically, he is sluggish. he gets tired quickly. he does not go out often. when he loses weight he always regains it and he gains back more than he lost. his biggest

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gained it back. He did six months of not drinking alcohol and not taking in many calories. He has been on multiple commercial weight loss programs including Slim Fast for one month one year ago and Atkin's Diet for one month two years ago.,PAST MEDICAL HISTORY: , He has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, difficulty walking, high cholesterol, and high blood pressure. He has asthma and difficulty walking two blocks or going eight to ten steps. He has sleep apnea and snoring. He is a diabetic, on medication. He has joint pain, knee pain, back pain, foot and ankle pain, leg and foot swelling. He has hemorrhoids.,PAST SURGICAL HISTORY: , Includes orthopedic or knee surgery.,SOCIAL HISTORY: , He is currently single. He drinks alcohol ten to twelve drinks a week, but does not drink five days a week and then will binge drink. He smokes one and a half pack a day for 15 years, but he has recently stopped smoking for the past two weeks.,FAMILY HISTORY: , Obesity, heart disease, and diabetes. Family history is negative for hypertension and stroke.,CURRENT MEDICATIONS:, Include Diovan, Crestor, and Tricor.,MISCELLANEOUS/EATING HISTORY: ,He says a couple of friends of his have had heart attacks and have had died. He used to drink everyday, but stopped two years ago. He now only drinks on weekends. He is on his second week of Chantix, which is a medication to come off smoking completely. Eating, he eats bad food. He is single. He eats things like bacon, eggs, and cheese, cheeseburgers, fast food, eats four times a day, seven in the morning, at noon, 9 p.m., and 2 a.m. He currently weighs 344 pounds and 5'9". His ideal body weight is 160 pounds. He is 184 pounds overweight. If he lost 70% of his excess body weight that would be 129 pounds and that would get him down to 215.,REVIEW OF SYSTEMS: , Negative for head, neck, heart, lungs, GI, GU, orthopedic, or skin. He also is positive for gout. He denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, pulmonary embolism, or CVA. He denies venous insufficiency or thrombophlebitis. Denies shortness of breath, COPD, or emphysema. Denies thyroid problems, hip pain, osteoarthritis, rheumatoid arthritis, GERD, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, rectal bleeding, polyps, incontinence of stool,	weight loss is 25 pounds and it was three months before he gained it back. he did six months of not drinking alcohol and not taking in many calories. he has been on multiple commercial weight loss programs including slim fast for one month one year ago and atkin's diet for one month two years ago. past medical history: , he has difficulty climbing stairs, difficulty with airline seats, tying shoes, used to public seating, difficulty walking, high cholesterol, and high blood pressure. he has asthma and difficulty walking two blocks or going eight to ten steps. he has sleep apnea and snoring. he is a diabetic, on medication. he has joint pain, knee pain, back pain, foot and ankle pain, leg and foot swelling. he has hemorrhoids. past surgical history: , includes orthopedic or knee surgery. social history: , he is currently single. he drinks alcohol ten to twelve drinks a week, but does not drink five days a week and then will binge drink. he smokes one and a half pack a day for 15 years, but he has recently stopped smoking for the past two weeks. family history: , obesity, heart disease, and diabetes. family history is negative for hypertension and stroke. current medications:, include diovan, crestor, and tricor. miscellaneous/eating history: ,he says a couple of friends of his have had heart attacks and have had died. he used to drink everyday, but stopped two years ago. he now only drinks on weekends. he is on his second week of chantix, which is a medication to come off smoking completely. eating, he eats bad food. he is single. he eats things like bacon, eggs, and cheese, cheeseburgers, fast food, eats four times a day, seven in the morning, at noon, 9 p. m. and 2 a. m. he currently weighs 344 pounds and 5'9". his ideal body weight is 160 pounds. he is 184 pounds overweight. if he lost 70% of his excess body weight that would be 129 pounds and that would get him down to 215. review of systems: , negative for head, neck, heart, lungs, gi, gu, orthopedic, or skin. he also is positive for gout. he denies chest pain, heart attack, coronary artery disease, congestive heart failure, arrhythmia, atrial fibrillation, pacemaker, pulmonary embolism, or cva. he denies venous insufficiency or thrombophlebitis. denies

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	urinary stress incontinence, or cancer. He denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis.,PHYSICAL EXAMINATION: ,He is alert and oriented x 3. Cranial nerves II-XII are intact. Neck is soft and supple. Lungs: He has positive wheezing bilaterally. Heart is regular rhythm and rate. His abdomen is soft. Extremities: He has 1+ pitting edema.,IMPRESSION/PLAN:, I have explained to him the risks and potential complications of laparoscopic gastric bypass in detail and these include bleeding, infection, deep venous thrombosis, pulmonary embolism, leakage from the gastrojejuno-anastomosis, jejunojejuno-anastomosis, and possible bowel obstruction among other potential complications. He understands. He wants to proceed with workup and evaluation for laparoscopic Roux-en-Y gastric bypass. He will need to get a letter of approval from Dr. XYZ. He will need to see a nutritionist and mental health worker. He will need an upper endoscopy by either Dr. XYZ. He will need to go to Dr. XYZ as he previously had a sleep study. We will need another sleep study. He will need H. pylori testing, thyroid function tests, LFTs, glycosylated hemoglobin, and fasting blood sugar. After this is performed, we will submit him for insurance approval.	shortness of breath, copd, or emphysema. denies thyroid problems, hip pain, osteoarthritis, rheumatoid arthritis, gerd, hiatal hernia, peptic ulcer disease, gallstones, infected gallbladder, pancreatitis, fatty liver, hepatitis, rectal bleeding, polyps, incontinence of stool, urinary stress incontinence, or cancer. he denies cellulitis, pseudotumor cerebri, meningitis, or encephalitis. physical examination: ,he is alert and oriented x 3. cranial nerves ii-xii are intact. neck is soft and supple. lungs: he has positive wheezing bilaterally. heart is regular rhythm and rate. his abdomen is soft. extremities: he has 1+ pitting edema. impression:/ plan:, i have explained to him the risks and potential complications of laparoscopic gastric bypass in detail and these include bleeding, infection, deep venous thrombosis, pulmonary embolism, leakage from the gastrojejuno-anastomosis, jejunojejuno-anastomosis, and possible bowel obstruction among other potential complications. he understands. he wants to proceed with workup and evaluation for laparoscopic roux-en-y gastric bypass. he will need to get a letter of approval from dr. xyz. he will need to see a nutritionist and mental health worker. he will need an upper endoscopy by either dr. xyz. he will need to go to dr. xyz as he previously had a sleep study. we will need another sleep study. he will need h. pylori testing, thyroid function tests, lfts, glycosylated hemoglobin, and fasting blood sugar. after this is performed, we will submit him for insurance approval.
3	2-D M-MODE: , ,1. Left atrial enlargement with left atrial diameter of 4.7 cm.,2. Normal size right and left ventricle.,3. Normal LV systolic function with left ventricular ejection fraction of 51%.,4. Normal LV diastolic function.,5. No pericardial effusion.,6. Normal morphology of aortic valve, mitral valve, tricuspid valve, and pulmonary valve.,7. PA systolic pressure is 36 mmHg.,DOPPLER: , ,1. Mild mitral and tricuspid regurgitation.,2. Trace aortic and pulmonary regurgitation.	2-d m-mode: , , 1. left atrial enlargement with left atrial diameter of 4. 7 cm. 2. normal size right and left ventricle. 3. normal lv systolic function with left ventricular ejection fraction of 51 percent. 4. normal lv diastolic function. 5. no pericardial effusion. 6. normal morphology of aortic valve, mitral valve, tricuspid valve, and pulmonary valve. 7. pa systolic pressure is 36 mmhg. doppler: , , 1. mild mitral and tricuspid regurgitation. 2. trace aortic and pulmonary regurgitation.
4	1. The left ventricular cavity size and wall thickness appear normal. The wall motion and left ventricular systolic function appears	1. the left ventricular cavity size and wall thickness appear normal. the wall motion and left ventricular systolic

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	hyperdynamic with estimated ejection fraction of 70% to 75%. There is near-cavity obliteration seen. There also appears to be increased left ventricular outflow tract gradient at the mid cavity level consistent with hyperdynamic left ventricular systolic function. There is abnormal left ventricular relaxation pattern seen as well as elevated left atrial pressures seen by Doppler examination.,2. The left atrium appears mildly dilated.,3. The right atrium and right ventricle appear normal.,4. The aortic root appears normal.,5. The aortic valve appears calcified with mild aortic valve stenosis, calculated aortic valve area is 1.3 cm square with a maximum instantaneous gradient of 34 and a mean gradient of 19 mm.,6. There is mitral annular calcification extending to leaflets and supportive structures with thickening of mitral valve leaflets with mild mitral regurgitation.,7. The tricuspid valve appears normal with trace tricuspid regurgitation with moderate pulmonary artery hypertension. Estimated pulmonary artery systolic pressure is 49 mmHg. Estimated right atrial pressure of 10 mmHg.,8. The pulmonary valve appears normal with trace pulmonary insufficiency.,9. There is no pericardial effusion or intracardiac mass seen.,10. There is a color Doppler suggestive of a patent foramen ovale with lipomatous hypertrophy of the interatrial septum.,11. The study was somewhat technically limited and hence subtle abnormalities could be missed from the study.,	function appears hyperdynamic with estimated ejection fraction of 70% to 75 percent. there is near-cavity obliteration seen. there also appears to be increased left ventricular outflow tract gradient at the mid cavity level consistent with hyperdynamic left ventricular systolic function. there is abnormal left ventricular relaxation pattern seen as well as elevated left atrial pressures seen by doppler: examination. 2. the left atrium appears mildly dilated. 3. the right atrium and right ventricle appear normal. 4. the aortic root appears normal. 5. the aortic valve appears calcified with mild aortic valve stenosis, calculated aortic valve area is 1. 3 cm square with a maximum instantaneous gradient of 34 and a mean gradient of 19 mm. 6. there is mitral annular calcification extending to leaflets and supportive structures with thickening of mitral valve leaflets with mild mitral regurgitation. 7. the tricuspid valve appears normal with trace tricuspid regurgitation with moderate pulmonary artery hypertension. estimated pulmonary artery systolic pressure is 49 mmhg. estimated right atrial pressure of 10 mmhg. 8. the pulmonary valve appears normal with trace pulmonary insufficiency. 9. there is no pericardial effusion or intracardiac mass seen. 10. there is a color doppler: suggestive of a patent foramen ovale with lipomatous hypertrophy of the interatrial septum. 11. the study was somewhat technically limited and hence subtle abnormalities could be missed from the study.
5	PREOPERATIVE DIAGNOSIS: , Morbid obesity.,POSTOPERATIVE DIAGNOSIS: ,Morbid obesity.,PROCEDURE: , Laparoscopic antecolic antegastric Roux-en-Y gastric bypass with EEA anastomosis.,ANESTHESIA: , General with endotracheal intubation.,INDICATION FOR PROCEDURE: , This is a 30-year-old female, who has been overweight for many years. She has tried many different diets, but is unsuccessful. She has been to our Bariatric Surgery Seminar, received some handouts, and signed the consent. The risks and benefits of the procedure have been explained to the patient.,PROCEDURE IN DETAIL: ,The patient was taken to the operating room and placed supine on the operating room table. All pressure points were carefully padded. She	preoperative diagnosis: , morbid obesity. postoperative diagnosis: ,morbid obesity. procedure: , laparoscopic antecolic antegastric roux-en-y gastric bypass with eea anastomosis. anesthesia: , general with endotracheal intubation. indication for procedure: , this is a 30-year-old female, who has been overweight for many years. she has tried many different diets, but is unsuccessful. she has been to our bariatric surgery seminar, received some handouts, and signed the consent. the risks and benefits of the procedure: have been explained to the patient. procedure: in detail: ,the patient was taken to the operating room and placed supine on the operating room table. all

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was given general anesthesia with endotracheal intubation. SCD stockings were placed on both legs. Foley catheter was placed for bladder decompression. The abdomen was then prepped and draped in standard sterile surgical fashion. Marcaine was then injected through umbilicus. A small incision was made. A Veress needle was introduced into the abdomen. CO2 insufflation was done to a maximum pressure of 15 mmHg. A 12-mm VersaStep port was placed through the umbilicus. I then placed a 5-mm port just anterior to the midaxillary line and just subcostal on the right side. I placed another 5-mm port in the midclavicular line just subcostal on the right side, a few centimeters below and medial to that, I placed a 12-mm VersaStep port. On the left side, just anterior to the midaxillary line and just subcostal, I placed a 5-mm port. A few centimeters below and medial to that, I placed a 15-mm port. I began by lifting up the omentum and identifying the transverse colon and lifting that up and thereby identifying my ligament of Treitz. I ran the small bowel down approximately 40 cm and divided the small bowel with a white load GIA stapler. I then divided the mesentery all the way down to the base of the mesentery with a LigaSure device. I then ran the distal bowel down, approximately 100 cm, and at 100 cm, I made a hole at the antimesenteric portion of the Roux limb and a hole in the antimesenteric portion of the duodenogastric limb, and I passed a 45 white load stapler and fired a stapler creating a side-to-side anastomosis. I reapproximated the edges of the defect. I lifted it up and stapled across it with another white load stapler. I then closed the mesenteric defect with interrupted Surgidac sutures. I divided the omentum all the way down to the colon in order to create a passageway for my small bowel to go antecolic. I then put the patient in reverse Trendelenburg. I placed a liver retractor, identified, and dissected the angle of His. I then dissected on the lesser curve, approximately 2.5 cm below the gastroesophageal junction, and got into a lesser space. I fired transversely across the stomach with a 45 blue load stapler. I then used two fires of the 60 blue load with SeamGuard to go up into my angle of His, thereby creating my gastric pouch. I then made a hole at the base of the gastric pouch and had Anesthesia remove the bougie and place the OG tube connected to the anvil. I pulled the anvil into place, and I then opened	pressure points were carefully padded. she was given general anesthesia with endotracheal intubation. scd stockings were placed on both legs. foley catheter was placed for bladder decompression. the abdomen was then prepped and draped in standard sterile surgical fashion. marcaine was then injected through umbilicus. a small incision was made. a veress needle was introduced into the abdomen. co2 insufflation was done to a maximum pressure of 15 mmhg. a 12-mm versastep port was placed through the umbilicus. i then placed a 5-mm port just anterior to the midaxillary line and just subcostal on the right side. i placed another 5-mm port in the midclavicular line just subcostal on the right side, a few centimeters below and medial to that, i placed a 12-mm versastep port. on the left side, just anterior to the midaxillary line and just subcostal, i placed a 5-mm port. a few centimeters below and medial to that, i placed a 15-mm port. i began by lifting up the omentum and identifying the transverse colon and lifting that up and thereby identifying my ligament of treitz. i ran the small bowel down approximately 40 cm and divided the small bowel with a white load gia stapler. i then divided the mesentery all the way down to the base of the mesentery with a ligasure device. i then ran the distal bowel down, approximately 100 cm, and at 100 cm, i made a hole at the antimesenteric portion of the roux limb and a hole in the antimesenteric portion of the duodenogastric limb, and i passed a 45 white load stapler and fired a stapler creating a side-to-side anastomosis. i reapproximated the edges of the defect. i lifted it up and stapled across it with another white load stapler. i then closed the mesenteric defect with interrupted surgidac sutures. i divided the omentum all the way down to the colon in order to create a passageway for my small bowel to go antecolic. i then put the patient in reverse trendelenburg. i placed a liver retractor, identified, and dissected the angle of his. i then dissected on the lesser curve, approximately 2. 5 cm below the gastroesophageal junction, and got into a lesser space. i fired transversely across the stomach with a 45 blue load stapler. i then used two

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	up my 15-mm port site and passed my EEA stapler. I passed that in the end of my Roux limb and had the spike come out antimesenteric. I joined the spike with the anvil and fired a stapler creating an end-to-side anastomosis, then divided across the redundant portion of my Roux limb with a white load GI stapler, and removed it with an Endocatch bag. I put some additional 2-0 Vicryl sutures in the anastomosis for further security. I then placed a bowel clamp across the bowel. I went above and passed an EGD scope into the mouth down to the esophagus and into the gastric pouch. I distended gastric pouch with air. There was no air leak seen. I could pass the scope easily through the anastomosis. There was no bleeding seen through the scope. We closed the 15-mm port site with interrupted 0 Vicryl suture utilizing Carter-Thomason. I copiously irrigated out that incision with about 2 L of saline. I then closed the skin of all incisions with running Monocryl. Sponge, instrument, and needle counts were correct at the end of the case. The patient tolerated the procedure well without any complications.	fires of the 60 blue load with seamguard to go up into my angle of his, thereby creating my gastric pouch. i then made a hole at the base of the gastric pouch and had anesthesia remove the bougie and place the og tube connected to the anvil. i pulled the anvil into place, and i then opened up my 15-mm port site and passed my eea stapler. i passed that in the end of my roux limb and had the spike come out antimesenteric. i joined the spike with the anvil and fired a stapler creating an end-to-side anastomosis, then divided across the redundant portion of my roux limb with a white load gi stapler, and removed it with an endocatch bag. i put some additional 2-0 vicryl sutures in the anastomosis for further security. i then placed a bowel clamp across the bowel. i went above and passed an egd scope into the mouth down to the esophagus and into the gastric pouch. i distended gastric pouch with air. there was no air leak seen. i could pass the scope easily through the anastomosis. there was no bleeding seen through the scope. we closed the 15-mm port site with interrupted 0 vicryl suture utilizing carter-thomason. i copiously irrigated out that incision with about 2 l of saline. i then closed the skin of all incisions with running monocryl. sponge, instrument, and needle counts were correct at the end of the case. the patient tolerated the procedure: well without any complications.
6	PREOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,POSTOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,PROCEDURES:,1. Revision, right breast reconstruction.,2. Excision, soft tissue fullness of the lateral abdomen and flank.,3. Liposuction of the supraumbilical abdomen.,ANESTHESIA: , General.,INDICATION FOR OPERATION:, The patient is a 31-year-old white female who previously has undergone latissimus dorsi flap and implant, breast reconstruction. She now had lateralization of the implant with loss of medial fullness for which she desired correction. It was felt that mobilization of the	preoperative diagnoses:, 1. deformity, right breast reconstruction. 2. excess soft tissue, anterior abdomen and flank. 3. lipodystrophy of the abdomen. postoperative diagnoses:, 1. deformity, right breast reconstruction. 2. excess soft tissue, anterior abdomen and flank. 3. lipodystrophy of the abdomen. procedure:s:, 1. revision, right breast reconstruction. 2. excision, soft tissue fullness of the lateral abdomen and flank. 3. liposuction of the supraumbilical abdomen. anesthesia: , general. indication for operation:, the patient is a 31-year-old white female who previously has undergone latissimus dorsi flap and implant, breast reconstruction. she now had lateralization of the implant with loss of medial fullness for which she desired

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implant medially would provide the patient significant improvement and this was discussed with the patient at length. The patient also had a small dog ear in the flank area on the right from the latissimus flap harvest, which was to be corrected. She had also had liposuction of the periumbilical and infraumbilical abdomen with desire to have great improvement superiorly, was felt to be a candidate for such. The above-noted procedure was discussed with the patient in detail. The risks, benefits and potential complications were discussed. She was marked in the upright position and then taken to the operating room for the above-noted procedure.,OPERATIVE PROCEDURE: , The patient was taken to the operating room and placed in the supine position. Following adequate induction of general LMA anesthesia, the chest and abdomen was prepped and draped in the usual sterile fashion. The supraumbilical abdomen was then injected with a solution of 5% lidocaine with epinephrine, as was the dog ear. At this time, the superior central scar was then excised, dissection continued through the subcutaneous tissue, the underlying latissimus muscle until the capsule of the implant was reached. This was then opened. The implant was removed and placed on the back table in antibiotic solution. Using Bovie cautery, the medial capsule was released and undermining was then performed with release of the muscle to the level of the proposed medial projection of the breast. The inframammary fold medially was secured with 2-0 PDS suture to create greater takeoff point at this level which in the upright position and using a sizer produced a good form. The lateral pocket was diminished by series of 2-0 PDS suture to provide medialization of the implant. The implant was then placed back into the submuscular pocket with much improved positioning and medial fullness. With this completed, the implant was again removed, antibiotic irrigation was performed. A drain was placed and brought out through a separate inferior stab wound incision and hemostasis was confirmed. The implant was then replaced and the wound was then closed in layers using 2-0 PDS running suture on the muscle and 3-0 Monocryl Dermabond subcuticular sutures. The 2.5 cm dog ear was then excised into and including the subcutaneous tissue, even contouring was achieved and this was closed with two layers using 3-0 Monocryl suture. Using a #3 cannula, a	correction. it was felt that mobilization of the implant medially would provide the patient significant improvement and this was discussed with the patient at length. the patient also had a small dog ear in the flank area on the right from the latissimus flap harvest, which was to be corrected. she had also had liposuction of the periumbilical and infraumbilical abdomen with desire to have great improvement superiorly, was felt to be a candidate for such. the above-noted procedure: was discussed with the patient in detail. the risks, benefits and potential complications were discussed. she was marked in the upright position and then taken to the operating room for the above-noted procedure:. operative procedure: , the patient was taken to the operating room and placed in the supine position. following adequate induction of general lma anesthesia, the chest and abdomen was prepped and draped in the usual sterile fashion. the supraumbilical abdomen was then injected with a solution of 5% lidocaine with epinephrine, as was the dog ear. at this time, the superior central scar was then excised, dissection continued through the subcutaneous tissue, the underlying latissimus muscle until the capsule of the implant was reached. this was then opened. the implant was removed and placed on the back table in antibiotic solution. using bovie cautery, the medial capsule was released and undermining was then performed with release of the muscle to the level of the proposed medial projection of the breast. the inframammary fold medially was secured with 2-0 pds suture to create greater takeoff point at this level which in the upright position and using a sizer produced a good form. the lateral pocket was diminished by series of 2-0 pds suture to provide medialization of the implant. the implant was then placed back into the submuscular pocket with much improved positioning and medial fullness. with this completed, the implant was again removed, antibiotic irrigation was performed. a drain was placed and brought out through a separate inferior stab wound incision and hemostasis was confirmed. the implant was then replaced and the wound was then closed in layers using

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	superior umbilical incision, liposuction was carried out into the supraumbilical abdomen, removing approximately 40 to 50 mL of fat with improved supraumbilical contours. This was closed with 6-0 Prolene suture. The patient was placed in a compressive garment after treating the incision with Dermabond, Steri-Strips and antibiotic ointment around the drain site and umbilicus. A Kerlix dressing and a surgical bra was placed to the chest area. A compressive garment was placed. The patient was then aroused from anesthesia, extubated, and taken to the recovery room in stable condition. Sponge, needle, lap, instrument counts were all correct. The patient tolerated the procedure well. There were no complications. The estimated blood loss was approximately 25 mL.	2-0 pds running suture on the muscle and 3-0 monocryl dermabond subcuticular sutures. the 2. 5 cm dog ear was then excised into and including the subcutaneous tissue, even contouring was achieved and this was closed with two layers using 3-0 monocryl suture. using a #3 cannula, a superior umbilical incision, liposuction was carried out into the supraumbilical abdomen, removing approximately 40 to 50 ml of fat with improved supraumbilical contours. this was closed with 6-0 prolene suture. the patient was placed in a compressive garment after treating the incision with dermabond, steri-strips and antibiotic ointment around the drain site and umbilicus. a kerlix dressing and a surgical bra was placed to the chest area. a compressive garment was placed. the patient was then aroused from anesthesia, extubated, and taken to the recovery room in stable condition. sponge, needle, lap, instrument counts were all correct. the patient tolerated the procedure: well. there were no complications. the estimated blood loss was approximately 25 ml.
7	2-D ECHOCARDIOGRAM,Multiple views of the heart and great vessels reveal normal intracardiac and great vessel relationships. Cardiac function is normal. There is no significant chamber enlargement or hypertrophy. There is no pericardial effusion or vegetations seen. Doppler interrogation, including color flow imaging, reveals systemic venous return to the right atrium with normal tricuspid inflow. Pulmonary outflow is normal at the valve. Pulmonary venous return is to the left atrium. The interatrial septum is intact. Mitral inflow and ascending aorta flow are normal. The aortic valve is trileaflet. The coronary arteries appear to be normal in their origins. The aortic arch is left-sided and patent with normal descending aorta pulsatility.	2-d echocardiogram,multiple views of the heart and great vessels reveal normal intracardiac and great vessel relationships. cardiac function is normal. there is no significant chamber enlargement or hypertrophy. there is no pericardial effusion or vegetations seen. doppler: interrogation, including color flow imaging, reveals systemic venous return to the right atrium with normal tricuspid inflow. pulmonary outflow is normal at the valve. pulmonary venous return is to the left atrium. the interatrial septum is intact. mitral inflow and ascending aorta flow are normal. the aortic valve is trileaflet. the coronary arteries appear to be normal in their origins. the aortic arch is left-sided and patent with normal descending aorta pulsatility.
8	PREOPERATIVE DIAGNOSIS: , Lipodystrophy of the abdomen and thighs.,POSTOPERATIVE DIAGNOSIS:, Lipodystrophy of the abdomen and thighs.,OPERATION: , Suction-assisted lipectomy.,ANESTHESIA:, General.,FINDINGS AND PROCEDURE:, With the patient under satisfactory general endotracheal anesthesia,	preoperative diagnosis: , lipodystrophy of the abdomen and thighs. postoperative diagnosis:, lipodystrophy of the abdomen and thighs. operation: , suction-assisted lipectomy. anesthesia:, general. findings: and procedure:, with the patient under satisfactory general

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	the entire abdomen, flanks, perineum, and thighs to the knees were prepped and draped circumferentially in sterile fashion. After this had been completed, a #15 blade was used to make small stab wounds in the lateral hips, the pubic area, and upper edge of the umbilicus. Through these small incisions, a cannula was used to infiltrate lactated Ringers with 1000 cc was infiltrated initially into the abdomen. A 3 and 4-mm cannulas were then used to carry out the liposuction of the abdomen removing a total of 1100 cc of aspirate, which was mostly fat, little fluid, and blood. Attention was then directed to the thighs both inner and outer. A total of 1000 cc was infiltrated in both lateral thighs only about 50 cc in the medial thighs. After this had been completed, 3 and 4-mm cannulas were used to suction 650 cc from each side, approximately 50 cc in the inner thigh and 600 on each lateral thigh. The patient tolerated the procedure very well. All of this aspirate was mostly fat with little fluid and very little blood. Wounds were cleaned and steri-stripped and dressing of ABD pads and ***** was then applied. The patient tolerated the procedure very well and was sent to the recovery room in good condition.	endotracheal anesthesia, the entire abdomen, flanks, perineum, and thighs to the knees were prepped and draped circumferentially in sterile fashion. after this had been completed, a #15 blade was used to make small stab wounds in the lateral hips, the pubic area, and upper edge of the umbilicus. through these small incisions, a cannula was used to infiltrate lactated ringers with 1000 cc was infiltrated initially into the abdomen. a 3 and 4-mm cannulas were then used to carry out the liposuction of the abdomen removing a total of 1100 cc of aspirate, which was mostly fat, little fluid, and blood. attention was then directed to the thighs both inner and outer. a total of 1000 cc was infiltrated in both lateral thighs only about 50 cc in the medial thighs. after this had been completed, 3 and 4-mm cannulas were used to suction 650 cc from each side, approximately 50 cc in the inner thigh and 600 on each lateral thigh. the patient tolerated the procedure: very well. all of this aspirate was mostly fat with little fluid and very little blood. wounds were cleaned and steri-stripped and dressing of abd pads and ***** was then applied. the patient tolerated the procedure: very well and was sent to the recovery room in good condition.
9	DESCRIPTION:,1. Normal cardiac chambers size.,2. Normal left ventricular size.,3. Normal LV systolic function. Ejection fraction estimated around 60%.,4. Aortic valve seen with good motion.,5. Mitral valve seen with good motion.,6. Tricuspid valve seen with good motion.,7. No pericardial effusion or intracardiac masses.,DOPPLER:,1. Trace mitral regurgitation.,2. Trace tricuspid regurgitation.,IMPRESSION:,1. Normal LV systolic function.,2. Ejection fraction estimated around 60%.,	description:, 1. normal cardiac chambers size. 2. normal left ventricular size. 3. normal lv systolic function. ejection fraction estimated around 60 percent. 4. aortic valve seen with good motion. 5. mitral valve seen with good motion. 6. tricuspid valve seen with good motion. 7. no pericardial effusion or intracardiac masses. doppler:, 1. trace mitral regurgitation. 2. trace tricuspid regurgitation. impression:, 1. normal lv systolic function. 2. ejection fraction estimated around 60 percent.
10	PREOPERATIVE DIAGNOSIS: , Morbid obesity. ,POSTOPERATIVE DIAGNOSIS: , Morbid obesity. ,PROCEDURE:, Laparoscopic Roux-en-Y gastric bypass, antecolic, antegastric with 25-mm EEA anastamosis, esophagogastroduodenoscopy. ,ANESTHESIA: , General with endotracheal intubation. ,INDICATIONS FOR PROCEDURE: , This is a 50-year-old male who has been overweight for many years and has tried multiple different weight loss diets and	preoperative diagnosis: , morbid obesity. ,postoperative diagnosis: , morbid obesity. , procedure:, laparoscopic roux-en-y gastric bypass, antecolic, antegastric with 25-mm eea anastamosis, esophagogastroduodenoscopy. ,anesthesia: , general with endotracheal intubation. ,indications for procedure: , this is a 50-year-old male who has been overweight for many years and has tried

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	programs. The patient has now begun to have comorbidities related to the obesity. The patient has attended our bariatric seminar and met with our dietician and psychologist. The patient has read through our comprehensive handout and understands the risks and benefits of bypass surgery as evidenced by the signing of our consent form.,PROCEDURE IN DETAIL: , The risks and benefits were explained to the patient. Consent was obtained. The patient was taken to the operating room and placed supine on the operating room table. General anesthesia was administered with endotracheal intubation. A Foley catheter was placed for bladder decompression. All pressure points were carefully padded, and sequential compression devices were placed on the legs. The abdomen was prepped and draped in standard, sterile, surgical fashion. Marcaine was injected into the umbilicus.	multiple different weight loss diets and programs. the patient has now begun to have comorbidities related to the obesity. the patient has attended our bariatric seminar and met with our dietician and psychologist. the patient has read through our comprehensive handout and understands the risks and benefits of bypass surgery as evidenced by the signing of our consent form. procedure: in detail: , the risks and benefits were explained to the patient. consent was obtained. the patient was taken to the operating room and placed supine on the operating room table. general anesthesia was administered with endotracheal intubation. a foley catheter was placed for bladder decompression. all pressure points were carefully padded, and sequential compression devices were placed on the legs. the abdomen was prepped and draped in standard, sterile, surgical fashion. marcaine was injected into the umbilicus.
11	2-D STUDY,1. Mild aortic stenosis, widely calcified, minimally restricted.,2. Mild left ventricular hypertrophy but normal systolic function.,3. Moderate biatrial enlargement.,4. Normal right ventricle.,5. Normal appearance of the tricuspid and mitral valves.,6. Normal left ventricle and left ventricular systolic function.,DOPPLER,1. There is 1 to 2+ aortic regurgitation easily seen, but no aortic stenosis.,2. Mild tricuspid regurgitation with only mild increase in right heart pressures, 30-35 mmHg maximum.,SUMMARY,1. Normal left ventricle.,2. Moderate biatrial enlargement.,3. Mild tricuspid regurgitation, but only mild increase in right heart pressures.	2-d study, 1. mild aortic stenosis, widely calcified, minimally restricted. 2. mild left ventricular hypertrophy but normal systolic function. 3. moderate biatrial enlargement. 4. normal right ventricle. 5. normal appearance of the tricuspid and mitral valves. 6. normal left ventricle and left ventricular systolic function. doppler: 1. there is 1 to 2+ aortic regurgitation easily seen, but no aortic stenosis. 2. mild tricuspid regurgitation with only mild increase in right heart pressures, 30-35 mmhg maximum. summary, 1. normal left ventricle. 2. moderate biatrial enlargement. 3. mild tricuspid regurgitation, but only mild increase in right heart pressures.
12	CC:, Confusion and slurred speech.,HX , (primarily obtained from boyfriend): This 31 y/o RHF experienced a "flu-like illness 6-8 weeks prior to presentation. 3-4 weeks prior to presentation, she was found "passed out" in bed, and when awoken appeared confused, and lethargic. She apparently recovered within 24 hours. For two weeks prior to presentation she demonstrated emotional lability, uncharacteristic of her (outbursts of anger and inappropriate laughter). She left a stove on.,She began slurring her speech 2 days prior to admission. On the day of presentation she developed	cc:, confusion and slurred speech. hx , (primarily obtained from boyfriend): this 31 y/o rhf experienced a "flu-like illness 6-8 weeks prior to presentation. 3-4 weeks prior to presentation, she was found "passed out" in bed, and when awoken appeared confused, and lethargic. she apparently recovered within 24 hours. for two weeks prior to presentation she demonstrated emotional lability, uncharacteristic of her (outbursts of anger and inappropriate laughter). she left a stove on. she began slurring her speech 2 days prior to

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right facial weakness and began stumbling to the right. She denied any associated headache, nausea, vomiting, fever, chills, neck stiffness or visual change. There was no history of illicit drug/ETOH use or head trauma.,PMH:, Migraine Headache.,FHX: , Unremarkable.,SHX: ,Divorced. Lives with boyfriend. 3 children alive and well. Denied tobacco/illicit drug use. Rarely consumes ETOH.,ROS:, Irregular menses.,EXAM: ,BP118/66. HR83. RR 20. T36.8C.,MS: Alert and oriented to name only. Perseverative thought processes. Utilized only one or two word answers/phrases. Non-fluent. Rarely followed commands. Impaired writing of name.,CN: Flattened right nasolabial fold only.,Motor: Mild weakness in RUE manifested by pronator drift. Other extremities were full strength.,Sensory: withdrew to noxious stimulation in all 4 extremities.,Coordination: difficult to assess.,Station: Right pronator drift.,Gait: unremarkable.,Reflexes: 2/2BUE, 3/3BLE, Plantars were flexor bilaterally.,General Exam: unremarkable.,INITIAL STUDIES:, CBC, GS, UA, PT, PTT, ESR, CRP, EKG were all unremarkable. Outside HCT showed hypodensities in the right putamen, left caudate, and at several subcortical locations (not specified).,COURSE: ,MRI Brian Scan, 2/11/92 revealed an old lacunar infarct in the right basal ganglia, edema within the head of the left caudate nucleus suggesting an acute ischemic event, and arterial enhancement of the left MCA distribution suggesting slow flow. The latter suggested a vasculopathy such as Moya Moya, or fibromuscular dysplasia. HIV, ANA, Anti-cardiolipin Antibody titer, Cardiac enzymes, TFTs, B12, and cholesterol studies were unremarkable.,She underwent a cerebral angiogram on 2/12/92. This revealed an occlusion of the left MCA just distal to its origin. The distal distribution of the left MCA filled on later films through collaterals from the left ACA. There was also an occlusion of the right MCA just distal to the temporal branch. Distal branches of the right MCA filled through collaterals from the right ACA. No other vascular abnormalities were noted. These findings were felt to be atypical but nevertheless suspicious of a large caliber vasculitis such as Moya Moya disease. She was subsequently given this diagnosis. Neuropsychologic testing revealed widespread cognitive dysfunction with particular impairment of language function. She had long latencies responding and	admission. on the day of presentation she developed right facial weakness and began stumbling to the right. she denied any associated headache, nausea, vomiting, fever, chills, neck stiffness or visual change. there was no history of illicit drug/etoh use or head trauma. pmh:, migraine headache. fhx: , unremarkable. shx: ,divorced. lives with boyfriend. 3 children alive and well. denied tobacco/illicit drug use. rarely consumes etoh. ros:, irregular menses. exam: ,bp118/ 66. hr 83. rr 20. t 36. 8c. ms: alert and oriented to name only. perseverative thought processes. utilized only one or two word answers/phrases. non-fluent. rarely followed commands. impaired writing of name. cn: flattened right nasolabial fold only. motor: mild weakness in rue manifested by pronator drift. other extremities were full strength. sensory: withdrew to noxious stimulation in all 4 extremities. coordination: difficult to assess. station: right pronator drift. gait: unremarkable. reflexes: 2/2bue, 3/3ble, plan:tars were flexor bilaterally. general exam: unremarkable. initial studies:, cbc, gs, ua, pt, ptt, esr, crp, ekg were all unremarkable. outside hct showed hypodensities in the right putamen, left caudate, and at several subcortical locations (not specified).course: ,mri brian scan, 2/11/92 revealed an old lacunar infarct in the right basal ganglia, edema within the head of the left caudate nucleus suggesting an acute ischemic event, and arterial enhancement of the left mca distribution suggesting slow flow. the latter suggested a vasculopathy such as moya moya, or fibromuscular dysplasia. hiv, ana, anti-cardiolipin antibody titer, cardiac enzymes, tfts, b12, and cholesterol studies were unremarkable. she underwent a cerebral angiogram on 2/12/ 92. this revealed an occlusion of the left mca just distal to its origin. the distal distribution of the left mca filled on later films through collaterals from the left aca. there was also an occlusion of the right mca just distal to the temporal branch. distal branches of the right mca filled through collaterals from the right aca. no other vascular abnormalities were noted. these findings: were felt to be atypical but nevertheless suspicious of a large

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	understood only simple questions. Affect was blunted and there was distinct lack of concern regarding her condition. She was subsequently discharged home on no medications.,In 9/92 she was admitted for sudden onset right hemiparesis and mental status change. Exam revealed the hemiparesis and in addition she was found to have significant neck lymphadenopathy. OB/GYN exam including cervical biopsy, and abdominal/pelvic CT scanning revealed stage IV squamous cell cancer of the cervix. She died 9/24/92 of cervical cancer.	caliber vasculitis such as moya moya disease. she was subsequently given this diagnosis:. neuropsychologic testing revealed widespread cognitive dysfunction with particular impairment of language function. she had long latencies responding and understood only simple questions. affect was blunted and there was distinct lack of concern regarding her condition. she was subsequently discharged home on no medications. in 9/92 she was admitted for sudden onset right hemiparesis and mental status change. exam revealed the hemiparesis and in addition she was found to have significant neck lymphadenopathy. ob/gyn exam including cervical biopsy, and abdominal/pelvic ct scanning revealed stage iv squamous cell cancer of the cervix. she died 9/24/92 of cervical cancer.
13	PAST MEDICAL HISTORY:, Significant for hypertension. The patient takes hydrochlorothiazide for this. She also suffers from high cholesterol and takes Crestor. She also has dry eyes and uses Restasis for this. She denies liver disease, kidney disease, cirrhosis, hepatitis, diabetes mellitus, thyroid disease, bleeding disorders, prior DVT, HIV and gout. She also denies cardiac disease and prior history of cancer.,PAST SURGICAL HISTORY: , Significant for tubal ligation in 1993. She had a hysterectomy done in 2000 and a gallbladder resection done in 2002.,MEDICATIONS: , Crestor 20 mg p.o. daily, hydrochlorothiazide 20 mg p.o. daily, Veramist spray 27.5 mcg daily, Restasis twice a day and ibuprofen two to three times a day.,ALLERGIES TO MEDICATIONS: , Bactrim which causes a rash. The patient denies latex allergy.,SOCIAL HISTORY: , The patient is a life long nonsmoker. She only drinks socially one to two drinks a month. She is employed as a manager at the New York department of taxation. She is married with four children.,FAMILY HISTORY: , Significant for type II diabetes on her mother's side as well as liver and heart failure. She has one sibling that suffers from high cholesterol and high triglycerides.,REVIEW OF SYSTEMS: , Positive for hot flashes. She also complains about snoring and occasional slight asthma. She does complain about peripheral ankle swelling and heartburn. She also gives a history of hemorrhoids and bladder infections in the past. She has weight bearing	past medical history:, significant for hypertension. the patient takes hydrochlorothiazide for this. she also suffers from high cholesterol and takes crestor. she also has dry eyes and uses restasis for this. she denies liver disease, kidney disease, cirrhosis, hepatitis, diabetes mellitus, thyroid disease, bleeding disorders, prior dvt, hiv and gout. she also denies cardiac disease and prior history of cancer. past surgical history: , significant for tubal ligation in 1993. she had a hysterectomy done in 2000 and a gallbladder resection done in 2002. medications: , crestor 20 mg p. o. daily, hydrochlorothiazide 20 mg p. o. daily, veramist spray 27. 5 mcg daily, restasis twice a day and ibuprofen two to three times a day. allergies to medications: , bactrim which causes a rash. the patient denies latex allergy. social history: , the patient is a life long nonsmoker. she only drinks socially one to two drinks a month. she is employed as a manager at the new york department of taxation. she is married with four children. family history: , significant for type ii diabetes on her mother's side as well as liver and heart failure. she has one sibling that suffers from high cholesterol and high triglycerides. review of systems: , positive for hot flashes. she also complains about snoring and occasional slight asthma. she does complain about

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	joint pain as well as low back degenerating discs. She denies obstructive sleep apnea, kidney stones, bloody bowel movements, ulcerative colitis, Crohn's disease, dark tarry stools and melena.,PHYSICAL EXAMINATION: ,On examination temperature is 97.7, pulse 84, blood pressure 126/80, respiratory rate was 20. Well nourished, well developed in no distress. Eye exam, pupils equal round and reactive to light. Extraocular motions intact. Neuro exam deep tendon reflexes 1+ in the lower extremities. No focal neuro deficits noted. Neck exam nonpalpable thyroid, midline trachea, no cervical lymphadenopathy, no carotid bruit. Lung exam clear breath sounds throughout without rhonchi or wheezes however diminished. Cardiac exam regular rate and rhythm without murmur or bruit. Abdominal exam positive bowel sounds, soft, nontender, obese, nondistended abdomen. No palpable tenderness. No right upper quadrant tenderness. No organomegaly appreciated. No obvious hernias noted. Lower extremity exam +1 edema noted. Positive dorsalis pedis pulses.,ASSESSMENT: , The patient is a 56-year-old female who presents to the bariatric surgery service with a body mass index of 41 with obesity related comorbidities. The patient is interested in gastric bypass surgery. The patient appears to be an excellent candidate and would benefit greatly in the management of her comorbidities.,PLAN: , In preparation for surgery will obtain the usual baseline laboratory values including baseline vitamin levels. Will proceed with our usual work up with an upper GI series as well as consultations with the dietician and the psychologist preoperatively. I have recommended six weeks of Medifast for the patient to obtain a 10% preoperative weight loss.	peripheral ankle swelling and heartburn. she also gives a history of hemorrhoids and bladder infections in the past. she has weight bearing joint pain as well as low back degenerating discs. she denies obstructive sleep apnea, kidney stones, bloody bowel movements, ulcerative colitis, crohn's disease, dark tarry stools and melena. physical examination: ,on examination temperature is 97. 7, pulse 84, blood pressure 126/80, respiratory rate was 20. well nourished, well developed in no distress. eye exam, pupils equal round and reactive to light. extraocular motions intact. neuro exam deep tendon reflexes 1+ in the lower extremities. no focal neuro deficits noted. neck exam nonpalpable thyroid, midline trachea, no cervical lymphadenopathy, no carotid bruit. lung exam clear breath sounds throughout without rhonchi or wheezes however diminished. cardiac exam regular rate and rhythm without murmur or bruit. abdominal exam positive bowel sounds, soft, nontender, obese, nondistended abdomen. no palpable tenderness. no right upper quadrant tenderness. no organomegaly appreciated. no obvious hernias noted. lower extremity exam +1 edema noted. positive dorsalis pedis pulses. assessment: , the patient is a 56-year-old female who presents to the bariatric surgery service with a body mass index of 41 with obesity related comorbidities. the patient is interested in gastric bypass surgery. the patient appears to be an excellent candidate and would benefit greatly in the management of her comorbidities. plan: , in preparation for surgery will obtain the usual baseline laboratory values including baseline vitamin levels. will proceed with our usual work up with an upper gi series as well as consultations with the dietician and the psychologist preoperatively. i have recommended six weeks of medifast for the patient to obtain a 10% preoperative weight loss.
14	PREOPERATIVE DIAGNOSIS:, Completely bony impacted teeth #1, #16, #17, and #32.,POSTOPERATIVE DIAGNOSIS: , Completely bony impacted teeth #1, #16, #17, and #32.,PROCEDURE: , Surgical removal of completely bony impacted teeth #1, #16, #17, and #32.,ANESTHESIA: , General nasotracheal.,COMPLICATIONS: ,	preoperative diagnosis:, completely bony impacted teeth #1, #16, #17, and # 32. postoperative diagnosis: , completely bony impacted teeth #1, #16, #17, and # 32. procedure: , surgical removal of completely bony impacted teeth #1, #16, #17, and # 32. anesthesia: , general nasotracheal. complications: ,

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None.,CONDITION: ,Stable to PACU.,DESCRIPTION OF PROCEDURE: , Patient was brought to the operating room, placed on the table in a supine position, and after demonstration of an adequate plane of general anesthesia via the nasotracheal route, patient was prepped and draped in the usual fashion for an intraoral procedure. A gauze throat pack was placed and local anesthetic was administered in all four quadrants, a total of 7.2 mL of lidocaine 2% with 1:100,000 epinephrine, and 3.6 mL of bupivacaine 0.5% with 1:200,000 epinephrine. Beginning on the upper right tooth #1, incision was made with a #15 blade. Envelope flap was raised with the periosteal elevator, and bone was removed on the buccal aspect with straight elevator. Potts elevator was then used to luxate the tooth from the socket. Remnants of the follicle were then removed with hemostat. The area was irrigated and then closed with 3-0 gut suture. On the lower right tooth #32, incision was made with a #15 blade. Envelope flap was raised with the periosteal elevator, and bone was removed on the buccal and distal aspect with a high-speed drill with a round bur. Tooth was then sectioned with the bur and removed in several pieces. Remnants of the follicle were removed with a curved hemostat. The area was irrigated with normal saline solution and closed with 3-0 gut sutures. Moving to #16 on the upper left, incision was made with a #15 blade. Envelope flap was raised with the periosteal elevator, and bone was removed on the buccal aspect with straight elevator. Potts elevator was then used to luxate the tooth from the socket. Remnants of the follicle were removed with a curved hemostat. The area was irrigated with normal saline solution and closed with 3-0 gut sutures. Moving to the lower left #17, incision was made with a #15 blade. Envelope flap was raised with the periosteal elevator, and bone was removed on the buccal and distal aspect with high-speed drill with a round bur. Then the bur was used to section the tooth vertically. Tooth was removed in several pieces followed by the removal of the remnants of the follicle. The area was irrigated with normal saline solution and closed with 3-0 gut sutures. Upon completion of the procedure, the throat pack was removed and the pharynx was suctioned. An NG tube was then inserted and small amount of gastric contents were suctioned. Patient was then awakened, extubated, and taken to the PACU in stable condition.	none. condition: ,stable to pacu. description: of procedure: , patient was brought to the operating room, placed on the table in a supine position, and after demonstration of an adequate plan:e of general anesthesia via the nasotracheal route, patient was prepped and draped in the usual fashion for an intraoral procedure:. a gauze throat pack was placed and local anesthetic was administered in all four quadrants, a total of 7. 2 ml of lidocaine 2% with 1:100,000 epinephrine, and 3. 6 ml of bupivacaine 0. 5% with 1:200,000 epinephrine. beginning on the upper right tooth #1, incision was made with a #15 blade. envelope flap was raised with the periosteal elevator, and bone was removed on the buccal aspect with straight elevator. potts elevator was then used to luxate the tooth from the socket. remnants of the follicle were then removed with hemostat. the area was irrigated and then closed with 3-0 gut suture. on the lower right tooth #32, incision was made with a #15 blade. envelope flap was raised with the periosteal elevator, and bone was removed on the buccal and distal aspect with a high-speed drill with a round bur. tooth was then sectioned with the bur and removed in several pieces. remnants of the follicle were removed with a curved hemostat. the area was irrigated with normal saline solution and closed with 3-0 gut sutures. moving to #16 on the upper left, incision was made with a #15 blade. envelope flap was raised with the periosteal elevator, and bone was removed on the buccal aspect with straight elevator. potts elevator was then used to luxate the tooth from the socket. remnants of the follicle were removed with a curved hemostat. the area was irrigated with normal saline solution and closed with 3-0 gut sutures. moving to the lower left #17, incision was made with a #15 blade. envelope flap was raised with the periosteal elevator, and bone was removed on the buccal and distal aspect with high-speed drill with a round bur. then the bur was used to section the tooth vertically. tooth was removed in several pieces followed by the removal of the remnants of the follicle. the area was irrigated with normal saline solution and closed with 3-0 gut sutures. upon completion of the

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		procedure: the throat pack was removed and the pharynx was suctioned. an ng tube was then inserted and small amount of gastric contents were suctioned. patient was then awakened, extubated, and taken to the pacu in stable condition.
15	HISTORY OF PRESENT ILLNESS: ,I have seen ABC today for her preoperative visit for weight management. I have explained to her the need for Optifast for weight loss prior to these procedures to make it safer because of the large size of her liver. She understands this.,IMPRESSION/PLAN:, We are going to put her on two weeks of Optifast at around 900 calories. I have also explained the risks and potential complications of laparoscopic cholecystectomy to her in detail including bleeding, infection, deep venous thrombosis, pulmonary embolism, injury to the small intestine, stomach, liver, leak from the cystic duct, common bile duct, and possible need for ERCP and further surgery. This surgery is going to be planned for October 6. This is for cholelithiasis prior to her Lap-Banding procedure.,I have also reviewed with her the risks and potential complications of laparoscopic gastric banding including bleeding, infection, deep venous thrombosis, pulmonary embolism, slippage of the band, erosion of the band, injury to the esophagus, stomach, small intestine, large intestine, spleen, liver, injury to the band, port, or tubing necessitating replacement of the band, port, or tubing among other potential complications and she understands. We are going to proceed for laparoscopic gastric banding. I have reviewed her entire chart in detail. I have also gone over with her the Fairfield County Bariatrics consent form for banding and all the risks. She has also signed the St. Vincent's Hospital consent form for Lap-Banding. She has taken the preoperative quiz for banding. She has signed the preop and postop instructions, and understands them and we reviewed them. She has taken the quiz and done fairly well. We have reviewed with her any potential other issues and I have answered her questions. She is planned for surgical intervention.,	history of present illness: ,i have seen abc today for her preoperative visit for weight management. i have explained to her the need for optifast for weight loss prior to these procedure:s to make it safer because of the large size of her liver. she understands this. impression:/ plan:, we are going to put her on two weeks of optifast at around 900 calories. i have also explained the risks and potential complications of laparoscopic cholecystectomy to her in detail including bleeding, infection, deep venous thrombosis, pulmonary embolism, injury to the small intestine, stomach, liver, leak from the cystic duct, common bile duct, and possible need for ercp and further surgery. this surgery is going to be plan:ned for october 6. this is for cholelithiasis prior to her lap-banding procedure:. i have also reviewed with her the risks and potential complications of laparoscopic gastric banding including bleeding, infection, deep venous thrombosis, pulmonary embolism, slippage of the band, erosion of the band, injury to the esophagus, stomach, small intestine, large intestine, spleen, liver, injury to the band, port, or tubing necessitating replacement of the band, port, or tubing among other potential complications and she understands. we are going to proceed for laparoscopic gastric banding. i have reviewed her entire chart in detail. i have also gone over with her the fairfield county bariatrics consent form for banding and all the risks. she has also signed the st. vincent's hospital consent form for lap-banding. she has taken the preoperative quiz for banding. she has signed the preop and postop instructions, and understands them and we reviewed them. she has taken the quiz and done fairly well. we have reviewed with her any potential other issues and i have answered her questions. she is plan:ned for surgical intervention.

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16	PREOPERATIVE DIAGNOSES,Airway obstruction secondary to severe subglottic tracheal stenosis with foreign body in the trachea.,POSTOPERATIVE DIAGNOSES,Airway obstruction secondary to severe subglottic tracheal stenosis with foreign body in the trachea.,OPERATION PERFORMED,Neck exploration; tracheostomy; urgent flexible bronchoscopy via tracheostomy site; removal of foreign body, tracheal metallic stent material; dilation distal trachea; placement of #8 Shiley single cannula tracheostomy tube.,INDICATIONS FOR SURGERY,The patient is a 50-year-old white male with history of progressive tracheomalacia treated in the National Tennessee, and several years ago he had a tracheal metallic stent placed with some temporary improvement. However developed progressive problems and he had two additional stents placed with some initial improvement. Subsequently, he developed progressive airway obstruction and came into the ABC Hospital critical airway service for further evaluation and was admitted on Month DD, YYYY. He underwent bronchoscopy by Dr. W and found to have an extensive subglottic upper tracheal and distal tracheal stenosis secondary to metallic stent extensive granulation and inflammatory tissue changes. The patient had some debridement and then was hospitalized and Laryngology and Thoracic Surgery services were consulted for further management. Exploration of trachea, removal of foreign body stents constricting his airway, dilation and stabilization of his trachea were offered to the patient. Nature of the proposed procedure including risks and complications of bleeding, infection, alteration of voice, speech, swallowing, voice changes permanently, possibility of tracheotomy temporarily or permanently to maintain his airway, loss of voice, cardiac risk factors, anesthetic risks, recurrence of problems, upon surgical intervention were all discussed at length. The patient stated that he understood and wished to proceed.,DESCRIPTION OF PROCEDURE,The patient was taken to the operating room, placed in the supine position. Following adequate monitoring by Anesthesia Service to maintain sedation, the patient's neck was prepped and draped in the sterile fashion. The neck was then infiltrated with 1% Xylocaine and 1000 epinephrine. A collar incision approximately 1 fingerbreadth above	preoperative diagnoses,airway obstruction secondary to severe subglottic tracheal stenosis with foreign body in the trachea. postoperative diagnoses,airway obstruction secondary to severe subglottic tracheal stenosis with foreign body in the trachea. operation performed,neck exploration; tracheostomy; urgent flexible bronchoscopy via tracheostomy site; removal of foreign body, tracheal metallic stent material; dilation distal trachea; placement of #8 shiley single cannula tracheostomy tube. indications for surgery,the patient is a 50-year-old white male with history of progressive tracheomalacia treated in the national tennessee, and several years ago he had a tracheal metallic stent placed with some temporary improvement. however developed progressive problems and he had two additional stents placed with some initial improvement. subsequently, he developed progressive airway obstruction and came into the abc hospital critical airway service for further evaluation and was admitted on month dd, yyyy. he underwent bronchoscopy by dr. w and found to have an extensive subglottic upper tracheal and distal tracheal stenosis secondary to metallic stent extensive granulation and inflammatory tissue changes. the patient had some debridement and then was hospitalized and laryngology and thoracic surgery services were consulted for further management. exploration of trachea, removal of foreign body stents constricting his airway, dilation and stabilization of his trachea were offered to the patient. nature of the proposed procedure: including risks and complications of bleeding, infection, alteration of voice, speech, swallowing, voice changes permanently, possibility of tracheotomy temporarily or permanently to maintain his airway, loss of voice, cardiac risk factors, anesthetic risks, recurrence of problems, upon surgical intervention were all discussed at length. the patient stated that he understood and wished to proceed. description: of procedure:the patient was taken to the operating room, placed in the supine position. following adequate monitoring by anesthesia service to maintain sedation, the

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the clavicle, this was an outline incision, was carried out. The skin, subcutaneous tissue, platysma, subplatysmal flaps elevated superiorly and inferiorly. Strap muscles were separated in the midline, dissection carried down to visceral fascia. Beneath the strap muscles, there was dense inflammation scarring obscuring palpable landmarks. There appeared to be significant scarring fusion of soft tissue at the perichondrium and cartilage of the cricoid making the cricoid easily definable. There was a markedly enlarged thyroid isthmus. Thyroid isthmus was divided and dense inflammation, attachment of the thyroid isthmus, fusion of the thyroid gland to the capsule to the pretracheal fascia requiring extensive blunt sharp dissection. Trachea was exposed from the cricoid to the fourth ring which entered down into the chest. The trachea was incised between the second and third ring inferior limb in the midline and excision of small ridge of cartilage on each side sent for pathologic evaluation. The tracheal cartilage externally had marked thickening and significant stiffness calcification, and the tracheal wall from the outside of the trachea to the mucosa measured 3 to 4 mm in thickness. The trachea was entered and visualized with thickening of the mucosa and submucosa was noted. The patient, however, was able to ventilate at this point a #6 Endo Tube was inserted and general anesthesia administered. Once the airway was secured, we then proceeded working around the #6 Endo Tube as well as with the tube intake and out to explore the trachea with ridged fiberoptic scopes as well as flexible fiberoptic bronchoscopy to the trach site. Examination revealed extrusion of metallic fragments from stent and multiple metallic fragments were removed from the stent in the upper trachea. A careful examination of the subglottic area showed inflamed and thickened mucosa but patent subglottis. After removal of the stents and granulation tissue, the upper trachea was widely patent. The mid trachea had some marked narrowing secondary to granulation. Stent material was removed from this area as well. In the distal third of the trachea, a third stent was embedded within the mucosa, not encroaching on the lumen without significant obstruction distally and this was not disturbed at this time. All visible stent material in the upper and mid trachea were removed. Initial attempt to place a #16 Montgomery T tube showed the distal lumen of the T tube to be too short to stent the	patient's neck was prepped and draped in the sterile fashion. the neck was then infiltrated with 1% xylocaine and 1000 epinephrine. a collar incision approximately 1 fingerbreadth above the clavicle, this was an outline incision, was carried out. the skin, subcutaneous tissue, platysma, subplatysmal flaps elevated superiorly and inferiorly. strap muscles were separated in the midline, dissection carried down to visceral fascia. beneath the strap muscles, there was dense inflammation scarring obscuring palpable landmarks. there appeared to be significant scarring fusion of soft tissue at the perichondrium and cartilage of the cricoid making the cricoid easily definable. there was a markedly enlarged thyroid isthmus. thyroid isthmus was divided and dense inflammation, attachment of the thyroid isthmus, fusion of the thyroid gland to the capsule to the pretracheal fascia requiring extensive blunt sharp dissection. trachea was exposed from the cricoid to the fourth ring which entered down into the chest. the trachea was incised between the second and third ring inferior limb in the midline and excision of small ridge of cartilage on each side sent for pathologic evaluation. the tracheal cartilage externally had marked thickening and significant stiffness calcification, and the tracheal wall from the outside of the trachea to the mucosa measured 3 to 4 mm in thickness. the trachea was entered and visualized with thickening of the mucosa and submucosa was noted. the patient, however, was able to ventilate at this point a #6 endo tube was inserted and general anesthesia administered. once the airway was secured, we then proceeded working around the #6 endo tube as well as with the tube intake and out to explore the trachea with ridged fiberoptic scopes as well as flexible fiberoptic bronchoscopy to the trach site. examination revealed extrusion of metallic fragments from stent and multiple metallic fragments were removed from the stent in the upper trachea. a careful examination of the subglottic area showed inflamed and thickened mucosa but patent subglottis. after removal of the stents and granulation tissue, the upper trachea

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	granulation narrowing of the trachea at the junction of the anterior two thirds and the distal third. Also, this was removed and a #8 Shiley single cannula tracheostomy tube was placed after removal of the endotracheal tube. A good ventilation was confirmed and the position of the tube confirmed it to be at the level just above the metallic stent which was embedded in the mucosa. The distal trachea and mainstem bronchi were widely patent. This secured his airway and no further manipulation felt to be needed at this time. Neck wound was thoroughly irrigated and strap muscles were closed with interrupted 3-0 Vicryl. The skin laterally to the trach site was closed with running 2-0 Prolene. Tracheostomy tube was secured with interrupted 2-0 silk sutures and the patient was taken back to the Intensive Care Unit in satisfactory condition. The patient tolerated the procedure well without complication.	was widely patent. the mid trachea had some marked narrowing secondary to granulation. stent material was removed from this area as well. in the distal third of the trachea, a third stent was embedded within the mucosa, not encroaching on the lumen without significant obstruction distally and this was not disturbed at this time. all visible stent material in the upper and mid trachea were removed. initial attempt to place a #16 montgomery t tube showed the distal lumen of the t tube to be too short to stent the granulation narrowing of the trachea at the junction of the anterior two thirds and the distal third. also, this was removed and a #8 shiley single cannula tracheostomy tube was placed after removal of the endotracheal tube. a good ventilation was confirmed and the position of the tube confirmed it to be at the level just above the metallic stent which was embedded in the mucosa. the distal trachea and mainstem bronchi were widely patent. this secured his airway and no further manipulation felt to be needed at this time. neck wound was thoroughly irrigated and strap muscles were closed with interrupted 3-0 vicryl. the skin laterally to the trach site was closed with running 2-0 prolene. tracheostomy tube was secured with interrupted 2-0 silk sutures and the patient was taken back to the intensive care unit in satisfactory condition. the patient tolerated the procedure: well without complication.
17	REASON FOR VISIT:, Lap band adjustment.,HISTORY OF PRESENT ILLNESS:, Ms. A is status post lap band placement back in 01/09 and she is here on a band adjustment. Apparently, she had some problems previously with her adjustments and apparently she has been under a lot of stress. She was in a car accident a couple of weeks ago and she has problems, she does not feel full. She states that she is not really hungry but she does not feel full and she states that she is finding when she is hungry at night, having difficulty waiting until the morning and that she did mention that she had a candy bar and that seemed to make her feel better.,PHYSICAL EXAMINATION: , On exam, her temperature is 98, pulse 76, weight 197.7 pounds, blood pressure 102/72, BMI is 38.5, she has lost 3.8 pounds since her last visit. She was alert and oriented in no	reason for visit:, lap band adjustment. history of present illness:, ms. a is status post lap band placement back in 01/09 and she is here on a band adjustment. apparently, she had some problems previously with her adjustments and apparently she has been under a lot of stress. she was in a car accident a couple of weeks ago and she has problems, she does not feel full. she states that she is not really hungry but she does not feel full and she states that she is finding when she is hungry at night, having difficulty waiting until the morning and that she did mention that she had a candy bar and that seemed to make her feel better. physical examination: , on exam, her temperature is 98, pulse 76, weight 197. 7 pounds, blood pressure 102/72, bmi is 38. 5, she

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	apparent distress. ,PROCEDURE: ,I was able to access her port. She does have an AP standard low profile. I aspirated 6 mL, I did add 1 mL, so she has got approximately 7 mL in her band, she did tolerate water postprocedure.,ASSESSMENT:, The patient is status post lap band adjustments, doing well, has a total of 7 mL within her band, tolerated water postprocedure. She will come back in two weeks for another adjustment as needed.,	has lost 3. 8 pounds since her last visit. she was alert and oriented in no apparent distress. , procedure: ,i was able to access her port. she does have an ap standard low profile. i aspirated 6 ml, i did add 1 ml, so she has got approximately 7 ml in her band, she did tolerate water postprocedure. assessment:, the patient is status post lap band adjustments, doing well, has a total of 7 ml within her band, tolerated water postprocedure. she will come back in two weeks for another adjustment as needed.
18	PROCEDURE: , Elective male sterilization via bilateral vasectomy.,PREOPERATIVE DIAGNOSIS: ,Fertile male with completed family.,POSTOPERATIVE DIAGNOSIS:, Fertile male with completed family.,MEDICATIONS: ,Anesthesia is local with conscious sedation.,COMPLICATIONS: , None.,BLOOD LOSS: , Minimal.,INDICATIONS: ,This 34-year-old gentleman has come to the office requesting sterilization via bilateral vasectomy. I discussed the indications and the need for procedure with the patient in detail, and he has given consent to proceed. He has been given prophylactic antibiotics.,PROCEDURE NOTE: , Once satisfactory sedation have been obtained, the patient was placed in the supine position on the operating table. Genitalia was shaved and then prepped with Betadine scrub and paint solution and were draped sterilely. The procedure itself was started by grasping the right vas deferens in the scrotum, and bringing it up to the level of the skin. The skin was infiltrated with 2% Xylocaine and punctured with a sharp hemostat to identify the vas beneath. The vas was brought out of the incision carefully. A 2-inch segment was isolated, and 1-inch segment was removed. The free ends were cauterized and were tied with 2-0 silk sutures in such a fashion that the ends double back on themselves. After securing hemostasis with a cautery, the ends were allowed to drop back into the incision, which was also cauterized.,Attention was now turned to the left side. The vas was grasped and brought up to the level of the skin. The skin was infiltrated with 2% Xylocaine and punctured with a sharp hemostat to identify the vas beneath. The vas was brought out of the incision carefully. A 2-inch segment was isolated, and 1-inch segment was removed. The free ends were cauterized and tied with 2-0 silk sutures in	procedure: , elective male sterilization via bilateral vasectomy. preoperative diagnosis: ,fertile male with completed family. postoperative diagnosis:, fertile male with completed family. medications: ,anesthesia is local with conscious sedation. complications: , none. blood loss: , minimal. indications: ,this 34-year-old gentleman has come to the office requesting sterilization via bilateral vasectomy. i discussed the indications and the need for procedure: with the patient in detail, and he has given consent to proceed. he has been given prophylactic antibiotics. procedure: note: , once satisfactory sedation have been obtained, the patient was placed in the supine position on the operating table. genitalia was shaved and then prepped with betadine scrub and paint solution and were draped sterilely. the procedure: itself was started by grasping the right vas deferens in the scrotum, and bringing it up to the level of the skin. the skin was infiltrated with 2% xylocaine and punctured with a sharp hemostat to identify the vas beneath. the vas was brought out of the incision carefully. a 2-inch segment was isolated, and 1-inch segment was removed. the free ends were cauterized and were tied with 2-0 silk sutures in such a fashion that the ends double back on themselves. after securing hemostasis with a cautery, the ends were allowed to drop back into the incision, which was also cauterized. attention was now turned to the left side. the vas was grasped and brought up to the level of the skin. the skin was infiltrated with 2% xylocaine and punctured with a sharp hemostat to identify the vas beneath. the vas was

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	such a fashion that the ends double back on themselves. After securing hemostasis with the cautery, the ends were allowed to drop back into the incision, which was also cauterized.,Bacitracin ointment was applied as well as dry sterile dressing. The patient was awakened and was returned to Recovery in satisfactory condition.	brought out of the incision carefully. a 2-inch segment was isolated, and 1-inch segment was removed. the free ends were cauterized and tied with 2-0 silk sutures in such a fashion that the ends double back on themselves. after securing hemostasis with the cautery, the ends were allowed to drop back into the incision, which was also cauterized. bacitracin ointment was applied as well as dry sterile dressing. the patient was awakened and was returned to recovery in satisfactory condition.
19	HISTORY OF PRESENT ILLNESS:, The patient is a 17-year-old female, who presents to the emergency room with foreign body and airway compromise and was taken to the operating room. She was intubated and fishbone.,PAST MEDICAL HISTORY: , Significant for diabetes, hypertension, asthma, cholecystectomy, and total hysterectomy and cataract.,ALLERGIES: ,No known drug allergies.,CURRENT MEDICATIONS: , Prevacid, Humulin, Diprivan, Proventil, Unasyn, and Solu-Medrol.,FAMILY HISTORY: , Noncontributory.,SOCIAL HISTORY: , Negative for illicit drugs, alcohol, and tobacco.,PHYSICAL EXAMINATION: ,Please see the hospital chart.,LABORATORY DATA: , Please see the hospital chart.,HOSPITAL COURSE: , The patient was taken to the operating room by Dr. X who is covering for ENT and noted that she had airway compromise and a rather large fishbone noted and that was removed. The patient was intubated and it was felt that she should be observed to see if the airway would improve upon which she could be extubated. If not she would require tracheostomy. The patient was treated with IV antibiotics and ventilatory support and at the time of this dictation, she has recently been taken to the operating room where it was felt that the airway sufficient and she was extubated. She was doing well with good p.o.s, good airway, good voice, and desiring to be discharged home. So, the patient is being prepared for discharge at this point. We will have Dr. X evaluate her before she leaves to make sure I do not have any problem with her going home. Dr. Y feels she could be discharged today and will have her return to see him in a week.	history of present illness:, the patient is a 17-year-old female, who presents to the emergency room with foreign body and airway compromise and was taken to the operating room. she was intubated and fishbone. past medical history: , significant for diabetes, hypertension, asthma, cholecystectomy, and total hysterectomy and cataract. allergies: ,no known drug allergies. current medications: , prevacid, humulin, diprivan, proventil, unasyn, and solu-medrol. family history: , noncontributory. social history: , negative for illicit drugs, alcohol, and tobacco. physical examination: ,please see the hospital chart. laboratory data: , please see the hospital chart. hospital course: , the patient was taken to the operating room by dr. x who is covering for ent and noted that she had airway compromise and a rather large fishbone noted and that was removed. the patient was intubated and it was felt that she should be observed to see if the airway would improve upon which she could be extubated. if not she would require tracheostomy. the patient was treated with iv antibiotics and ventilatory support and at the time of this dictation, she has recently been taken to the operating room where it was felt that the airway sufficient and she was extubated. she was doing well with good p. o. s, good airway, good voice, and desiring to be discharged home. so, the patient is being prepared for discharge at this point. we will have dr. x evaluate her before she leaves to make sure i do not have any problem with her going home. dr. y feels she could be discharged today and will have her return to see him in a week.

In [69]:
```
df_final = df[[
    'description_clean',
    'medical_specialty_clean',
    'sample_name_clean',
    'keywords_clean',
    'transcription_formatted'
]]
```

In [70]:
```
df_final.to_csv('cleaned_medical_transcriptions.csv', index=False)
```

In [71]:
```
!ls -lh cleaned_medical_transcriptions.csv
```

```
-rw-r--r--@ 1 sujanayeasmin  staff    16M Aug  6 21:59 cleaned_medical_trans
criptions.csv
```

In [72]:
```
df_check = pd.read_csv('cleaned_medical_transcriptions.csv')
```

In [73]:
```
df_check.head()           # See first 5 rows
df_check.sample(5)        # See 5 random rows
df_check.columns          # View column names
df_check.info()           # Get structure, nulls, dtypes
```

```
<class 'pandas.core.frame.DataFrame'>
RangeIndex: 4999 entries, 0 to 4998
Data columns (total 5 columns):
 #   Column                  Non-Null Count  Dtype 
---  ------                  --------------  ----- 
 0   description_clean       4993 non-null   object
 1   medical_specialty_clean  4999 non-null   object
 2   sample_name_clean       4999 non-null   object
 3   keywords_clean          3850 non-null   object
 4   transcription_formatted  4966 non-null   object
dtypes: object(5)
memory usage: 195.4+ KB
```

In [ ]:
```

```