3282\_:-:\_14190\_:-:\_

Admission Date: [\*\*2679-10-23\*\*] Discharge Date: [\*\*2679-10-30\*\*]

Date of Birth: [\*\*2636-11-25\*\*] Sex: F

Service: Neurology

HISTORY OF PRESENT ILLNESS: This is a 42 year old woman with

history of metastatic melanoma diagnosed in [\*\*2673\*\*], status post

chemotherapy here at [\*\*Hospital6 273\*\*] who

presents with acute onset of right hemiparesis and expressive

aphasia since earlier this evening. History is provided by

her fiance and husband who are at the bedside. At 7:35 PM

tonight she lost motor movement of her right arm without

sensory loss. Over the next 15 to 20 minutes she noted that

her right leg was also weak. Emergency medical services was

called and as she was on her way here she began to lose her

speech. She was unable to talk but was able to understand

and follow commands. Her symptoms progressively got worse

over time and have stabilized over the last two hours and

there have been no significant changes since. The family

denies any seizure activity or shaking movements. She denies

any headache, sensory loss or other complaints. There was no

loss of bowel or bladder control or candlelighting. There

were no similar episodes in the past. Review of systems is

essentially negative per family except for longstanding left

hip pain due to metaphysis.

PAST MEDICAL HISTORY: 1. Metastatic melanoma on maintenance

IL2 with Dr. [\*\*Last Name (STitle) \*\*]; 2. Left groin metaphysis in the

gluteal region, status post surgery.

MEDICATIONS: MS Contin 60 mg p.o. q.d.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: She lives in her fiance and is from [\*\*Location (un) \*\*],

Mass.

FAMILY HISTORY: Multiple relatives with cancer and paternal

grandmother with coronary artery disease.

PHYSICAL EXAMINATION: Afebrile, blood pressure 142/71, pulse

100, respiratory rate 18. Generally, lucid woman in general

discomfort holding her fiance's hand. Neck, limited range of

motion with no pain. The patient resists movements. Lungs

are clear to auscultation bilaterally. Cardiovascular,

regular rate and rhythm. On neurological examination, she is

awake and for the most part alert, mostly cooperative with

examination. Language no verbal output. She can follow

simple commands like closing her eyes and protruding her

tongue. She can also follow more complex commands, crossing

midline, showing two fingers. On cranial nerve examination,

she blinks to visual threat bilaterally. Funduscopic not

well visualized due to lack of cooperation. Pupils equal,

round and reactive to light, 42 mm bilaterally. Extraocular

eye movements are intact with sticcottic eye movements and no

nystagmus. Facial sensation can not be assessed. Facial

movement has marked right facial droop as well as some slight

right upper face weakness. Hearing is intact to finger rub

bilaterally. Tongue is midline without fasciculation.

Sternocleidomastoid and trapezius is normal only on the left.

On motor examination, she has normal bulk and tone

bilaterally. There is no tremor. There is dense right

hemiparesis 0 out of 5 with the right arm flexed upward in

upper motor neuron pattern. Muscle strength on the left was

suboptimal effort but no focal weakness besides that limited

by pain, especially on the left lower extremity. Sensory

examination, it is difficult to assess but she denies any

changes to light touch, pinprick, temperature or vibration.

She withdraws to pain in the left lower extremity and upper

extremity. Her reflexes are brisk throughout 3 out of 4 and

symmetric. Her grasp reflex is absent. Toes are upgoing

bilaterally. On coordination examination, she is intact to

finger-to-nose test on the left with slow rapid alternating

movements. Gait was not assessed.

LABORATORY DATA: Laboratory data and radiology upon

admission revealed sodium 142, chloride 105, BUN 10, glucose

123, potassium 3.2, bicarbonate 27, creatinine 0.6, calcium

9.8, magnesium 1.8, phosphate 2.9. White count 6.7,

hemoglobin 11.3, hematocrit 34.1, platelets 227. PT 12.6,

PTT 27.1, INR 1.1. Noncontrast head computerized tomography

scan shows a left frontal 3.5 by 3.4 cm hemorrhagic

metastatic lesion and a left posterior parietal hemorrhagic

lesion. The patient was started on Dilantin for seizure

prophylaxis.

HOSPITAL COURSE: She was initially admitted to the Intensive

Care Unit for blood pressure monitoring. A magnetic

resonance imaging scan of the brain was done showing a left

frontal, left posterior parietal and left superior parietal

hemorrhagic metastatic lesion. The patient remained stable

and was called out to the floor. While on the floor, she

continued to have a dense right hemiplegia but her verbal

output did return. The Neurosurgery Service was consulted

and they recommended that the left frontal metastatic lesion

be excised and the patient was accepting of this offer.

Radiation Oncology and Neuro-Oncology was consulted and both

felt that the patient should have stereotactic radiation

after the surgical resection of her left frontal metastatic

lesion. In addition, her Dilantin was switched over to

Keppra given that the Dilantin will give her a higher

threshold of seizures during the radiation. The patient was

seen by physical therapy and found to be able to move around

with minimal assistance. She was discharged and set up for

surgery one day next week. Given the edema around the

hemorrhagic metastatic lesion, the patient was started on

Decadron.

DISCHARGE DIAGNOSIS:

1. Hemorrhagic brain metastases

2. Metastatic melanoma

DISCHARGE MEDICATIONS:

1. Tylenol 325 mg p.o. q. 4-6 hours prn pain

2. Morphine Sulfate sustained release 16 mg p.o. q.d.

3. Percocet 5/325 one tablet p.o. q 4-6 hours prn pain

4. Famotidine 20 mg p.o. b.i.d.

5. Dilantin 150 mg p.o. b.i.d. times three days and then 100

mg p.o. b.i.d. for three days and then discontinue

6. Keppra 1000 mg p.o. b.i.d. times three days and then 1500

mg p.o. b.i.d.

7. Decadron 4 mg p.o. t.i.d. times five days

CONDITION ON DISCHARGE: Stable.

DISCHARGE STATUS: To home.

[\*\*First Name8 (NamePattern2) \*\*] [\*\*First Name8 (NamePattern2) \*\*] [\*\*Last Name (NamePattern1) \*\*], M.D. [\*\*MD Number 5713\*\*]

Dictated By:[\*\*Last Name (NamePattern1) 2635\*\*]

MEDQUIST36

D: [\*\*2679-11-2\*\*] 14:30

T: [\*\*2679-11-2\*\*] 16:28

JOB#: [\*\*Job Number 10285\*\*]

Signed electronically by: DR. [\*\*First Name8 (NamePattern2) 1569\*\*] [\*\*Last Name (NamePattern1) 1565\*\*]

on: MON [\*\*2679-11-24\*\*] 10:41 AM

(End of Report)

20113\_:-:\_17352\_:-:\_

Admission Date: [\*\*2981-2-27\*\*] Discharge Date: [\*\*2981-5-17\*\*]

Date of Birth: [\*\*2913-2-21\*\*] Sex: F

Service: NEUROSURGERY

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[\*\*First Name3 (LF) 3199\*\*]

Chief Complaint:

headache for 6 days

Major Surgical or Invasive Procedure:

SAH clippig

History of Present Illness:

HPI: 68 year old left handed woman with history of hypertension

who presents to [\*\*Hospital3 3824\*\*] on [\*\*2-27\*\*] for 6 days of

"exploiding headache". She was still able to function at home

but finally [\*\*Hospital 3825\*\*] medical attentionbecause she normally does

not have headache. Head CT revealed subararocnoid hemorrhage in

the sylvian fissureand around the left sulci of parietal lobe so

she was sent to [\*\*Hospital1 13\*\*] for management.Initial exam arrival to ED

oriented x3, fluent speech and no focal deficits on motor exam,

was opening her eyes to voice, squeezing her hands and moving

her toes on

command.In the ER she was started on Dilantin 1gm, Decadron

10mg. Patient admitted for Cerebral angio/clipping of aneurysm.

Past Medical History:

hypothyroidism

HTN

Social History:

Widowed and lives with son; 2 daughters.no etoh, tobacco,

or ivdu.

Family History:

grandma- stroke. no seizures

Physical Exam:

AVSS

NAD

CTA-B

RRR

ABD NT/ND

NEURO: minimally responsive to pain (grimace), occasional

non-directed motion of extremities, intermittent tracking.

PERRLA.

Pertinent Results:

[\*\*2981-5-17\*\*] 07:12AM BLOOD WBC-9.2 RBC-2.96\* Hgb-9.7\* Hct-27.9\*

MCV-94 MCH-32.7\* MCHC-34.7 RDW-19.2\* Plt Ct-364

[\*\*2981-5-10\*\*] 04:00AM BLOOD Neuts-74.9\* Lymphs-17.2\* Monos-3.7

Eos-3.8 Baso-0.5

[\*\*2981-5-17\*\*] 07:12AM BLOOD Plt Ct-364

[\*\*2981-5-17\*\*] 05:28AM BLOOD PT-13.2 PTT-28.2 INR(PT)-1.2

[\*\*2981-5-17\*\*] 05:28AM BLOOD Glucose-122\* UreaN-17 Creat-0.4 Na-136

K-3.8 Cl-99 HCO3-30\* AnGap-11

[\*\*2981-2-27\*\*] 03:30PM BLOOD Glucose-139\* UreaN-12 Creat-0.8 Na-139

K-3.8 Cl-105 HCO3-25 AnGap-13

[\*\*2981-2-27\*\*] 03:30PM BLOOD WBC-14.1\* RBC-5.11 Hgb-15.1 Hct-44.7

MCV-88 MCH-29.5 MCHC-33.8 RDW-12.6 Plt Ct-251

[\*\*2981-2-27\*\*] 03:30PM BLOOD Neuts-95.5\* Bands-0 Lymphs-4.2\*

Monos-0.3\* Eos-0 Baso-0.1

[\*\*2981-2-27\*\*] 03:30PM BLOOD PT-13.6 PTT-21.6\* INR(PT)-1.2

[\*\*2981-2-27\*\*] 03:30PM BLOOD Plt Smr-NORMAL Plt Ct-251

[\*\*2981-5-10\*\*] 04:00AM BLOOD ALT-81\* AST-40 LD(LDH)-233 AlkPhos-149\*

TotBili-0.3

[\*\*2981-3-3\*\*] 09:17AM BLOOD ALT-18 AST-25 AlkPhos-63 TotBili-0.5

[\*\*2981-3-24\*\*] 02:48AM BLOOD Lipase-377\*

[\*\*2981-3-7\*\*] 12:44PM BLOOD Lipase-148\*

[\*\*2981-5-17\*\*] 05:28AM BLOOD Calcium-9.3 Phos-3.1 Mg-2.1

[\*\*2981-2-27\*\*] 03:30PM BLOOD Calcium-10.0 Phos-2.1\* Mg-2.2

[\*\*2981-5-16\*\*] 04:12AM BLOOD Phenyto-10.8

[\*\*2981-5-15\*\*] 04:10AM BLOOD Phenyto-7.9\*

[\*\*2981-5-14\*\*] 04:53AM BLOOD Phenoba-48.5\* Phenyto-3.1\*

[\*\*2981-5-9\*\*] 04:30AM BLOOD Phenoba-56.3\*

[\*\*2981-4-5\*\*] 11:20AM CEREBROSPINAL FLUID (CSF) WBC-7 RBC-29\* Polys-4

Lymphs-92 Monos-4

[\*\*2981-4-25\*\*] 02:31PM CEREBROSPINAL FLUID (CSF) WBC-2 RBC-59\* Polys-3

Lymphs-94 Monos-3

CULTURES: all cultures with NO GROWTH at time of discharge.

Brief Hospital Course:

68 year old white female S/P SAH clipping on the [\*\*2981-2-28\*\*]. She

had a ventricular drain placed in the right ventricle She was

able to follow commands off propofol wiggling the toes, until

[\*\*3-2\*\*] where she was noted to not follow any commands but could

still move all four extremities spontaneously and symmetrically.

A metabolic workup and repeat NCHCT was done that reportedly

showed no abnormalities except for new right caudate and

anterior corpus callosum hypodenisty. MRI brain on [\*\*3-3\*\*] did not

show any new infarcts.

EEG was done on [\*\*3-4\*\*] showed focal seizure activity/PLEDs over

the right fronto- central region. Patient was given 2 mg Ativan

and loaded with 1500 mg dilantin and continued on 100mg TID and

Keppra 500 mg BID, and placed on a continues bedside EEG.

Repeat head CTA on [\*\*2981-3-4\*\*] demonstrated new evolving infarct on

caudate/anterior corpus callosum. Brainstem reflexes and

extensor posturing remained intact.

[\*\*2981-3-6\*\*] bedside EEG monitoring showed nonconvulsive status

epilepticus involving right > left lobes. Keppra/dilantin

increased due to status epilepticus on 3/30 per neurology.

[\*\*2981-3-10\*\*] patient condition complicated by PE/DVT anticoagulation

therapy instituted and ICV filter placed on [\*\*2981-3-10\*\*]. patient had

peg and trach placed on [\*\*3-28\*\*]. She had GI bleed on [\*\*4-2\*\*] and was

found to have bleeding from diverticulum on colonoscopy. she was

transfered to step down on [\*\*4-3\*\*]. She had serial head ct which

continued to show infarcts in the midline affecting the genu of

the corpus collosum and anterior cingulate cortices bilaterally.

She had an LP done on [\*\*4-27\*\*] which showed an opening pressure of

16. after discussion with the other neurosurgical attendings the

patient was preoped for the OR for VP shunt. On [\*\*5-2\*\*] the

patient dropped her saturation levels, surgery was cancelled and

she was sent for ultrasound of her legs and CTA of chest to r/o

new PE and DVT's both tests were negative. Patient was seen by

medicine consult for management of sinusitis/klebsiella UTI/?

Pneumonia with bilat pleural effusions. Bactrim was used to

treat both UTI and sinusitis and they did not feel it was

necessary to treat for pnemonia. Neurologically she started

opening her eyes and tracking, and occassionally sticking out

her tongue to command. she remains on keppra/dilantin/phenobarb.

She was seen and evaluated by Dr [\*\*First Name (STitle) 654\*\*] the Behavior

neurologist who's recommedations have not been finalized.

Because of improving neurologic status the vp shunt will be

postponed until needed. Beginning earlier in the week of the

[\*\*12-13\*\*], her neurological status as per nusring staff and

family members improved, such that she intermittently tracked,

responded with semi-purposeful movements to suctioning and

response ot pain. She is considered stable for discharge to a

skilled rehab facility at this time.

Discharge Medications:

1. Levetiracetam 500 mg Tablet Sig: Three (3) Tablet PO QAM

(once a day (in the morning)).

2. Lansoprazole 30 mg Susp,Delayed Release for Recon Sig: One

(1) PO DAILY (Daily).

3. Levetiracetam 500 mg Tablet Sig: Four (4) Tablet PO QPM (once

a day (in the evening)).

4. Artificial Tear Ointment 0.1-0.1 % Ointment Sig: One (1) Appl

Ophthalmic PRN (as needed).

5. Nystatin 100,000 unit/mL Suspension Sig: Five (5) ML PO QID

(4 times a day) as needed for thrush: as needed.

6. Docusate Sodium 150 mg/15 mL Liquid Sig: One (1) PO BID (2

times a day).

7. Miconazole Nitrate 2 % Powder Sig: One (1) Appl Topical PRN

(as needed).

8. Bisacodyl 10 mg Suppository Sig: One (1) Suppository Rectal

BID (2 times a day) as needed: as needed.

9. Pramoxine-Mineral Oil-Zinc 1-12.5 % Ointment Sig: One (1)

Appl Rectal TID (3 times a day) as needed for PRN.

10. Insulin Regular Human 100 unit/mL Cartridge Sig: One (1) qs

Injection as written: apply according to sliding scale.

Disp:\*qs qs\* Refills:\*0\*

11. Albuterol 90 mcg/Actuation Aerosol Sig: 1-2 Puffs Inhalation

Q6H (every 6 hours) as needed.

12. Senna 8.6 mg Tablet Sig: One (1) Tablet PO BID (2 times a

day).

13. Ipratropium Bromide 18 mcg/Actuation Aerosol Sig: Two (2)

Puff Inhalation Q4-6H (every 4 to 6 hours) as needed.

14. Folic Acid 1 mg Tablet Sig: One (1) Tablet PO DAILY (Daily).

15. Albuterol Sulfate 0.083 % Solution Sig: One (1) Inhalation

Q6H (every 6 hours) as needed.

16. Ipratropium Bromide 0.02 % Solution Sig: One (1) Inhalation

Q6H (every 6 hours) as needed: as needed.

17. Therapeutic Multivitamin Liquid Sig: Five (5) ML PO

DAILY (Daily).

18. Phenobarbital 100 mg Tablet Sig: 2.25 Tablets PO BID (2

times a day): Please do not administer at the same time as the

dilantin; will blunt mutual efficacy.

19. Enoxaparin Sodium 80 mg/0.8 mL Syringe Sig: One (1)

Subcutaneous Q12H (every 12 hours).

20. Metoprolol Tartrate 25 mg Tablet Sig: One (1) Tablet PO BID

(2 times a day).

21. Furosemide 20 mg Tablet Sig: One (1) Tablet PO DAILY (Daily)

for 3 weeks.

22. Phenytoin 100 mg/4 mL Suspension Sig: Two (2) PO Q8H (every

8 hours): please do not give at the same time as the phenobarb.

23. Levofloxacin 500 mg Tablet Sig: One (1) Tablet PO Q24H

(every 24 hours) for 6 days.

24. Heparin Flush PICC (100 units/ml) 2 ml IV DAILY:PRN

10 ml NS followed by 2 ml of 100 Units/ml heparin (200 units

heparin) each lumen Daily and PRN. Inspect site every shift.

25. Levothyroxine Sodium 110 mcg IV DAILY

Discharge Disposition:

Extended Care

Facility:

[\*\*Hospital6 35\*\*] - [\*\*Location (un) 36\*\*]

Discharge Diagnosis:

1) Left insular subarachnoid hemorrhage

2) Anterior comminsure artery aneurysm

3) Status epilepticus

4) Anterior corpus callosum infarct

5) UTI

Discharge Condition:

Minimally responsive, but improving from hospital nadir

Discharge Instructions:

Discharge to [\*\*Hospital3 \*\*]. Continue trach

management/PEG/PICC management.

Followup Instructions:

Please call Dr.[\*\*Doctor Last Name 3529\*\*] office to schedule a follow-up

appointment: ([\*\*Telephone/Fax (1) 693\*\*]. Dr. [\*\*Last Name (STitle) 45\*\*] may have relocated to

[\*\*Hospital1 2193\*\*] at time of scheduled f/u

[\*\*Name6 (MD) 46\*\*] [\*\*Last Name (NamePattern4) 47\*\*] MD, [\*\*MD Number 3201\*\*]

Completed by: [\*\*First Name11 (Name Pattern1) 1693\*\*] [\*\*Last Name (NamePattern4) 1694\*\*] MD [\*\*MD Number 1695\*\*] [\*\*2981-5-17\*\*] @ 1741

Signed electronically by: DR. [\*\*First Name8 (NamePattern2) 46\*\*] [\*\*Name (STitle) \*\*]

on: FRI [\*\*2981-5-25\*\*] 8:42 PM

(End of Report)

4942\_:-:\_18824\_:-:\_

Admission Date: [\*\*3178-1-20\*\*] Discharge Date: [\*\*3178-1-28\*\*]

Date of Birth: [\*\*3102-5-24\*\*] Sex: F

Service: Cardiothoracic Surgery

HISTORY OF PRESENT ILLNESS: This is a 75-year-old female who

experienced shortness of breath while mowing the lawn during

the Summer and recently had angina precipitated by cold. She

had a positive exercise tolerance test and received a cardiac

catheterization on the day prior to admission at [\*\*Hospital6 5760\*\*]. She was transferred to the [\*\*Hospital1 550\*\*]. The results of the cardiac catheterization

showed a 70% lesion of the left anterior descending artery,

60% lesion of the ramus, 100% lesion of the right coronary

artery, and an ejection fraction of 45%.

She was transferred to the [\*\*Hospital1 754\*\*] for bypass surgery by Dr. [\*\*First Name8 (NamePattern2) 897\*\*] [\*\*Last Name (NamePattern1) \*\*].

PAST MEDICAL HISTORY: (Past Medical History includes)

1. Hypertension.

2. Right hip injury.

3. Tonsillectomy.

4. Appendectomy.

5. Shingles to the left side of her face in [\*\*3168\*\*].

6. She also admits to a shaking palsy of her left hand.

MEDICATIONS ON ADMISSION: (Medications on admission

included)

1. Hydrochlorothiazide.

2. Aspirin.

3. Chlorampheniramine maleate.

4. Acyclovir (for neuralgia of her face).

PHYSICAL EXAMINATION ON PRESENTATION: On examination, her

blood pressure was 140/80, a sinus rhythm, heart rate was 70

beats per minute. Distal pulses were all palpable. She had

right carotid bruits. Her chest was clear. Heart sounds

were normal and without murmurs. She had bilateral varicose

veins with the left side greater than the right.

PERTINENT LABORATORY VALUES ON PRESENTATION: Preoperative

laboratory work revealed white blood cell count was 8.4,

hematocrit was 39.1, and platelet count was 274,000.

Prothrombin time was 12.5, partial thromboplastin time was

26.6, and INR was 1.1. Sodium was 141, potassium was 4,

chloride was 105, bicarbonate was 22, blood urea nitrogen was

14, creatinine was 0.7, and blood glucose was 168.

PERTINENT RADIOLOGY/IMAGING: A preoperative carotid

ultrasound showed minimal plaque with less than 40% stenoses

bilaterally. Liver function tests were also normal. Albumin

was 3.5.

HOSPITAL COURSE: The patient was referred to Dr. [\*\*First Name8 (NamePattern2) 897\*\*]

[\*\*Last Name (NamePattern1) \*\*] for coronary artery bypass grafting.

On [\*\*1-23\*\*], the patient underwent coronary artery bypass

grafting times two by Dr. [\*\*First Name8 (NamePattern2) 897\*\*] [\*\*Last Name (NamePattern1) \*\*] with left internal

mammary artery to the left anterior descending artery and a

vein graft to the right coronary artery. The patient was

transferred to the Cardiothoracic Intensive Care Unit in

stable condition on a nitroglycerin drip at 0.5 mcg/kg per

minute and a propofol drip at 10 mcg/kg per minute.

The patient was extubated that evening. The patient's oxygen

saturation was 100% on 4 liters via nasal cannula. Glucose

was evaluated, and an insulin drip was started according to

the Cardiothoracic Surgery Recovery Unit protocol.

The patient was in a sinus rhythm on postoperative day one at

76, with a blood pressure of 125/51, with a cardiac index of

3.41. Postoperative hematocrit was 28 with a white blood

cell count of 9.9. The patient was continued on

perioperative vancomycin and remained on an insulin drip at

2. Postoperatively, blood urea nitrogen was 11 and

creatinine was 0.4. Sodium was 136 and potassium was 4. The

patient's started Lopressor beta blockade. Her diet was

advanced. Chest tube were discontinued, and the patient was

transferred out to the floor on postoperative day one.

On postoperative day two, the patient had no new issues. She

did well overnight and was in a sinus rhythm. She was

maintaining good blood pressures and was saturating 95% on 2

liters. The lungs were clear. The heart was regular in rate

and rhythm. The abdomen was soft. The pacing wires were

pulled. The patient began ambulating with Physical Therapy

and rehabilitation planning was begun.

On postoperative day three, the patient was doing well. The

Foley catheter was out, and the patient voided. The patient

remained in a sinus rhythm. The incisions were healing

nicely. The patient continued to ambulate and was encouraged

to increase pulmonary toilet with incentive spirometry. The

patient was seen by Case Management to discuss discharge

needs; with hopefully being able to return to her daughter's

house and have [\*\*Hospital1 587\*\*] Visiting Nurse Association.

On postoperative day four, the patient continued to improve.

Her physical examination was unremarkable. She had an

excellent heart rate and blood pressure at 67 in a sinus

rhythm with a blood pressure of 110/60. The patient was

saturating 96% on room air. The patient had a temperature

maximum of 99.1. She diuresed off one liter in a 24-hour

period. She was continuing to increase her ambulation, and

she continued to improve.

On [\*\*1-28\*\*], on postoperative day five, the chest incision

was clean and dry. The chest incisions had no erythema or

swelling with a little bit of edema in the right leg. The

chest was clear except for some upper airway wheezing. The

patient remained in sinus bradycardia and sinus rhythm at 53

to 72 with occasional premature ventricular contractions.

The patient did have a small limited beat run of

supraventricular tachycardia. The patient did a level V.

She continued to ambulate well.

CONDITION AT DISCHARGE: Condition on discharge was stable.

DISCHARGE DISPOSITION: The patient was discharged to home

with Visiting Nurse Association services on [\*\*3178-1-28\*\*].

DISCHARGE DIAGNOSES: (Discharge diagnoses were as follows)

1. Status post coronary artery bypass grafting times two.

2. Hypertension.

3. Past history of shingles with neuralgia to the face.

4. Status post right hip injury.

5. Tonsillectomy.

6. Appendectomy.

MEDICATIONS ON DISCHARGE: (Discharge medications were as

follows)

1. Aspirin 325 mg p.o. once per day.

2. Colace 100 mg p.o. twice per day.

3. Lopressor 25 mg p.o. twice per day.

4. Lasix 20 mg p.o. once per day (times seven days).

6. Potassium 20 mEq p.o. once per day (times seven days).

7. Percocet one to two tablets p.o. q.4-6h. as needed (for

pain).

8. Motrin 400 mg p.o. q.4-6h. as needed (for pain).

DISCHARGE INSTRUCTIONS/FOLLOWUP:

1. The patient was instructed that the [\*\*Hospital1 587\*\*] Visiting

Nurse Association would be in contact to monitor the patient.

2. The patient was also instructed to follow up with Dr.

[\*\*Last Name (STitle) \*\*] in the office in approximately four weeks.

3. The patient was to follow up with her primary care

physician (Dr. [\*\*First Name8 (NamePattern2) \*\*] [\*\*Last Name (NamePattern1) 6772\*\*]) within two weeks of

discharge home.

[\*\*First Name11 (Name Pattern1) \*\*] [\*\*Last Name (NamePattern4) 1536\*\*], M.D. [\*\*MD Number 1537\*\*]

Dictated By:[\*\*Last Name (NamePattern1) 1332\*\*]

MEDQUIST36

D: [\*\*3178-4-18\*\*] 13:58

T: [\*\*3178-4-18\*\*] 14:02

JOB#: [\*\*Job Number 7213\*\*]

Signed electronically by: DR. [\*\*First Name11 (Name Pattern1) \*\*] [\*\*Initial (NamePattern1) \*\*] [\*\*Last Name (NamePattern4) \*\*]

on: WED [\*\*3178-6-21\*\*] 4:37 PM

(End of Report)

30095\_:-:\_29751\_:-:\_

Admission Date: [\*\*3333-9-3\*\*] Discharge Date: [\*\*3333-9-8\*\*]

Date of Birth: [\*\*3253-7-6\*\*] Sex: F

Service: CARDIOTHORACIC

Allergies:

Erythromycin Base / Adhesive Tape / Sudafed / Percocet

Attending:[\*\*First Name3 (LF) 1\*\*]

Chief Complaint:

dyspnea on exertion

Major Surgical or Invasive Procedure:

[\*\*3333-9-3\*\*] Minimally invasive MVR (25mm Mosaic porcine heart valve)

History of Present Illness:

Ms. [\*\*Known patient lastname 3206\*\*] is an 80 year old woman has a history of worsening

mitral valve prolapse, which has been followed for some time via

serial echocardiograms. She has become increasingly symptomatic

and a recent echo revealed 3+ mitral regurgitation, so she was

referred for surgical evaluation.

Past Medical History:

mitral valve prolapse

hyperlipidemia

hypertension

chronic renal insufficiency

[\*\*Doctor Last Name \*\*] apnea without CPAP

depression

atrial fibrillation

tachy-brady syndrome

asthma

restless leg syndrome

osteoarthritis

osteoporosis

[\*\*Hospital Ward Name \*\*] cyst

s/p PPM 2005 DDD

resection of thyroid goiter

cataract surgery

Social History:

Ms. [\*\*Known patient lastname 3206\*\*] is retired and lives with her husband. She has never

smoked and reports drinking 3 alcoholic beverages per week.

Family History:

Ms. [\*\*Known patient lastname 5814\*\*] father passed away at the age of 54 years of a

myocardial infarction and her sister passed away of heart

disease in her 60s.

Physical Exam:

PE on Discharge:

VSS: 98.9, 127/46, 66, RR:20, 98% R/A 02SAT, 68.9Kg

General:A&Ox3, NAD

CVS: RRR, No m/r/g

Lungs: right basilar crackles

ABd: benign

EXT:(B) LE edema.

Incisions: right axillary incision:C/D/I, right groin incion:

C/D/I

Pertinent Results:

[\*\*3333-9-6\*\*] 06:45AM BLOOD WBC-8.8 RBC-2.79\* Hgb-8.7\* Hct-24.7\*

MCV-89 MCH-31.0 MCHC-35.0 RDW-15.5 Plt Ct-93\*

[\*\*3333-9-3\*\*] 05:14PM BLOOD WBC-9.1# RBC-2.81\*# Hgb-8.8\*# Hct-25.7\*#

MCV-92 MCH-31.3 MCHC-34.2 RDW-13.4 Plt Ct-118\*#

[\*\*3333-9-6\*\*] 06:45AM BLOOD Glucose-107\* UreaN-24\* Creat-1.0 Na-134

K-3.5 Cl-100 HCO3-29 AnGap-9

[\*\*3333-9-3\*\*] 05:57PM BLOOD UreaN-18 Creat-0.8 Cl-110\* HCO3-23

[\*\*Known patient lastname \*\*],[\*\*Known patient firstname \*\*] 187-24-25 F 80 [\*\*3253-7-6\*\*]

Radiology Report CHEST (PORTABLE AP) Study Date of [\*\*3333-9-6\*\*] 2:45

PM

Final Report

HISTORY: Chest tube removal.

FINDINGS: In comparison with the study of 8/8, the right chest

tube has been

removed. The endotracheal tube, nasogastric tube, and Swan-Ganz

catheter have

all been removed. Bibasilar atelectasis persists. Subcutaneous

gas along the

right lateral chest wall and pectoral muscles is slightly more

prominent than

on the previous study.

DR. [\*\*First Name8 (NamePattern2) 5\*\*] [\*\*First Name8 (NamePattern2) 6\*\*] [\*\*Last Name (NamePattern1) 7\*\*]

Approved: SUN [\*\*3333-9-6\*\*] 4:51 PM

Imaging Lab

Brief Hospital Course:

[\*\*3333-9-3\*\*] Mrs. [\*\*Known patient lastname 3206\*\*] was taken to the OR by Dr.[\*\*Last Name (STitle) \*\*] and

underwent a minimally invasive MVR (#25mm Mosaic porcine valve).

Please refer to Dr.[\*\*Doctor First Name 5815\*\*] operative report for further

details. XCT:68min. CPB:87min. She was intubated and sedated ,

requiring Neosynephrine to optimize her BP and CO when

transferred to the CVICU.All drips were weaned to off and the

pt. was extubated in a timely fashion. POD#1 EP interrogated

her PPM. Lines and tubes were discontinued and she was

transferred to the SDU on POD#2. On POD#3 One unit of PRBCs was

transfused for anemia. During the evening hours, Mrs.[\*\*Known patient lastname 3206\*\*]

became confused and agitated. By the morning of POD#4 her mental

status was improved but she was still having episodes of

confusion. All narcotics were discontinued and she kept for

observation for an additional 24 hours. On POD#5 Mrs[\*\*Known patient lastname 5816\*\*]

mental status was markedly improved, back to baseline, and was

discharged to rehab for further increase in strength and

endurance. She was instructed on all neccessary followup

appointments once discharged from rehab.

Medications on Admission:

rythmol 225mg BID

effexor 37.5mg

atenolol 25mg

triamterene/HCTZ 36.5/25mg

MVI

glucosamine

aspirin 81mg

vitamin D calcium 600

singulair 10mg

lipitor 40mg

diovan 20mg

actonel 35mg on tuesdays

advair 250/50 2 puffs

combivant 2 puffs PRN

Discharge Medications:

1. Aspirin 81 mg Tablet, Delayed Release (E.C.) Sig: One (1)

Tablet, Delayed Release (E.C.) PO DAILY (Daily).

2. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2

times a day).

3. Ipratropium-Albuterol 18-103 mcg/Actuation Aerosol Sig: [\*\*1-28\*\*]

Puffs Inhalation Q4H (every 4 hours) as needed.

4. Atorvastatin 40 mg Tablet Sig: One (1) Tablet PO DAILY

(Daily).

5. Venlafaxine 37.5 mg Tablet Sig: One (1) Tablet PO BID (2

times a day).

6. Montelukast 10 mg Tablet Sig: One (1) Tablet PO DAILY

(Daily).

7. Metoprolol Tartrate 25 mg Tablet Sig: One (1) Tablet PO BID

(2 times a day).

8. Fluticasone-Salmeterol 250-50 mcg/Dose Disk with Device Sig:

Two (2) Disk with Device Inhalation BID (2 times a day).

9. Propafenone 225 mg Tablet Sig: One (1) Tablet PO BID (2 times

a day).

10. Pantoprazole 40 mg Tablet, Delayed Release (E.C.) Sig: One

(1) Tablet, Delayed Release (E.C.) PO Q24H (every 24 hours).

11. Ibuprofen 400 mg Tablet Sig: One (1) Tablet PO Q8H (every 8

hours): x6weeks.

12. Ferrous Gluconate 325 mg (37.5 mg Iron) Tablet Sig: One (1)

Tablet PO DAILY (Daily).

13. Ascorbic Acid 500 mg Tablet Sig: One (1) Tablet PO BID (2

times a day).

14. Magnesium Hydroxide 400 mg/5 mL Suspension Sig: Thirty (30)

ML PO Q6H (every 6 hours) as needed.

15. Potassium Chloride 20 mEq Tab Sust.Rel. Particle/[\*\*Doctor First Name 636\*\*]

Sig: One (1) Tab Sust.Rel. Particle/[\*\*Doctor First Name 636\*\*] PO DAILY (Daily).

16. Furosemide 20 mg Tablet Sig: One (1) Tablet PO BID (2 times

a day).

Discharge Disposition:

Extended Care

Facility:

Life Care Center of [\*\*Location 1408\*\*]

Discharge Diagnosis:

mitral regurgitation

Discharge Condition:

good

Discharge Instructions:

Please shower daily including washing incisions, no baths or

swimming

Monitor wounds for infection - redness, drainage, or increased

pain

Report any fever greater than 101

Report any weight gain of greater than 2 pounds in 24 hours or 5

pounds in a week

No creams, lotions, powders, or ointments to incisions

No driving for approximately one month

No lifting more than 10 pounds for 10 weeks

Please call with any questions or concerns [\*\*Telephone/Fax (1) 15\*\*]

Followup Instructions:

Following discharge from rehab:

Dr [\*\*Last Name (STitle) \*\*] in 4 weeks ([\*\*Telephone/Fax (1) 15\*\*]) please call for

appointment

Dr [\*\*First Name4 (NamePattern1) \*\*] [\*\*Last Name (NamePattern1) 5730\*\*] (PCP) in 1-2 weeks ([\*\*Telephone/Fax (1) 5731\*\*]) please call

for appointment

Dr [\*\*Last Name (STitle) 469\*\*] in 1-2 weeks, please call for appointment

Wound check appointment [\*\*Hospital Ward Name 292\*\*] 2 as instructed by nurse

([\*\*Telephone/Fax (1) 4694\*\*])

[\*\*Name6 (MD) \*\*] [\*\*Name8 (MD) \*\*] MD [\*\*MD Number 16\*\*]

Completed by: [\*\*First Name8 (NamePattern2) 2376\*\*] [\*\*Last Name (NamePattern1) \*\*] [\*\*MD Number 4313\*\*] [\*\*3333-9-8\*\*] @ 1112

Signed electronically by: DR. [\*\*First Name11 (Name Pattern1) \*\*] [\*\*Initials (NamePattern4) \*\*] [\*\*Last Name (NamePattern4) \*\*]

on: MON [\*\*3333-9-21\*\*] 4:22 PM

(End of Report)