- FOOT AP LAT W/OBLIQ LT
Attending Provider: Samer ElDirani, MD

RESEARCH MEDICAL CENTER
2316 EAST MEYER BLVD
KANSAS CITY, MO 64132
Sex: F

PHONE #: 816-276-4141
FAX #: 816-276-4890

Name: [redacted]
Phys: ElDirani,Samer MD
DOB: [redacted] Age: 64

Acct: D72716985519 Loc: D.4124 A
Exam Date: 01/26/2016 Status: ADM IN
Radiology No:
Unit No: D01113686

EXAMS:	REASON FOR EXAM:	CPT CODE:
500826099 FOOT AP LAT W/OBLIQ L	DIABETIC FOOT, GETTING WOR	73630

Left foot 3 views

Reason for exam: Diabetic foot, osteitis

Old osteotomy is straightening and shortening of the distal first metatarsal has been performed.
Medial aspect of first metatarsal head has been removed.
A screw extends through the distal first metatarsal.
Degenerative changes of first metatarsophalangeal joint are present.
The bony structures appear intact and there is no evidence of focal lytic or sclerotic bone lesion.
No soft tissue abnormality is visible.

Impression:
1. Previous first metatarsal osteotomy with straightening
2. No specific features to indicate osteitis

** Electronically Signed by GRAHAM LEE M.D. on 01/27/2016 at 0754 **
Reported and signed by: LEE M.D., GRAHAM

CC: Linda C Singh MD

Dictated Date/Time: 01/27/2016 (0753)
Technologist: XFR9485
Transcribed Date/Time: 01/27/2016 (0753)
Transcriptionist: RADPS
Orig Print D/T: S: 01/27/2016 (0756)
BATCH NO: N/A

 Signed Report **Electronically signed by Misty Aguirre RN on 01/27/2016 at 11:00 AM**

STRESS REPORT
Originating Physician: Kiranmayi Chilappa, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

.
PATIENT NAME: [redacted] LOCATION: D.4W
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.4124-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
.
STRESS REPORT
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Research Medical Center
2316 East Meyer Blvd.
Kansas City, MO 64132
(816)276-4000
.
Stress Gated/Rest SPECT Myocardial Perfusion Imaging after Lexiscan
Patient: [redacted] L [redacted]
MR #: K16671
Account #: D72716985519
DOB: [redacted]
Age: 64 years
Study date: 01/27/2016
Study time: 0940
Gender: Female
Ht-Wt: 67 in- 164 lb
BSA: 1.86 m squared
MPI #: D01113686
Location: D.4124-A
Status: Inpatient
.
Ordering Physician: Willie E Lawrence, MD
Nuclear Med Tech: Michael Thomas, CNMT
Stress Lab RN: Mary Warner, RN
Reading Group: MWH_Midwest Heart and Vascular Specialists
Reading Physician: Kiranmayi Chilappa, MD
.
Conclusions
Impressions
Abnormal study after pharmacologic stress. There was a small infarct with mild
to moderate amount of ischemia involving the inferolateral wall. Left ventricular systolic function was reduced, with regional wall motion

abnormalities. This study has features consistent with moderate risk.
Summary
Rest ECG: Normal sinus rhythm. Nonspecific ST abnormalities were present.
Stress results: There was no chest pain during stress. The patient experienced
dyspnea during stress; resolved spontaneously. The patient experienced dyspnea
and hypotension during stress; resolved following administration of aminophylline. Perfusion imaging: There was a small to moderate in size,
moderate in intensity, partially reversible myocardial perfusion defect of the
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inferior wall.The defect suggests a past myocardial infarction withmild to
moderate peri infarct ischemia. Gated SPECT: There was moderate hypokinesis of
the inferior wall of the left ventricle. The calculated stress left ventricular
ejection fraction was 32 %.
.
History and indications
Clinical indication
Evaluation of known coronary artery disease. Evaluate for coronary artery
disease based on below reported symptoms.
History
Chest pain status: chest pain, radiation to neck and jaw area. Other symptoms:
dyspnea and decreased effort tolerance. Coronary artery disease risk factors:
dyslipidemia, hypertension, smoking, and diabetes mellitus. Cardiovascular
history: coronary artery disease and prior myocardial infarction. Prior
cardiovascular procedures: percutaneous transcoronary angioplasty (on
3/3/2013). Medications: a beta blocker, aspirin, a lipid lowering agent, and
diabetic medications.
Rest ECG
Normal sinus rhythm. Nonspecific ST abnormalities were present.
Procedure
A Lexiscan infusion pharmacologic stress test was performed. Stress gated and
rest SPECT myocardial perfusion imaging performed. One day imaging protocol.
Stress-Prone imaging was performed. Prior to the study, the procedure was
explained to the patient and informed consent was obtained. Stress test plan of
care implemented. The study was performed in the hospital department.
.
Stress data

Lexiscan infused at a rate 0.4mg/5ml/10sec.
Stress summary
Duration of pharmacologic stress was 6 min. There was no chest pain during
stress. The patient experienced dyspnea during stress; resolved spontaneously.
The patient experienced dyspnea and hypotension during stress; resolved
following administration of aminophylline. The stress test was terminated due
to protocol completion. The baseline heart rate was 96 bpm. The baseline blood
pressure was 144/73mmHg. The maximum heart rate was 111 bpm. The maximum blood
pressure was 103/64mmHg. There were no stress arrhythmias or conduction
abnormalities. No change from the baseline rhythm.
.
Imaging data
Isotope administration

Resting isotope administration	Stress isotope administration
Agent Tc99m Sestamibi intravenous	Tc99m Sestamibi intravenous
Dose 12.1 mCi	32.7 mCi
Date 01/27/2016	01/27/2016
Injection time 09:40	12:20

.
Image properties
Imaging information: gated.
Myocardial perfusion imaging
The image quality was good.
Perfusion defects
There was a small to moderate in size, moderate in intensity, partially
reversible myocardial perfusion defect of the inferior wall.The defect suggests
a past myocardial infarction withmild to moderate peri infarct ischemia.
.
PATIENT NAME: [redacted] ACCOUNT # D72716985519
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.
Gated SPECT
There was moderate hypokinesis of the inferior wall of the left ventricle. The
calculated stress left ventricular ejection fraction was 32 %.
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Prepared and electronically signed by
.
Kiranmayi Chilappa, MD
Signed 01/27/2016 16:05:30
Study date: 01/27/2016
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PATIENT NAME: [redacted] ACCOUNT #

D72716985519 **Electronically signed by Renee Richards on 01/28/2016 at 7:31 AM**

CONSULTATION
Originating Physician: Radmila Samardzija, DPM
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

PATIENT NAME: [redacted] LOCATION: D.5E
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.5246-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
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CONSULTATION

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CONSULTING:
Radmila Samardzija MD (F)
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DATE OF SERVICE:
01/28/2016
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CHIEF COMPLAINT:
Left chronic foot wounds.
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HISTORY OF PRESENT ILLNESS:
The patient is a 64-year-old female with past medical history significant for diabetes and status post I and D of the left first ray in 2011. The patient relates to continued callus formation and draining wounds to the left foot and is concerned for infection. She also complains of long thickened and incurvated toenails, bilateral foot. She states that her toenails have been falling off.
She denies nausea, vomiting, fever, chills, shortness of breath, or chest pain at this time.
.
PAST MEDICAL HISTORY:
Supraventricular tachycardia; coronary artery disease status post myocardial infarction in 03/2015, status post cardiac catheterization and stent inserted back in 03/2015; diabetes; peripheral neuropathy; history of chronic

diabetic
foot wound to the left foot; and dyslipidemia.
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MEDICATIONS:
Reviewed in the chart.
.
ALLERGIES:
SULFA.
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SOCIAL HISTORY:
Denies alcohol or drug use and admits to previous history of smoking cigarettes.
She lives with her daughter and is retired.
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FAMILY HISTORY:
Noncontributory.
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REVIEW OF SYSTEMS:
As per above, otherwise negative.
.
PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 36.8, pulse 87, blood pressure 135/65, and patient has
100% oxygen to room air.
GENERAL: Patient is alert and oriented x3, in no apparent distress.
EXTREMITIES: Lower extremities; skin is warm, xerotic, and supple. Normal
turgor. Nails are long x 10 with noted incurvation to the medial and lateral
nail border of bilateral hallux. Also of note, thickening and discoloration of
all nails with loosening of nail from the nail bed to the lesser digits,
specifically digits 4 and 3 bilateral. No maceration is noted. No cellulitis.
There is diffuse hyperkeratosis to the plantar and plantar medial first
metatarsal of the left foot. There is hyperpigmentation noted with central
hypopigmentation. This was debrided with a scalpel, the hyperkeratotic tissue.
Do note, there is a fissure in the sub first metatarsal, measuring 1 x 0.1 x 0.2
cm. There is no active drainage. There is no probe to bone. There is no
fluctuance, no malodor. DP is 2 out of 4 and PT is 1 out of 4. CFT is 3
seconds to all digits. There is +1 nonpitting edema to bilateral lower
extremities. Sensation is diminished to sharp, dull, and to light touch.
Patient does have dorsally contracted digits 2 through 5 bilateral. Muscle

strength is 5 out of 5. Patient is status post hallux valgus correction to the
left foot. Note, satisfactory alignment of the first ray. There is a mild
hallux valgus deformity noted to the right foot. No pain with range of motion.
There is decreased first metatarsophalangeal joint range of motion, loaded,
improved, unloaded on the left.
.
LABORATORY DATA AND DIAGNOSTIC STUDIES:
White blood cell is 8, hemoglobin is 11.8, hematocrit is 36.1, and platelets are
246. Blood sugars are 238, _____. CRP was 0.4, albumin is 3.1, and hemoglobin
A1c is 13.1 that is averaging 329 mg per dL.
.
X-ray: Foot x-ray taken on 01/26/2016, 3 views of the left foot shows previous
first metatarsal osteotomy with straightening and no specific features to
indicate osteitis.
.
ASSESSMENT/PLAN:
The patient is a 64-year-old female with diabetes, peripheral neuropathy,
hyperkeratosis (corn/callus), fissure plantar left foot, onychauxis, and
onychomycosis. Nails were debrided x 10 at this time. Also, debrided
hyperkeratotic lesion/callus, sub left first metatarsal at this time. Please
note this is not a wound debridement, it is a callus debridement, so partial
skin using the scalpel. Patient is to apply exfoliating lotion b.i.d., lactic
acid 12% cream twice daily to bilateral foot, may apply daily gauze and Benadryl
to the left foot if drainage. The patient might have a hypertrophic scarring
due to previous incision and drainage in 2011 as well as a hallux limitus
deformity on the left, which also could be contributing to her callus. I would
recommend conservative treatment with custom foot orthotics with offloading of
this lesion, which can be done as an outpatient. The patient does have
orthotics that she had for finger, which also may be able to be modified as an
outpatient. Reinforce proper diabetic foot care. The patient is to follow up
in 2 weeks in my office at Belton Regional Medical Center.
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Thank you for consultation.
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PATIENT NAME: [redacted] ACCOUNT # D72716985519
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DD: 01/28/2016 17:27 CT   DT: 01/29/2016 00:57 CT
Job#3796833
Confirmation#513753
Radmila Samardzija MD (F)
Dictated By: Radmila Samardzija MD (F)
Authenticated by Radmila Samardzija, DPM On 01/29/2016 09:09:26 AM
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TR:
DD: 01/28/16 1727
DT: 01/29/16 0057
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Radmila Samardzija, DPM
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Electronically Signed by Radmila Samardzija, DPM on 01/29/16 at 0909
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PATIENT NAME: [redacted]   ACCOUNT #

D72716985519 **Electronically signed by Misty Aguirre RN on 01/29/2016 at 10:13 AM**

CONSULTATION
Originating Physician: Madhavi Yarlagadda, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

PATIENT NAME: [redacted] LOCATION: D.5E
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.5246-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
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CONSULTATION

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CONSULTING:
Madhavi Yarlagadda MD (F)
.
DATE OF SERVICE:
01/28/2016
.
REASON FOR CONSULTATION:
Uncontrolled type 2 diabetes mellitus.
.
HISTORY OF PRESENT ILLNESS:
Ms. [redacted] [redacted] is a 64-year-old woman who presented with complaints of retrosternal chest pain radiating to the left upper extremity, associated with cold sweat and mild nausea. She has a history of coronary artery disease, status post MI. She is admitted to rule out acute myocardial infarction.
Patient also has a history of type 2 diabetes and A1c this hospitalization is elevated at 13.1%. I am asked to manage the condition.
.
On further questioning, patient tells me that she has been diagnosed with type 2 diabetes 16 years ago. She takes Levemir 44 units at night, Apidra per sliding scale starting with 6 units above 150. She has had insurance issues over the past 6 months and has not been able to get her medications regularly. She also

admits to dietary noncompliance during the holidays. She checks blood sugars 2
times a day. Fasting readings are in the 185 to 260 range, lunch readings are
in the 253 to 300 range, and she does not check rest of the day. Hypoglycemia
occurs very rarely. She gets shaky and sweaty when her blood sugar drops.
She has no known history of retinopathy. No known CKD. She does have coronary
artery disease status post MI. No known CVA, he has symptoms suggestive of
neuropathy. Her appetite in the hospital has been good.
.
Currently, in the hospital, she is ordered for 15 units twice a day of Levemir
with algorithm-2 sliding scale insulin. Her blood sugar readings have been
ranging in the 53 to 277 range.
.
REVIEW OF SYSTEMS:
Denies chest pain. All other review of systems other than those listed in HPI
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are negative.
.
PATIENT NAME: [redacted] ACCOUNT # D72716985519
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.
PAST MEDICAL HISTORY:
Supraventricular tachycardia, coronary artery disease, status post myocardial
infarction, status post cardiac catheterization and stent placement in 03/2015,
type 2 diabetes mellitus, history of diabetic foot in the left foot, and
dyslipidemia.
.
PAST SURGICAL HISTORY:
I and D of the left foot ulcer and eye surgery.
.
FAMILY HISTORY:
Diabetes, both parents have history of diabetes. Two sisters and one brother
have a history of diabetes.
.
SOCIAL HISTORY:
Patient does not drink excess alcohol. She does not use illicit drugs. She is
a retired nurse. She has half a pack a day, 15-year history of smoking. She
quit 8 months ago. She currently lives with her daughter.
.
ALLERGIES:
TO SULFA DRUGS.
.

MEDICATIONS:
Currently, in the hospital, she is ordered for:
1. Metoprolol.
2. Levemir 15 units twice a day.
3. Algorithm-2 sliding scale insulin.
4. Lac-Hydrin.
5. Lipitor.
6. Aspirin.
7. Protonix.
8. Lopressor.
9. Lovenox.
10. Colace.
11. MiraLax.
12. Zofran.
13. Morphine sulfate.
14. Tylenol.
15. Magnesium and potassium protocol.
.
PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 37.2, heart rate 80, respiratory rate 14, and blood
pressure 105/61.
GENERAL: This is a middle-aged woman sitting up in the bed.
HEENT: Head is atraumatic and normocephalic.
NECK: Thyroid is not enlarged to palpation.
LUNGS: Clear to auscultation bilaterally.
HEART: Regular rate and rhythm. No appreciable murmurs.
ABDOMEN: Soft, nontender, and nondistended, with normal bowel sounds.
EXTREMITIES: There is no edema of bilateral lower extremities.
NEUROLOGIC: There is no tremor of outstretched hands. She is alert, awake, and
oriented x3 and has no motor deficits.
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LABORATORY DATA:
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Hemoglobin A1c 13.1% and creatinine 0.8. Blood glucose readings on 01/27/2016,
179, 103, 270, 351; on 01/28/2016, 53, 232, 238, and 277.
.
IMPRESSION:
Type 2 diabetes mellitus, poorly controlled as shown by her A1c of 13.1%.
Patient has had issues with obtaining her medication due to insurance problems.
She also admits to dietary noncompliance during the holidays. SHe notes
worsening of BG after stopping MFM 500 mg BID several month ago.
.
Discussed goals for treatment of Diabetes and complications of uncontrolled
Diabetes. She had an episode of hypoglycemia this morning. I will plan to
change Levemir to 25 units once a day. Start Humalog 5 units with

meals with
algorithm-2 sliding scale insulin and increase as needed. Start
metformin 500
mg twice a day. Creatinine is normal. Blood glucose monitoring a.c.,
at
bedtime, and 3 a.m. Further adjustments of this regimen will be based
on her
response.
.
Thank you very much for the consult. I will follow with you.
.
DD: 01/28/2016 23:43 CT   DT: 01/29/2016 03:03 CT
Job#3797209
Confirmation#514128
Madhavi Yarlagadda MD (F)
Dictated By: Madhavi Yarlagadda MD (F)
Authenticated and Edited by Madhavi Yarlagadda, MD On 1/29/16 5:55:18
PM
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TR:
DD: 01/28/16 2343
DT: 01/29/16 0303
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Madhavi Yarlagadda, MD
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Electronically Signed by Madhavi Yarlagadda, MD on 01/29/16 at 1817
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PATIENT NAME: [redacted] ACCOUNT #
D72716985519 **Electronically signed by Misty Aguirre RN on 02/02/2016 at 11:54 AM**
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CONSULTATION
Originating Physician: Willie E Lawrence, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

PATIENT NAME: [redacted] LOCATION: D.5E
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.5246-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
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CONSULTATION

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CONSULTING:
Willie E Lawrence Jr MD (F)
.
DATE OF SERVICE:
01/27/2016
.
PATIENT OF:
Samer El Dirani, MD (F)
.
CHIEF COMPLAINT:
A 64-year-old with chest pain, palpitations, and fatigue.
.
HISTORY OF PRESENT ILLNESS:
Ms. [redacted] is a 63-year-old female who has a history of coronary artery disease. She had an abnormal stress test in 2012 and at that time underwent complex stenting of the left circumflex and obtuse marginal branch. She stopped her dual antiplatelets and had complication of acute stent thrombosis and required acute intervention.
.
She has a history of a supraventricular tachycardia and had been maintained on a beta-blocker. She says in October, she cut the dose of her beta-blocker in half due to its cost.
.
Three days ago, she began to experience fatigue with intermittent

chest
pressure. She had some palpitations and this discontinued over the last couple
of days. Yesterday, she had substernal chest heaviness with radiation to her
jaw and her left arm. This was intermittent throughout the day. She continued
to feel fatigued and she presented to the emergency room where she was noted to
have a supraventricular tachycardia. She was treated with adenosine and sinus
rhythm was restored. She has had no subsequent chest discomfort. There has
been no recent exertional chest, arm, or jaw discomfort. She has had no pedal
edema, orthopnea, or paroxysmal nocturnal dyspnea. She has had episodic
dizziness, but no near-syncope or syncope.
.
PAST MEDICAL HISTORY:
Notable for coronary artery disease as described above. She did have a stress
test in 02/2015, which showed evidence of inferolateral infarct with
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mild-to-moderate peri-infarction ischemia, but this overall appeared to be a
low-to-moderate risk study and no cardiac catheterization was undertaken. She
has a history of hypertension and hyperlipidemia. She is a diabetic with
complications of peripheral neuropathy.
.
FAMILY HISTORY:
Negative for premature coronary artery disease.
.
SOCIAL HISTORY:
She lives with her daughter. She smokes rarely and has not smoked in several
weeks.
.
ALLERGIES:
SHE IS ALLERGIC TO SULFA.
.
HOME MEDICATIONS:
Have included:
1. Lipitor 40 mg p.o. daily.
2. Aspirin 81 mg daily.
3. Metoprolol 25 mg b.i.d.
.
PHYSICAL EXAMINATION:
GENERAL: She is alert and comfortable at rest.
VITAL SIGNS: She is afebrile, heart rate is 92 and regular, blood pressure is
119/69.

CHEST: Clear.
NECK: There is no jugular venous distention. I hear no carotid bruits.
HEART: S1 and S2 are normal. There are no murmurs or gallops.
ABDOMEN: Soft and nontender. I palpate no masses.
EXTREMITIES: Without clubbing, cyanosis, or edema. Dorsal pedis pulses are 1+
bilaterally.
SKIN: Warm and dry to the touch.
HEENT: Her sclerae are nonicteric.
.
LABORATORY STUDIES:
Notable for a creatinine of 0.7. The troponin is 0.03. The hematocrit is 36.
.
DIAGNOSTIC STUDIES:
The EKG on admission showed supraventricular tachycardia at 170 beats per
minute, left axis deviation, nonspecific ST and T-wave changes. Following
conversion, her EKG showed normal sinus rhythm, left axis deviation with very
nonspecific T-wave changes.
.
IMPRESSION:
1. Supraventricular tachycardia.
2. Fatigue.
3. Chest pain.
4. History of coronary artery disease.
5. Hypertension.
6. Hyperlipidemia.
7. Diabetes.
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DISCUSSION:
Ms. [redacted] has a history of coronary artery disease with risk factors including
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hypertension and diabetes. She has a history of supraventricular tachycardia,
which seemingly had been suppressed by beta-blocker though she in recent months
has decreased the doses of her beta-blocker and generally seems to have been not
as compliant with her medications. Some of her symptoms suggest angina, but
despite prolonged chest discomfort, her enzymes are not elevated and her EKG is
unremarkable. I suspect that much of her symptoms were related to sustained
supraventricular tachycardia. Long-term, she needs aggressive continued
secondary prevention. We will proceed as follows:
1. Lexiscan Cardiolite study.
2. Resume beta-blocker.

3. Continue current dosage of Lipitor, the LDL is 70.
4. Continue daily aspirin.
5. Diabetes is poorly controlled. We will defer management to the hospitalist.
.
DD: 01/27/2016 08:58 CT   DT: 01/27/2016 10:53 CT
Job#3792055
Confirmation#508995
Willie E Lawrence Jr MD (F)
Dictated By: Willie E Lawrence Jr MD (F)
Authenticated by Willie E Lawrence, MD On 02/04/2016 06:04:19 PM
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TR:
DD: 01/27/16 0858
DT: 01/27/16 1053
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Willie E Lawrence, MD, Jr
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Electronically Signed by Willie E Lawrence, MD, Jr on 02/04/16 at 1804
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PATIENT NAME: [redacted] ACCOUNT #
D72716985519 **Electronically signed by Misty Aguirre RN on 02/08/2016 at 10:53 AM**
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HISTORY AND PHYSICAL
Originating Physician: Samer ElDirani, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

PATIENT NAME: [redacted] LOCATION: D.5E
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.5246-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
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HISTORY AND PHYSICAL

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DATE OF SERVICE:
01/26/2016
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CHIEF COMPLAINT:
Recurrent episode of chest pain with chest palpitations.
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HISTORY OF PRESENT ILLNESS:
Ms. [redacted] is a 64-year-old with multiple underlying medical problems including coronary artery disease, status post myocardial infarction and stent inserted back in March 2015, history of hypertension, diabetes mellitus type 2, coronary artery disease, dyslipidemia, and diabetic foot; who presented to our facility with above chief complaint. The patient's history dates back to 1 day prior to presentation, started having recurrent episode of retrosternal chest pain radiating to left upper extremity that showed no specific predisposing or relieving factor, occurring even at rest. Pain is 8 to 10 over 10, pressure-like, and associated with cold sweat and mild nausea. No similar episode over the last few months. The patient said that those episodes will last usually few minutes. However, today she said on the top of that, she started having chest palpitation and some shortness of breath, intermittent in

nature and that brought her to the emergency room. When patient arrived to the emergency room, she was found to be in SVT with heart rate in the 160s. The patient was given adenosine and heart rate was much better controlled and patient was admitted for further management. When I saw the patient, she denied any current chest pain per se. She said that she is still having some nonspecific mild chest pressure. The patient denied any fever, cough, phlegm production, abdominal pain, recurrent nausea, vomiting, or diarrhea. No skin rash. No recent travel. No history of recurrent chest palpitation over the last few days. She said that she did have history of SVT in the past. Of note, patient said that she has been taking metoprolol; however, she had to cut the tablet by half from 50 mg to 25 mg twice a day because of trying to save some insurance.

.

REVIEW OF SYSTEMS:

As per history of present illness. Otherwise, a 12-point review of system was checked and found negative.

.

FAMILY HISTORY:

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Checked and found noncontributory.

.

ALLERGIES:

THE PATIENT IS ALLERGIC TO SULFA.

.

PAST MEDICAL AND PAST SURGICAL HISTORY:

1. History of supraventricular tachycardia.
2. Coronary artery disease, status post myocardial infarction back in March 2015.
3. Status post cardiac cath and stent inserted back in March 2015.
4. Diabetes mellitus type 2.
5. History of diabetic foot in the left foot, mainly.
6. Dyslipidemia.

.

CURRENT HOME MEDICATIONS:

1. Aspirin 81 mg p.o. daily.
2. Lipitor 20 mg 1 tab p.o. daily.
3. Lopressor 25 mg 1 tab p.o. b.i.d. instead of 50 mg 1 tab p.o. b.i.d.
4. Lantus 44 units subcutaneous at bedtime.
5. Vitamin D3 1000 units p.o. daily.

.

SOCIAL HISTORY:
No IV drug abuse or alcohol abuse. The patient did have history of smoke in the
past, not anymore. She is a full code. Currently, she lives with her daughter.
She is retired.
.
PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.9, pulse originally was 168 in SVT after adenosine
went down to 100 beats per minute, respiratory rate 20, blood pressure 129/103.
GENERAL APPEARANCE: Lying down, not in visible respiratory distress, conscious,
alert, and oriented x3.
HEENT: EOMI. PERRLA.
CARDIOVASCULAR: S1, S2. No JVD. No significant bilateral lower extremity
swelling.
ABDOMEN: Soft, lax. No tenderness. No shifting dullness. No organomegaly.
NECK: No neck tenderness, enlarged thyroid, or palpable lymph node.
EAR EXAMINATION: No ear discharge.
ORAL EXAMINATION: No oral ulceration.
SKIN: Did not reveal any skin rash.
CHEST: Good bilateral air entry. No crackles, no wheezes, no rhonchi.
SKIN EXAMINATION: Did not reveal any skin rash.
MUSCULOSKELETAL: No visible joint redness or tenderness by palpation; however,
I noticed around the left toe presence of a significant diabetic foot scar,
nontender to palpation. No drainage noticed, but scar is significant and
spherical in nature.
.
LAB WORK/MEDICATION REVIEWED.
Sodium 131, potassium 4.8, chloride 97, anion gap 11, blood glucose 460,
creatinine 1.2 with baseline creatinine around 0.8, calcium 8.8, albumin 3.1,
total protein 7.6, AST 30, ALT 19, alkaline phosphatase 144, magnesium 1.7.
Troponin 0.02. White count 9.8, hemoglobin 16.0, and platelet is 261.
.
ASSESSMENT:
A 64-year-old with multiple current active medical issues.
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PLAN:
1. Recurrent episode of retrosternal chest pressure radiating to the jaw,
radiating to the left upper extremity, highly suspicious for unstable

angina due
to the fact that those episodes has been more frequent and occurring
at rest.
The patient will be started on subcutaneous Lovenox. Patient also
will be on
aspirin 325 mg 1 tab p.o. daily on the top of beta blockade,
metoprolol 50 mg
twice and on the top of atorvastatin 20 mg 1 tab p.o. at bedtime.
The patient
to get 2D echo ordered. The patient to be on telemetry bed. The
patient also
to get on pain medication as needed. The patient is status post
abnormal stress
test back in February 2015 and there is no point in repeating another
stress
test _____ unless cardiology want that. We will get a consult
cardiology
service on board for possible cardiac cath. We are going to defer
the decision
to the cardiology service as needed.
2. Acutely uncontrolled diabetes mellitus type 2 with significant
elevated
blood sugar at around 400. Patient to get IV fluids and insulin.
Chem-7 will
be monitored. Patient also will be started on detemir on the top of
her
diabetic diet, 1800 kilocalorie. HbA1c also will be checked.
Further
adjustment of insulin will be implemented as needed.
3. Supraventricular tachycardia with current heart rate in the 160s
upon
presentation. The patient's beta blockade, metoprolol will be bumped
to 50 mg 1
tab p.o. b.i.d. instead of 25 mg 1 tab p.o. b.i.d. Heart rate/blood
pressure
will be closely monitored. Further adjustment of metoprolol dose
will be
implemented as needed.
4. Barely acute renal failure with creatinine around 1.2 with GFR of
55 with a
baseline creatinine around 0.8. The patient to be on IV fluids.
Overall, fluid
balance, urine output, and electrolytes will be monitored and
medication will be
adjusted accordingly.
5. Hyponatremia with sodium around 131. Again, the patient will be
on IV
fluid. Sodium level will be rechecked to make sure that it is
trending up and
getting better, if not further management to be implemented as
needed.
6. Gastrointestinal/deep venous thrombosis prophylaxis. The patient
to be on
Protonix 40 mg per day in addition to subcutaneous Lovenox.
7. History of significant left diabetic foot with current large
scar. The
patient to be assessed by podiatry to see if there is any room for
any surgical

intervention and/or other management that might be needed.
8. Coronary artery disease, status post myocardial infarction back in March
2015, status post cardiac catheterization and stent inserted back in March 2015.
 Again, patient will be on aspirin, beta blockade, metoprolol, statin,
(atorvastatin).
.
A thorough discussion occurred with the patient about our current management
plan and I answered all of her questions. Patient will be admitted to
telemetry.
.
DD: 01/27/2016 08:16 CT   DT: 01/27/2016 11:26 CT
Job#3791893
Confirmation#508836
Samer El Dirani MD (F)
Dictated By: Samer El Dirani MD (F)
Authenticated by Samer El Dirani On 02/08/2016 05:57:06 AM
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TR:
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PATIENT NAME: [redacted] ACCOUNT # D72716985519
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DD: 01/27/16 0816
DT: 01/27/16 1126
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Samer ElDirani, MD
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Electronically Signed by Samer ElDirani, MD on 02/08/16 at 0557
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PATIENT NAME: [redacted] ACCOUNT #
D72716985519 **Electronically signed by Misty Aguirre RN on 02/08/2016 at 10:45 AM**

Primary Physician: Singh,Linda

[redacted]

Report Name: CONSULTATION
Accession ID: D.HIM20160129-0066
Admit Date:

REPORT

Research Medical Center

2316 E. Meyer Blvd

Kansas City, Missouri 64132

[redacted]0

LOCATION: D.5E

ACCOUNT#: D72716985519

ROOM/BED: D.5246-A

REPORT STATUS: Signed

ATTEND PHYSICIAN: ElDirani,Samer MD

PRIMARY CARE PHYSICIAN: Singh,Linda C MD

REFERRING PHYISICIAN: SELF REFERRED

CONSULTATION

CONSULTING:

Madhavi Yarlagadda MD (F)

DATE OF SERVICE:

01/28/2016

REASON FOR CONSULTATION:

Uncontrolled type 2 diabetes mellitus.

HISTORY OF PRESENT ILLNESS:

[redacted] is a 64-year-old woman who presented with complaints of retrosternal chest pain radiating to the left upper extremity, associated with cold sweat and mild nausea. She has a history of coronary artery disease, status post MI. She is admitted to rule out acute myocardial infarction. Patient also has a history of type 2 diabetes and A1c this hospitalization is elevated at 13.1%. I am asked to manage the condition.

On further questioning, patient tells me that she has been diagnosed with type 2 diabetes 16 years ago. She takes Levemir 44 units at night, Apidra per sliding scale starting with 6 units above 150. She has had insurance issues over the past 6 months and has not been able to get her medications regularly. She also admits to dietary noncompliance during the holidays. She checks blood sugars 2 times a day. Fasting readings are in the 185 to 260 range, lunch readings are in the 253 to 300 range, and she does not check rest of the day. Hypoglycemia occurs very rarely. She gets shaky and sweaty when her blood sugar drops. She has no known history of retinopathy. No known CKD. She does have coronary artery disease status post MI. No known CVA, he has symptoms suggestive of neuropathy. Her appetite in the hospital has been good.

Currently, in the hospital, she is ordered for 15 units twice a day of Levemir with algorithm-2 sliding scale insulin. Her blood sugar readings have been ranging in the 53 to 277 range.

REVIEW OF SYSTEMS:

Denies chest pain. All other review of systems other than those listed in HPI

are negative.

[redacted]

PAST MEDICAL HISTORY:

Supraventricular tachycardia, coronary artery disease, status post myocardial infarction, status post cardiac catheterization and stent placement in 03/2015, type 2 diabetes mellitus, history of diabetic foot in the left foot, and dyslipidemia.

PAST SURGICAL HISTORY:

I and D of the left foot ulcer and eye surgery.

FAMILY HISTORY:

Diabetes, both parents have history of diabetes. Two sisters and one brother have a history of diabetes.

SOCIAL HISTORY:

Patient does not drink excess alcohol. She does not use illicit drugs. She is a retired nurse. She has half a pack a day, 15-year history of smoking. She quit 8 months ago. She currently lives with her daughter.

ALLERGIES:

TO SULFA DRUGS.

MEDICATIONS:

Currently, in the hospital, she is ordered for:

1. Metoprolol.
2. Levemir 15 units twice a day.
3. Algorithm-2 sliding scale insulin.
4. Lac-Hydrin.
5. Lipitor.
6. Aspirin.
7. Protonix.
8. Lopressor.
9. Lovenox.
10. Colace.
11. MiraLax.
12. Zofran.

13. Morphine sulfate.

14. Tylenol.

15. Magnesium and potassium protocol.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 37.2, heart rate 80, respiratory rate 14, and blood pressure 105/61.

GENERAL: This is a middle-aged woman sitting up in the bed.

HEENT: Head is atraumatic and normocephalic.

NECK: Thyroid is not enlarged to palpation.

LUNGS: Clear to auscultation bilaterally.

HEART: Regular rate and rhythm. No appreciable murmurs.

ABDOMEN: Soft, nontender, and nondistended, with normal bowel sounds.

EXTREMITIES: There is no edema of bilateral lower extremities.

NEUROLOGIC: There is no tremor of outstretched hands. She is alert, awake, and oriented x3 and has no motor deficits.

LABORATORY DATA:

[redacted]

Hemoglobin A1c 13.1% and creatinine 0.8. Blood glucose readings on 01/27/2016, 179, 103, 270, 351; on 01/28/2016, 53, 232, 238, and 277.

IMPRESSION:

Type 2 diabetes mellitus, poorly controlled as shown by her A1c of 13.1%. Patient has had issues with obtaining her medication due to insurance problems. She also admits to dietary noncompliance during the holidays. SHe notes worsening of BG after stopping MFM 500 mg BID several month ago.

Discussed goals for treatment of Diabetes and complications of uncontrolled Diabetes. She had an episode of hypoglycemia this morning. I will plan to change Levemir to 25 units once a day. Start Humalog 5 units with meals with

algorithm-2 sliding scale insulin and increase as needed. Start metformin 500 mg twice a day. Creatinine is normal. Blood glucose monitoring a.c., at bedtime, and 3 a.m. Further adjustments of this regimen will be based on her response.

Thank you very much for the consult. I will follow with you.

DD: 01/28/2016 23:43 CT DT: 01/29/2016 03:03 CT

Job#3797209

Confirmation#514128

Madhavi Yarlagadda MD (F)

Dictated By: Madhavi Yarlagadda MD (F)

Authenticated and Edited by Madhavi Yarlagadda, MD On 1/29/16 5:55:18 PM

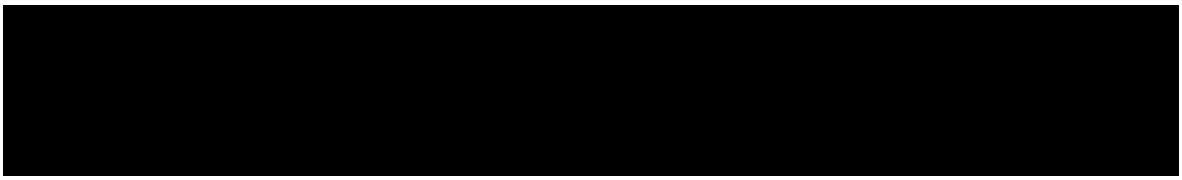
TR:

DD: 01/28/16 2343

DT: 01/29/16 0303

Madhavi Yarlagadda, MD

Electronically Signed by Madhavi Yarlagadda, MD on 01/29/16 at 1817



ECHOCARDIOGRAM
Originating Physician: Cesar D Rios, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD

Research Medical Center
2316 E. Meyer Blvd
Kansas City, Missouri 64132
Phone: 816-276-4000

PATIENT NAME: [redacted] LOCATION: D.4W
MEDICAL RECORD#: D01113686 ACCOUNT#: D72716985519
DATE OF BIRTH: [redacted] ROOM/BED: D.4124-A
DATE OF ADMIT: 01/26/16 REPORT STATUS: Signed
PT GENDER: F
.
ATTEND PHYSICIAN: ElDirani,Samer MD
PRIMARY CARE PHYSICIAN: Singh,Linda C MD
REFERRING PHYISICIAN: SELF REFERRED
.

ECHOCARDIOGRAM

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Research Medical Center
2316 East Meyer Blvd.
Kansas City, MO 64132
(816)276-4000
.
Transthoracic Echocardiogram
2D, M-mode, Doppler, and Color Doppler
.
Patient: [redacted] L [redacted]
MR #: K16671
Account #: D72716985519
DOB: [redacted]
Age: 64 years
Study date: 01/27/2016
Study time: 11: 0
Gender: Female
Ht-Wt: 67 in- 163.7 lb
BSA: 1.86 m squared
MPI #: D01113686
Location: D.4124-A
Status: Inpatient
BP: 112/ 76 mmHg
Heart rate:
.
Sonographer: Shannita Khemraj-Beharry, RDCS, RRT
Ordering Physician: Samer El Dirani, MD
Reading Physician: C David Rios, MD
.
SUMMARY:
.
- Left ventricle: Size was normal. Systolic function was moderately reduced.

Ejection fraction was estimated in the range of 35 % to 40 %. There was
hypokinesis of the basal inferolateral, basal-mid anterolateral, and apical
lateral wall(s). Wall thickness was normal. Features were consistent with a
pseudonormal left ventricular filling pattern, with concomitant abnormal
relaxation and increased filling pressure (grade 2 diastolic dysfunction).
Doppler parameters were consistent with high ventricular filling pressure.
.
- Left atrium: Size was at the upper limits of normal.
.
PATIENT NAME: [redacted] ACCOUNT # D72716985519
.
.
.
.
- Right ventricle: The size was normal. Systolic function was normal.
.
- Right atrium: Size was normal.
.
- Mitral valve: There was mild regurgitation.
.
- Aortic valve: There was no evidence for stenosis. There was no regurgitation.
.
- Pericardium: There was no significant pericardial effusion.
.
INDICATIONS: Angina pectoris.
.
HISTORY: PRIOR HISTORY: Tachycardia, CAD
.
PROCEDURE: The procedure was performed in the echo lab. This was a routine
study. The transthoracic approach was used. The study included complete 2D
imaging, M-mode, complete spectral Doppler, and color Doppler. Images were
obtained from the parasternal, apical, subcostal, and suprasternal notch
acoustic windows. Image quality was good.
.
SYSTEM MEASUREMENT TABLES
.
2D
Ao Diam: 2.87 cm
LA Diam: 2.36 cm
LA Index: 29.38
IVSd: 1 cm
LVIDd: 5.58 cm
LVIDs: 4.96 cm
LVOT Diam: 2.17 cm
LVPWd: 0.89 cm
.

CW
AV Vmax: 1.16 m/s
AV maxPG: 5.36 mmHg
AV meanPG: 3.27 mmHg
.
PW
AVA (VTI): 2.06 cm2
E': 0.06 m/s
E/E': 20.01
MV E/A Ratio: 0.84
.
LEFT VENTRICLE: Size was normal. Systolic function was moderately reduced.
Ejection fraction was estimated in the range of 35 % to 40 %. There was
hypokinesis of the basal inferolateral, basal-mid anterolateral, and apical
lateral wall(s). Wall thickness was normal. DOPPLER: Features were consistent
with a pseudonormal left ventricular filling pattern, with concomitant abnormal
relaxation and increased filling pressure (grade 2 diastolic dysfunction).
Doppler parameters were consistent with high ventricular filling pressure.
.
LEFT ATRIUM: Size was at the upper limits of normal.
.
PATIENT NAME: [redacted] ACCOUNT # D72716985519
.
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.
.
RIGHT VENTRICLE: The size was normal. Systolic function was normal. Wall
thickness was normal.
.
RIGHT ATRIUM: Size was normal.
.
MITRAL VALVE: Valve structure was normal. There was normal leaflet separation.
DOPPLER: The transmitral velocity was within the normal range. There was no
evidence for stenosis. There was mild regurgitation.
.
AORTIC VALVE: The valve was trileaflet. Leaflets exhibited normal thickness.
DOPPLER: Transaortic velocity was within the normal range. There was no
evidence for stenosis. There was no regurgitation.
.
PULMONIC VALVE: Not well visualized.
.
TRICUSPID VALVE: The valve structure was normal. DOPPLER: There was no evidence
for stenosis. There was no regurgitation.
.
PERICARDIUM: There was no significant pericardial effusion. The

pericardium was
normal in appearance.
.
AORTA: The root was normal in size.
.
Prepared and signed by
.
C David Rios, MD
Signed 01/27/2016 14:21:23
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PATIENT NAME: [redacted] ACCOUNT #
D72716985519 **Electronically signed by Renee Richards on 01/28/2016 at 7:31 AM**

Consultation Note - Brief
Originating Physician: Madhavi Yarlagadda, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD
.
RESEARCH MEDICAL CENTER (COCRC)
Consultation Note - Brief
REPORT#:0128-1193 REPORT STATUS: Signed
DATE:01/28/16 TIME: 2344
.
PATIENT: [redacted] UNIT #: D01113686
ACCOUNT#: D72716985519 ROOM/BED: D.5246-A
DOB: [redacted] AGE: 64 SEX: F ATTEND: ElDirani,Samer MD
ADM DT: 01/26/16 AUTHOR: Yarlagadda,Madhavi
MD
REP SRV DT: 01/28/16 REP SRV TM: 2344
* ALL edits or amendments must be made on the electronic/computer
document *
.
.
History
.
Past History
Past family history:
Relation not specified for:
  Family History: Cancer
  Family History: Diabetes
  Family History: Heart disease
.
Allergies:
Coded Allergies:
Sulfa (Sulfonamide Antibiotics) (RASH 01/26/16)
.
.
Brief Consult Note
Reason for consult:
T2DM uncontrolled
.
Physical Exam
General appearance: alert, awake, oriented, no acute distress,
pleasant,
conversant, no respiratory distress
.
Full note dictated: Yes (514128)
.
Electronically Signed by Yarlagadda,Madhavi MD on 01/28/16 at 2346
.
RPT #: 0128-1193
END OF REPORT **Electronically signed by Misty Aguirre RN on 01/29/2016 at 11:27 AM**

Primary Physician: Singh,Linda

[redacted]

Report Name: Consultation Note - Brief
Accession ID: D.PDOC20160128-1193
Admit Date:

REPORT

RESEARCH MEDICAL CENTER (COCRC)

Consultation Note - Brief

REPORT#:0128-1193 REPORT STATUS: Signed

DATE:01/28/16 TIME: 2344

[redacted]

UNIT #: D01113686

ROOM/BED: D.5246-A

ATTEND: ElDirani,Samer MD

ADM DT: 01/26/16

AUTHOR: Yarlagadda,Madhavi MD

REP SRV DT: 01/28/16

REP SRV TM: 2344

* ALL edits or amendments must be made on the electronic/computer document *

History

Past History

Past family history:

Relation not specified for:

Family History: Cancer

Family History: Diabetes

Family History: Heart disease

Allergies:

Coded Allergies:

Sulfa (Sulfonamide Antibiotics) (RASH 01/26/16)

Brief Consult Note

Reason for consult:

T2DM uncontrolled

Physical Exam

General appearance: alert, awake, oriented, no acute distress, pleasant, conversant, no respiratory distress

Full note dictated: Yes (514128)

Electronically Signed by Yarlagadda,Madhavi MD on 01/28/16 at 2346

RPT #: 0128-1193

END OF REPORT

Research Med Center
Kansas City, MO

[redacted]

ACCT: D72716985519
LOCATION: D.5E

ATTENDING: Samer ElDirani
CONSULTING: Madhavi Yarlagadda MD (F)

CONSULTATION REPORT

REASON FOR CONSULTATION:
Uncontrolled type 2 diabetes mellitus.

HISTORY OF PRESENT ILLNESS:
[redacted] is a 64-year-old woman who presented with complaints of retrosternal chest pain radiating to the left upper extremity, associated with cold sweat and mild nausea. She has a history of coronary artery disease, status post MI. She is admitted to rule out acute myocardial infarction. Patient also has a history of type 2 diabetes and A1c at this hospitalization is elevated at 13.1%. I am asked to manage the condition.

On further questioning, patient tells me that she has been diagnosed with type 2 diabetes 16 years ago. She takes Levemir 44 units at night. Apidra per sliding scale starting with 6 units above 150. She has had insurance issues over the past 6 months and has not been able to get her medications regularly. She checks blood sugars 2 times a day. Fasting readings are in the 185 to 260 range, lunch readings are in the 253 to 300 range, and she does not check rest of the day. Hypoglycemia occurs very rarely. She gets shaky and sweaty when her blood sugar drops. She has no known history of retinopathy. No known CKD. She does have coronary artery disease status post MI. No known CVA or she has symptoms suggestive of neuropathy. Patient tells me that her appetite in the hospital has been good. She also admits to dietary noncompliance during the holidays.

Currently, in the hospital, she is ordered for 15 units twice a day of Levemir with algorithm-2 sliding scale insulin. Her blood sugar readings have been ranging in the 53 to 277 range.

REVIEW OF SYSTEMS:
Denies chest pain. All other review of systems other than those listed in HPI are negative.

PAST MEDICAL HISTORY:
Supraventricular tachycardia, coronary artery disease, status post myocardial infarction, status post cardiac catheterization and stent placement in 03 2015, type 2 diabetes mellitus, history of diabetic foot in the left foot, and dyslipidemia.

PAST SURGICAL HISTORY:

[redacted]

I and D of the left foot ulcer and eye surgery.

FAMILY HISTORY:
Diabetes, both parents have history of diabetes. Two sisters and one brother have a history of diabetes.

SOCIAL HISTORY:
Patient does not drink excess alcohol. She does not use illicit drugs. She is a retired nurse. She has half a pack a day, 15-year history of smoking. She quit 8 months ago. She currently lives with her daughter.

ALLERGIES:
TO SULFA DRUGS.

MEDICATIONS:
Currently, in the hospital, she is ordered for:
1. Metoprolol.
2. Levemir 15 units twice a day.
3. Algorithm-2 sliding scale insulin.
4. Lac-Hydrin.
5. Lipitor.
6. Aspirin.
7. Protonix.
8. Lopressor.
9. Lovenox.
10. Colace.
11. MiraLax.
12. Zofran.
13. Morphine sulfate.
14. Tylenol.
15. Magnesium and potassium protocol.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 37.2, heart rate 80, respiratory rate 14, and blood pressure 105/61.
GENERAL: This is a middle-aged woman sitting up in the bed.
HEENT: Head is atraumatic and normocephalic.
NECK: Thyroid is not enlarged to palpation.
LUNGS: Clear to auscultation bilaterally.
HEART: Regular rate and rhythm. No appreciable murmurs.
ABDOMEN: Soft, nontender, and nondistended, with normal bowel sounds.
EXTREMITIES: There is no edema of bilateral lower extremities.
NEUROLOGIC: There is no tremor of outstretched hands. She is alert, awake, and oriented x3 and has no motor deficits.

[redacted]

LABORATORY DATA:
Hemoglobin A1c 13.1% and creatinine 0.8. Blood glucose readings on 01/27/2016, 179, 103, 270, 351; on 01/28/2016, 53, 232, 238, and 277.

IMPRESSION:
Type 2 diabetes mellitus, poorly controlled as shown by her A1c of 13.1%. Patient has had issues with obtaining her medication due to insurance problems. She also admits to dietary noncompliance during the holidays. She had an episode of hypoglycemia this morning. I will plan to change Levemir to 25 units once a day. Start Humalog 5 units with meals with algorithm-2 sliding scale insulin and increase as needed. Start metformin 500 mg twice a day. Creatinine is normal. Blood glucose monitoring a.c., at bedtime, and 3 a.m. Further adjustments of this regimen will be based on her response.

Thank you very much for the consult. I will follow with you.

DD: 01/28/2016 23:43 CT
DT: 01/29/2016 03:03 CT
HSC.V.TRSD; Job#3797209
Last Submitted On:

Madhavi Yarlagadda MD (F)

[redacted] **LOC:** D.5E **U #:** D01113686
ROOM: D.5246 **REG:** 01/26/16
DOB: 06/02/51 **BED:** A **DIS:** 01/31/16
REG DR: ElDirani,Samer MD **STATUS:** DIS IN

SPEC #: 0127:RC:C00359T **COLL:** 01/27/16-0418 **STATUS:** COMP **REQ #:** 07296626
RECD: 01/27/16-0427 **SUBM DR:** ElDirani,Samer MD

ENTERED: 01/27/16-0336 **OTHR DR:** SELF REFERRED
Rios,Cesar D MD
Singh,Linda C MD

ORDERED: BASIC MET PANEL/R, LIPID/R, MAGNESIUM/R, T4F/R, TSH/R, CPKMB/R, TROPONIN I/R

Test	Normal	Abnormal	Flag	Reference	Site
BASIC MET PANEL					
LYTES					
LIPID					
TRIGLYCERIDES	141			0-149 MG/DL 01/27/16-0508	
CHOLESTEROL	134			0-199 MG/DL 01/27/16-0508	
HDL (AUTOMATED)		35	L	40-60 MG/DL 01/27/16-0508	
LDL-CALC	71			0-129 MG/DL 01/27/16-0508	
NON HDL-CALC	99			SEE CHART MG/DL 01/27/16-0508	

INTERPRETIVE DATA FOR LIPID PANEL

	Normal	*Border-High*	*High*	*Very High*
Triglyceride mg/dl	*<150*	*150-199*	*200-499*	*>500*
Cholesterol mg/dl	*<200*	*200-239*	*=/>240*	

	Low	*Risk Average*	*High*
HDL Chol mg/dl	*>60*	*40-60*	*<40*

	0-1	*Risk Factors 2+*	*CHD*	*CHD/Diabetic*
Patient Goals				
LDL-calc mg/dl	*<160*	*<130*	*<100*	*<70*
Non-HDL-calc				

** CONTINUED ON NEXT PAGE **

[redacted] (Continued)

Test	Normal	Abnormal	Flag	Reference	Site
	mg/dl	*<190*		*<160*	*<130*	*<100*
	Reference: *1.Third Report of NCEP ATP III. JAMA.2001;285:2486-2497* *2.NON-HDL Their Risk Predictive Values in Cornary Heart Disease. AM J Cardiol 2006;98:1363-1368*				
SODIUM	138			135-146 MMOL/L	01/27/16-0508
POTASSIUM	4.2			3.6-5.2 MMOL/L	01/27/16-0508
CHLORIDE	105			100-108 MMOL/L	01/27/16-0508
CARBON DIOXIDE	26			21-32 MMOL/L	01/27/16-0508
ANION GAP		11	L	12-21	01/27/16-0508
GLUCOSE, RANDOM		228	H	70-99 MG/DL	01/27/16-0508
BUN	17			6-22 MG/DL	01/27/16-0508
CREATININE/GFR					
CREATININE	0.7			0.5-1.5 MG/DL	01/27/16-0508
eGFR	107.9			>60	01/27/16-0508
	The Glomerular Filtration Rate is a calculated parameter based on serum Creatinine levels, patient age, race, and sex. It is most accurate at levels below 60 mL/min/1.73 square meters. *GFR values less than 60 mL/min/1.73 square meters are indicative of Chronic Kidney Disease.* *GFR values less than 15 mL/min/1.73 square meters indicate Kidney Failure.*				
CALCIUM		7.8	L	8.7-10.7 MG/DL	01/27/16-0508
MAGNESIUM	1.8			1.6-2.4 MG/DL	01/27/16-0508
T4F	1.22			0.90-1.94 NG/DL	01/27/16-0508
TSH	0.95			0.40-4.00	01/27/16-0508
	Reported in Micro-International Units/ML				

** CONTINUED ON NEXT PAGE **

[redacted]

Test	Normal	Abnormal	Flag	Reference	Site
CPKMB					
CK TOTAL	67			11-178 UNITS/L	01/27/16-0508
CKMB	1.7			0.0-3.2 NG/ML	01/27/16-0508
CKMBI REL	2.500			0-3.6	01/27/16-0508
TROPONIN I	0.03			0.00-0.07 NG/ML	01/27/16-0508

INTERPRETATION
0.00-0.07 NG/ML
Acute myocardial infarction (AMI) not likely (value is within 99th percentile of normal population). Recommend repeat testing if clinical suspicion of AMI is high.

0.08-1.49 NG/ML
Troponin-I exceeds 99th percentile consistent with myocyte damage. In the absence of clinical evidence of ischemia, repeat testing may be clinically indicated.

=/>1.5 NG/ML
Elevation of Troponin-I consistent with AMI or myocardial injury. Clinical correlation is recommended.

** END OF REPORT **

Discharge Summary
Originating Physician: Samer ElDirani, MD
Referring Physician: SELF REFERRED,
Consulting Physician: Linda C Singh, MD
.
RESEARCH MEDICAL CENTER (COCRC)
Discharge Summary
REPORT#:0131-0517 REPORT STATUS: Signed
DATE:01/31/16 TIME: 1336
.
PATIENT: [redacted] UNIT #: D01113686
ACCOUNT#: D72716985519 ROOM/BED: D.5246-A
DOB: [redacted] AGE: 64 SEX: F ATTEND: ElDirani,Samer MD
ADM DT: 01/26/16 AUTHOR: ElDirani,Samer MD
REP SRV DT: 01/31/16 REP SRV TM: 1336
* ALL edits or amendments must be made on the electronic/computer document *
.
.
Med Rec
.
Med Rec
Discharge meds:
Stop taking the following medications:
ASPIRIN EC (ASPIRIN EC) 81 MG TAB.EC ORAL DAILY AT 0900
.
ATORVASTATIN (LIPITOR) 20 MG TAB ORAL DAILY AT 0900
.
METOPROLOL TARTRATE (LOPRESSOR) 25 MG TAB ORAL TWICE A DAY
.
INSULIN GLARGINE (LANTUS) 100 UNITS/ML VIAL SUBCUTANEOUS AT BEDTIME
.
INSULIN GLULISINE (APIDRA) 100 UNITS/ML VIAL
.
Continue taking these medications:
CHOLECALCIFEROL (VITAMIN D3) 1,000 UNITS CAP
1,000 UNITS ORAL DAILY AT 0900
.
Start taking the following new medications:
ATORVASTATIN (LIPITOR) 40 MG TAB
40 MILLIGRAM ORAL DAILY AT 0900
Days = 30
No Refills
.
METOPROLOL SUCCINATE XL (TOPROL XL) 100 MG TAB.SA
100 MILLIGRAM ORAL DAILY AT 0900
Days = 30
No Refills
.
ASPIRIN (ASPIRIN) 325 MG TAB
325 MILLIGRAM ORAL DAILY AT 0900
Days = 30
No Refills
.
PANTOPRAZOLE (PROTONIX) 40 MG TAB.DR

40 MILLIGRAM ORAL DAILY AT 0600
Days = 30
No Refills

.

INSULIN LISPRO (HumaLOG) 100 UNITS/ML VIAL
5 UNIT SUBCUTANEOUS WITH BREAKFAST
Days = 30
No Refills

.

INSULIN LISPRO (HumaLOG) 100 UNITS/ML VIAL
3 UNIT SUBCUTANEOUS WITH LUNCH AND DINNER
Days = 30
No Refills

.

INSULIN DETEMIR (LEVEMIR) 100 UNITS/ML INSULN.PEN
25 UNITS SUBCUTANEOUS DAILY AT 0900
Days = 30
No Refills

.

metFORMIN XR (GLUCOPHAGE XR) 500 MG TAB.SA
500 MILLIGRAM ORAL TWICE A DAY
Days = 30
No Refills

.

.

.

Physical Exam
VS/I O
Last Documented:

	Result	Date Time
Pulse Ox	100	01/31 1221
B/P	124/74	01/31 1221
Temp	37.1	01/31 1221
Pulse	79	01/31 1221
Resp	20	01/31 1221

.

24 hour I O ending at 0700:

	01/31 0700	01/30 1900
Intake Total	240	740
Output Total		800
Balance	240	-60

.

Intake, Oral	240	740
Number	2	0
Bowel Movements		
Output, Urine		800
Patient Weight	73.1 kg	

.

.

General appearance: alert, awake
Head/Eyes: atraumatic, clear cornea, EOMI, normocephalic, normal conjunctiva/
sclera, normal fundi, normal eyelids/periorb., PERRLA
ENT: normal dentition, normal ear left, normal ear right, normal nose, normal
pharynx, normal sinus

Neck: full range of motion, non-tender, no bruit/NL carotids, no JVD, no
lymphadenopathy, no masses or swelling, normal thyroid, supple/no
meningismus
Breast: symmetrical, no mass
Cardiovascular: normal capillary refill, regular rate   rhythm
Respiratory: clear to auscultation, no distress, no tenderness
GI: soft, non-tender, no guarding, no rebound, no distention, no
mass/
organomegaly, no pulsatile mass, no hernia, normal abdominal aorta
  Abdomen quadrants:
LLQ normal bowel sounds, LUQ normal bowel sounds, RLQ normal bowel
sounds, RUQ
normal bowel sounds
Genitourinary: not indicated
Extremities: moves all, no edema, normal capillary refill, normal
range of
motion, normal sensory, normal motor function
Musculoskeletal: full range of motion, normal inspection
Neuro/CNS: alert, oriented X 3
Skin: dry, intact, no gross abnormalities
Lymphatic: axilla normal, inguinal normal, no lymphadenopathy, neck
normal
Psychiatry: no hallucinations, normal affect, normal
judgment/insight, normal
mood, not homicidal, not suicidal
.
.
General Information
Hospital course:
Active Meds + DC'd Last 24 Hrs
Insulin Human Lispro   3 UNIT   C LU DIN   SUBQ   (CKD)
Insulin Human Lispro   5 UNIT   C BK   SUBQ   (CKD)
Ammonium Lactate   1 APPLIC   BID   TOPICAL
Insulin Detemir   25 UNITS   DAILY   SUBQ
Metoprolol Succinate   100 MG   DAILY   PO
Insulin Human Lispro   5 UNIT   C MEALS   SUBQ   (DC)
Ammonium Lactate   1 APPLIC   BID   TOPICAL   (DC)
Metformin HCl   500 MG   BID MEALS   PO   (DC)
Atorvastatin Calcium   40 MG   DAILY   PO
Miscellaneous Medication   1 EACH   AS DIRECTED   MISC   (DC)
Aspirin   325 MG   DAILY   PO
Pantoprazole Sodium   40 MG   QDAY6   PO
Docusate Sodium   100 MG   BID   PO
Enoxaparin Sodium   70 MG   BID   SUBQ
Acetaminophen   650 MG   Q4H PRN PRN   PO
Morphine Sulfate   1 MG   Q3H PRN PRN   IV
Morphine Sulfate   2 MG   Q3H PRN PRN   IV
Ondansetron HCl   4 MG   Q6H PRN PRN   IV
Polyethylene Glycol   17 GM   BID PRN PRN   PO   (CKD)
Dextrose   1,000 ML   ONCALL PRN   IV
Dextrose   25-50 mL
        Q30M PRN MRX1 PRN   IV
Glucagon   1 MG   Q30M PRN MRX1 PRN   SUBQ
Glucose   16 G   Q30M PRN MRX1 PRN   PO
Insulin Human Lispro   SUPPLEMENTAL ORDERS
        AC BEDTIME PRN   SUBQ
Magnesium Sulfate   1 EACH   ASDIR   IV   (CKD)

Miscellaneous Medication 1 EACH AS DIRECTED MISC
Potassium Chloride 1 EACH ASDIR IV
.
64 YEARS ODL WITH MULTIPLE CURRENT ACTIVE MEDICAL ISSUES
.
1-UNSTABLE ANGINA : WITH RECURRENT CHES TPAIN AT REST : PT DID HAVE HX OF MI
BACK IN MARCH 2013, WITH S/P CATH AN STENTS INSERTED AT THAT TIME, PT STARTED ON
SC LOVENOX, IN ADDITON TO BB, STATINS AND PAIN MEDS AS NEEDED IT, SERIAL EKG/
CARDIAC ENZYMES ALSO WILL EB ORDERED.,
CARDIOLOGY SERVICE ON BOARD
.
2-SVT WITH HR IN THE 160'S , RESPONDED V WELL TO ADENOSIN, PT HAS BEEN ON
METOPROLOL 50MG BID, HOWEVER SHE DECIDED TO DECREASE HER DOSE BY 50%, PROBABLY
THIS HAVE PREDISPOSED THE PT TO THIS SVT EPISODE, AS PER PT, SHE SAID THAT SHE
DID HAVE HX OF SVT IN THE PAST.
PT GOT 2 D ECHO, AND PUT BACK ON METOPROLOL 50MG BID, HR WILL BE CLSOELY
MONITORED, AS WELL AS ELECTROLYTES MAINLY MAG/POTASSIUM, FURTHER MANAGEMENT WILL
BE IMPLEMENTED AS PER PT'S CLINCIAL PIC.
.
3-DM2 : ACUTELY UNCONTROLED PT TO BE ON DETEMI, A1C CHECKED, PT TO BE DIABETIC
DIET, PT'S ACCUCKES WILL EB MONIOTRED AND FURTHER ISNULINE SUPPLEMENTAITON WILL
BE IMPLEMENTED AS NEEDED IT.
.
4-HX OF DIABETIC FOOT , ON THE LEFT SIDE, NO ACTIVE DRAINAGE WAS NOTICED, PT GOT
PODIATRY SERVICE TO EVALAUTE, CURRENTLY NO FEVER, NO DRAINAGE NOTICED, PT GOT X
RAY 2 VIEWS, AND CRP/WBC CHECKED, NO CURRENT ACTIVE INFECTIOUS PROCESS.
.
5-COMBINED DIASTOLIC /SYSTOLIC CHF : AS PER 2 D ECHO RESULT, OVERALL FLUID
BALANCE MONIOTRED AND IF NEEDED IT, FURTHER DIURESIS WILL BE IMPLEMENTED
.
6-"MODERATE RISK" CARDIAC STRESS TEST RESULT :EVALUATED VIA CARDIOLOGY SERVICE
, AND PT WILL BE ON MEDICAL MANAGEMENT FOR THE TIME BEING, LIPITOR DOSE
INCREASED AND ASA DOSE INCREASED TO 325 MG PER DAY
.
PT'S INSULINE DOSE ADJUSTED, TRYING TO AVOID HYPOGLYCEMIC EVENT BUT ALSO TAKE
CARE OF THE ELEVATED A1C THAT THE PATIENT IS HAVING.
.
.
.
.

Discharge Instructions
Special instructions:
D/C HOME
FOLLOW UP WITH PCP IN 1-2 WEEKS
FOLLOW UP WITH DR LAWRENCE , CARDIOLOGY CLINIC IN 2-4 WEEKS
FOLLOW UP WITH DR YARLAGAD/ENDOCRINOLOGY CLINIC IN 1-2 WEEKS
.
.
TOTAL OF 40 MINUTES OF UN-INTERRUPTED TIME WAS SPENT RELATED TO THIS PT'S
DISCHARGE
.
Electronically Signed by ElDirani,Samer MD on 01/31/16 at 1401
.
RPT #: 0131-0517
END OF REPORT **Electronically signed by Misty Aguirre RN on 02/02/2016 at 12:02 PM**

[redacted]

LOC: D.5E **U #:** D01113686
ROOM: D.5246 **REG:** 01/26/16
BED: A **DIS:** 01/31/16

SPEC #: 0126:RC:CG00133S **COLL:** 01/26/16-1645 **STATUS:** COMP **REQ #:** 07295580
RECD: 01/26/16-1710 **SUBM DR:** Curry,Kristy Genners MD

ENTERED: 01/26/16-1645 **OTHR DR:** Lewis,Kelsey N NP
ORDERED: PT, PTT

Test	Normal	Abnormal	Flag	Reference	Site
PT					
PT PATIENT	10.3			9.0-11.0 SECONDS	01/26/16-1727
INR	1.0			0.9-1.1	01/26/16-1727

INR INTERPRETATION

Patients NOT Receiving Coumadin therapy should be monitored using only the Protime (PT) value in seconds.

Patients RECEIVING Coumadin therapy should be monitored using only the INR value. An INR therapeutic range of 2.0-3.0 is recommended for all oral anticoagulant indications except mechanical prosthetic heart valves, where the recommended INR range is 2.5-3.5.

PTT					
PTT	23.1			22.0-30.0 SECONDS	01/26/16-1727

** END OF REPORT **

[redacted]

LOC: D.5E **U #:** D01113686
ROOM: D.5246 **REG:** 01/26/16
BED: A **DIS:** 01/31/16

SPEC #: 0126:RC:H00360S **COLL:** 01/26/16-1645 **STATUS:** COMP **REQ #:** 07295580
RECD: 01/26/16-1710 **SUBM DR:** Curry,Kristy Genners MD

ENTERED: 01/26/16-1645 **OTHR DR:** Lewis,Kelsey N NP
ORDERED: CBCD

Test	Normal	Abnormal	Flag	Reference	Site
CBCD					
CBC HEMOGRAM					
WBC	9.8			4.1-11.1 x10 3/uL	01/26/16-1719
RBC		5.21	H	3.90-5.10 x10 6/u	01/26/16-1719
HGB		16.0	H	11.5-15.3 g/dL	01/26/16-1719
HCT		48.8	H	35.2-45.1 %	01/26/16-1719
MCV	93.7			81.8-97.9 fL	01/26/16-1719
MCH	30.7			27.2-33.0 pg	01/26/16-1719
MCHC	32.8			31.9-36.1 g/dL	01/26/16-1719
RDW	13.9			11.9-15.1 %	01/26/16-1719
PLT	261			160-401 x10 3/uL	01/26/16-1719
MPV	11.3			9.4-12.4 fl	01/26/16-1719
DIFF					
NEUT	54			%	01/26/16-1719
NEUT ABSOLUTE	5.3			2.3-7.8 x10 3/uL	01/26/16-1719
LYMPH	40			%	01/26/16-1719
LYMPH ABSOLUTE	3.9			0.8-4.0 x10 3/uL	01/26/16-1719
MONO	5			%	01/26/16-1719
MONO ABSOLUTE	0.5			0.3-1.2 x10 3/uL	01/26/16-1719
EOS	1			%	01/26/16-1719
EOS ABSOLUTE	0.1			0.0-0.5 x10 3/uL	01/26/16-1719

** CONTINUED ON NEXT PAGE **

[redacted] #D72716985519 **(Continued)**

Test	Normal	Abnormal	Flag	Reference	Site
BASO	1			%	01/26/16-1719
BASO ABSOLUTE	0.1			0.0-0.1 x10 3/uL	01/26/16-1719
IMMATURE GRAN	0.3			0.0-1.5 %	01/26/16-1719
Immature granulocytes (promyelocytes, myelocytes, and metamyelocytes) >1.5% indicates that a left shift is present. Bands are included in the automated neutrophil count and not in the IG fraction.					
IMM GRAN ABS	0.0			0.0-0.2 x10 3/uL	01/26/16-1719
NRBC	0			0-0 /100 WBC	01/26/16-1719

** END OF REPORT **