HISTORY: ,I had the pleasure of meeting and evaluating the patient today, referred for evaluation of tracheostomy tube placement and treatment recommendations. As you are well aware, he is a pleasant 64-year-old gentleman who unfortunately is suffering from end-stage COPD, who required tracheostomy tube placement about three months ago when being treated for acute exacerbation of COPD and having difficulty coming off ventilatory support. He now resides in an extended care facility with a capped tracheostomy tube, and he unfortunately states he has had not had to use the tracheostomy tube since his discharge and admission to the extended care facility. He requires constant oxygen administration and has been having no problems with shortness of breath, worsening, requiring opening the tracheostomy tube site. He states there has been some tenderness associated with the tracheostomy tube and difficulty with swallowing and he wishes to have it removed. Apparently there is no history of any airway issues while sleeping or need for uncapping the tube and essentially the tube has just remained present for months capped in his neck. No history of any previous tracheostomy tube insertion.,PAST MEDICAL HISTORY: , COPD, history of hypercarbic hypoxemia, history of coronary artery disease, history of previous myocardial infarction, and history of liver cirrhosis secondary to alcohol use.,PAST SURGICAL HISTORY: ,Tonsillectomy, adenoidectomy, cholecystectomy, appendectomy, hernia repair, and tracheostomy.,FAMILY HISTORY: ,Strong for heart disease, coronary artery disease,

hypertension, diabetes mellitus, and cerebrovascular accident.,CURRENT MEDICATIONS:, Prevacid, folic acid, aspirin, morphine sulfate, Pulmicort, Risperdal, Colace, clonazepam, Lotrisone, Roxanol, Ambien, Zolpidem tartrate, simethicone, Robitussin, and prednisone.,ALLERGIES: , Nitroglycerin.,SOCIAL HISTORY: , The patient has a 25-year-smoking history, which I believe is quite heavy and he has a significant alcohol use in the past.,PHYSICAL EXAMINATION: ,VITAL SIGNS: Age 64, blood pressure is 110/78, pulse 96, and temperature is 98.6.,GENERAL: The patient was examined in his wheelchair, resting comfortably, in no acute distress.,HEAD: Normocephalic. No masses or lesions noted.,FACE: No facial tenderness or asymmetry noted.,EYES: Pupils are equal, round and reactive to light and accommodation bilaterally. Extraocular movements are intact bilaterally.,EARS: The tympanic membranes are intact bilaterally with a good light reflex. The external auditory canals are clear with no lesions or masses noted. Weber and Rinne tests are within normal limits.,NOSE: The nasal cavities are patent bilaterally. The nasal septum is midline. There are no nasal discharges. No masses or lesions noted.,THROAT: The oral mucosa appears healthy. Dental hygiene is maintained well. No oropharyngeal masses or lesions noted. No postnasal drip noted.,NECK: The patient has a stable-appearing tracheostomy tube site and the stoma appears to be without signs of infection. The previous incision was vertical in nature and there is no hypertrophic scar formation. No adenopathy noted. No stridor

noted.,NEUROLOGIC: Cranial nerve VII intact bilaterally. No signs of tremor.,LUNGS: Diminished breath sounds in all four quadrants. No wheezes noted.,HEART: Regular rate and rhythm.,PROCEDURE: , Limited bronchoscopy and then fiberoptic laryngoscopy.,IMPRESSION: ,1. End-stage chronic obstructive pulmonary disease with a history of respiratory failure requiring mechanical ventilatory support with tracheostomy tube placement.,2. Difficulty tolerating tracheostomy tubes secondary to swallow discomfort and neck irritation with no further need for tracheostomy tube over the past few months with the patient tolerating capped tracheostomy tube 24 hours a day.,3. History of coronary artery disease.,4. History of myocardial infarction.,5. History of cirrhosis of liver.,RECOMMENDATIONS: , I discussed with the patient in detail after fiberoptic laryngoscopy and limited bronchoscopy was performed in the office whether or not to pull out the tracheostomy tube. His vocal cords moved well, and I do not see any signs of granuloma or airway obstruction either in the supraglottic or subglottic region, and I felt he would tolerate the tube being removed with close monitoring by nursing at his extended care facility. I did impress the fact that I believe he probably will have other events requiring airway support, which could include intubation, and if the intubation is prolonged a tracheostomy may be needed. Creation of a long-term tracheostoma may be beneficial whereas the patient would not need such a long tracheostomy tube, and I informed the patient there are other options other than the tube he has at the present time. The patient still

wished to have the tube removed and he is aware he may need to have it replaced or he may have trouble with the area healing or scarring or he could end up having an emergent airway situation with the tube gone, but wishes to have it removed, and I did remove it today. Dressing was applied and we will see him back next week to make sure everything is healing properly.