UH HOSPITALS AND CLINICS
50 N Medical Dr
Salt Lake City UT 84132-0001
Phone: 801-581-2121

02/03/2025 - ED in University Hospital Emergency Department

Abstract Notes

Consults

Erica Perez, LCSW at 2/3/2025 2056

Consult Orders
1. IP Consult to Crisis (ED Only) [402990668] ordered by Morgan Nicole Williams, MD at 02/03/25 1913

ED Crisis Initial Consult

Admission Date: 2/3/2025
Provider: Jason Raine Pickett, MD

Initial Recommendations and Plan:

Received order for ED Crisis Crisis Consult. Reviewed records, then met with Boone Cabal for initial assessment. Spoke with Jason Raine Pickett, MD to discuss recommendation and plan.

Erica Perez, LCSW

Electronically signed by Erica Perez, LCSW at 02/03/25 2057

Leslie Brosius Perez, LCSW at 2/4/2025 1518

REASSESSMENT 02/04/25 3:18 PM

Current Presentation:

Met with patient Boone Cabal for a re-evaluation. Upon entering his room, pt expressed frustration with staff at Fortitude who is requiring him to check in every 2 hours. Pt states that he has a dissociative condition and will not be able to remember to check in so often. Pt went on to say that his dissociative symptoms are the reason he is where he is at in life. He states that he is unable to maintain employment or keep housing because of his condition. Pt states that he will forget things after 2 seconds and will dissociate over 3,000x a day.

Pt reports that he attends treatment with Stephanie Larsen with Valley Behavioral Health once a week and his therapist is helping him get connected with a neurologist. Pt states that he is prescribed Mydayis, gabapentin, and lamictal and takes his medications as prescribed. Pt reports that he has been given various diagnosis over the years including ADHD, social anxiety, Asperger's, avoidant personality, and PTSD. This crisis worker assessed for current suicidal ideation and pt stated, "I never said I was suicidal." Pt went on to state that he is careful what he says to mental health providers because he doesn't want to be held against his will. Pt said he went to HMHI for a screening to see how they could help him with his dissociative symptoms. CW explained to pt the purpose of HMHI for stabilization of those who cannot keep themself or others safe. Pt indicated that he no longer wanted to pursue psychiatric hospitalization and wanted to discharge home. Pt stated that he didn't want to stay any longer and is not interested in a safety plan.

Recommendation:

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Staffed case with ED Attending and are in agreement with discharging pt back home to Fortitude with a plan to continue in mental health treatment with Valley Behavioral Health. Called Fortitude to inform them pt will be discharge back to them. They do not have enough staffing to pick up pt and will be expecting him via public transit. CW spoke with pt who is agreeable to transport back to Fortitude via trax. He states he knows how to travel via trax and has a trax pass. Pt reports no other needs at this time.

Leslie Brosius Perez, LCSW

Electronically signed by Leslie Brosius Perez, LCSW at 02/04/25 1719

ED Provider Notes

Morgan Nicole Williams, MD at 2/3/2025 1914

Attestation signed by Jason Raine Pickett, MD at 02/04/25 0059

Patient seen and examined with the resident. I personally participated in the history, physical and medical decision making for this patient. Case was discussed with resident and I agree with the results interpretation and disposition of this patient.

History of Present Illness

Chief complaint(s): Suicidal

HPI: This is a 45 year old male with past medical history of mood disorder, obesity, hyperhidrosis, and recent admission for abdominal pain with ogilvie ileus who presents today for suicidal ideation. The patient reports about how he is unable to see out of prison, has dissociative identity disorder, and is unable to hold a job. Because of this he feels that he is "socially terminal" and because of this, he wants to end his life. He is looking into euthanasia options, and has attempted suicide by gun in the past. He has been admitted for mental health problems in the past, but has not been admitted following a suicide attempt. He also mentions that he may have jumped universe is at some point in his life, as this universe is being taken over by AI that is not his original universe. He currently endorses suicidal ideation with plan. He denies any medical problems including chest pain, shortness of breath, nausea, vomiting, diarrhea, dysuria, headache, or other symptoms.

Physical Exam

Physical Exam:

GENERAL: Well developed, well-nourished, cooperative patient in no acute distress

HEAD: Atraumatic, normocephalic head

EYES: Non-icteric sclerae. Extraocular movements grossly intact.

ENT: Oropharynx clear. Mucous membranes are moist.

NECK: Neck supple. No cervical adenopathy.

RESPIRATORY: Clear to auscultation bilaterally, without crackles or wheezes. No increased work of breathing.

CARDIOVASCULAR: Normal S1, S2. Regular rate and rhythm, no murmurs.

GASTROINTESTINAL: Abdomen is soft, non-tender and non-distended. No rebound tenderness or guarding. No organomegaly or masses

MUSCULOSKELETAL: No peripheral edema or cyanosis noted.

SKIN: Warm and dry without rashes or lesions.

NEUROLOGIC: Awake, alert, and appropriate. No focal motor or sensory deficits noted.

Medical Decision Making
Procedures

MDM:
Patient presents with concerns for suicidal ideation. Upon arrival patient is hemodynamically stable and overall well appearing on my initial examination.

Patient does endorse active, ongoing active suicidal ideation with plan. Crisis social work was consulted to evaluation the patient at the bedside. Appropriate screening laboratory workup was performed with overall reassuring findings. Patient had a mild anemia, was positive for stimulants, details are below. Overall medically cleared for inpatient psychiatric admission.

I am concerned for the patient's wellbeing and do feel this patient needs an inpatient admission with the information we have gathered so far. Patient was pink sheeted prior to arrival.

In discussion with the crisis team, for the patient is high risk for suicide and also delusional. They are working on finding placement for the patient.

Patient remains in the ED pending psychiatric placement and was signed out to the oncoming provider team in stable condition.

ED Course as of 02/04/25 1514

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Mon Feb 03, 2025

2023 Stimulant Amines Detection(!): Positive
Positive for stimulants [MW]

2023 Urinalysis, Complete(!)
Negative for UTI [MW]

2024 12 Lead ECG
Normal sinus rhythm with right axis deviation [MW]

2041 Sodium: 139 [MW]

2041 Potassium: 3.8 [MW]

2041 Chloride(!): 111 [MW]

2041 Carbon Dioxide: 20 [MW]

2041 BUN: 13 [MW]

2041 Creatinine: 0.97 [MW]

2041 AST: 35 [MW]

2041 ALT: 41 [MW]

2041 Comprehensive Metabolic Panel(!)
CMP is unremarkable, including electrolytes, kidney function, and liver function [MW]

2041 WBC: 7.70 [MW]

2041 HGB(!): 12.6 [MW]

2041 HCT(!): 37.8 [MW]

2041 Platelet: 257 [MW]

2041 CBC with Platelet Count and Automated Differential(!)
Mild anemia, slightly worse compared to labs 2 weeks ago. CBC otherwise unremarkable [MW]

2041 Alcohol: <10 [MW]

2041 Salicylate: <5 [MW]

2041 Acetaminophen, Level: <3 [MW]

2041 Screen for acetaminophen, salicylate, and ethanol negative [MW]

2054 Crisis is working on placement at HMHI [MW]

Tue Feb 04, 2025

0039 Patient signed out to the oncoming team in stable condition with placement pending per crisis. [MW]

ED Course User Index
[MW] Morgan Nicole Williams, MD

Clinical Impressions as of 02/04/25 1514

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Patient needs medical hold for evaluation

Disposition: Data Unavailable

MDM Complexity

Launch MDCalc MDM Tool

MDCalc MDM Module
Feb 04 2025 12:39 AM [Morgan Williams]
Data:
- Discussed with external professional: Case discussed with provider from Crisis/SW/CM. See MDM section and/or ED Course for additional details on the discussion.
- Test/documents/historian: 3+ tests ordered

Vitals and Results

Vitals

	02/03/25 1907
BP:	131/87
Pulse:	90
Temp:	37.2 °C (98.9 °F)
Resp:	18
SpO2:	96%

CBC WITH PLATELET COUNT AND AUTOMATED DIFFERENTIAL - Abnormal

Result	Value	Ref Range
WBC	7.70	4.30 - 11.30 k/uL
Hemoglobin	12.6 (*)	14.8 - 17.8 g/dL
Hematocrit	37.8 (*)	44.2 - 53.0 %
Platelet	257	159 - 439 k/uL
Red Blood Cell	4.41 (*)	4.70 - 6.14 M/uL
Mean Corpuscular Volume	85.7	81.2 - 96.6 fL
Mean Corpuscular	28.6	25.8 -

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Hemoglobin		33.1 pg
Mean Corpuscular HGB Concentration	33.3	31.9 - 35.2 g/dL
Red Cell Distribution Width	14.6	11.5 - 15.3 %
Mean Platelet Volume	9.2	8.6 - 12.3 fL
Neutrophil %	49.0	39.4 - 72.5 %
Lymphocyte %	42.1	17.6 - 49.6 %
Monocyte %	6.0	4.1 - 12.4 %
Eosinophil %	2.1	0.4 - 6.7 %
Basophil %	0.5	0.3 - 1.4 %
Neutrophil # (ANC)	3.78	2.00 - 7.40 k/uL
Lymphocyte #	3.24	1.30 - 3.60 k/uL
Monocyte #	0.46	0.30 - 1.00 k/uL
Eosinophil #	0.16	0.00 - 0.50 k/uL
Basophil #	0.04	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.3	0.2 - 0.9 %
Immature Granulocytes #	<0.03	0.01 - 0.09 k/uL

COMPREHENSIVE METABOLIC PANEL - Abnormal

Sodium S/P	139	136 - 144 mmol/L
Potassium	3.8	3.3 - 5.0 mmol/L
Chloride	111 (*)	102 - 110 mmol/L
Carbon Dioxide	20	20 - 26

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

		mmol/L
BUN	13	8 - 24 mg/dL
Creatinine S/P	0.97	0.72 - 1.25 mg/dL
Glucose	116	64 - 128 mg/dL
Anion Gap	8	5 - 14 mmol/L
Calcium	8.6	8.4 - 10.5 mg/dL
Protein, Total, S/P	7.2	6.5 - 8.4 g/dL
Albumin	4.3	3.5 - 5.0 g/dL
Bilirubin, Total	0.3	0.2 - 1.4 mg/dL
Alkaline Phosphatase	74	38 - 126 U/L
AST	35	16 - 40 U/L
ALT	41	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	98	mL/min/1.73m2

DRUG SCREEN STAT, URINE - Abnormal

Stimulant Amines Detection	Positive (*)	Negative
Cocaine and Metabolites	Negative	Negative
Opiates, Detection	Negative	Negative
Barbiturates Detection, Urine	Negative	Negative
Methadone, Qualitative, Urine	Negative	Negative
Oxycodone, Urine, Qualitatitive	Negative	Negative
Fentanyl, Qualitative, Urine	Negative	Negative
Benzodiazepines, Qual Urine	Negative	Negative
Cannabinoids, Qual, Urine	Negative	Negative
Buprenorphine, Qual, Urine	Negative	Negative

URINALYSIS, COMPLETE - Abnormal

Color, Urine	Yellow

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Appearance, Urine	Turbid (*)	Clear, Not Applicable
Leukocyte Esterase,Urine	Negative	Negative
Urobilinogen,Urine	1.0	<2.0 mg/dL
Specific Gravity, Urine	1.035 (*)	1.003 - 1.030
pH, Urine	6.5	5.0 - 7.5
Protein, Urine	30 (*)	Negative
Glucose, Urine	Negative	Negative
Ketones, Urine	Trace (*)	Negative
Bilirubin, Urine	Negative	Negative
Nitrites, Urine	Negative	Negative
Bacteria, Urine	None	Negative
Blood, Urine	Negative	Negative
RBC Auto, Urine	3	0 - 5 /HPF
WBC Auto, Urine	0	0 - 5 /HPF
EPI Auto, Urine	0	0 - 5 /HPF
Casts Auto, Urine	<4	0 - 3 /LPF

ETHANOL STAT - Normal

ETHANOL	<10	<=10 mg/dL

SALICYLATE ASSAY - Normal

Salicylate	<5	2 - 10 mg/dL

ACETAMINOPHEN - Normal

Acetaminophen, Level	<3	<=30 ug/mL

12 LEAD ECG (EKG)

Ventricular Rate	86	BPM
Atrial Rate	86	BPM
P-R Interval	150	ms
QRS Duration	90	ms
Q-T Interval	372	ms
QTC Calculation (Bezet)	445	ms
Calculated P Axis	25	degrees
Calculated R Axis	98	degrees
Calculated T Axis	19	degrees

Diagnosis

Value: Normal sinus rhythm
Right axis deviation
Borderline ECG
No previous ECGs available

02/03/2025 - ED in University Hospital Emergency Department (continued)

Abstract Notes (continued)

Confirmed by Pickett, Jason (3576) on 2/3/2025 10:18:52 PM

IP CONSULT TO CRISIS (ED ONLY)
EXTRA SPECIMEN URINE GRAY
Extra Specimen Urine Gray Complete
EXTRA SPECIMEN URINE
Extra Specimen Urine Complete
CLOSE SUPERVISION
COMMUNICATION ORDER MD TO NURSING

Imaging Results
None

Morgan Nicole Williams, MD
Resident
02/04/25 0040

Electronically signed by Morgan Nicole Williams, MD at 02/04/25 0040
Electronically signed by Jason Raine Pickett, MD at 02/04/25 0059

Results for orders placed or performed during the hospital encounter of 02/03/25
CBC with Platelet Count and Automated Differential

Result	Value	Ref Range
WBC	7.70	4.30 - 11.30 k/uL
Hemoglobin	12.6 (L)	14.8 - 17.8 g/dL
Hematocrit	37.8 (L)	44.2 - 53.0 %
Platelet	257	159 - 439 k/uL
Red Blood Cell	4.41 (L)	4.70 - 6.14 M/uL
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Mean Corpuscular Hemoglobin	28.6	25.8 - 33.1 pg
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02/03/2025 - ED in University Hospital Emergency Department (continued)

Eosinophil %	2.1	0.4 - 6.7 %
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NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.3	0.2 - 0.9 %
Immature Granulocytes #	<0.03	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Result	Value	Ref Range
Sodium S/P	139	136 - 144 mmol/L
Potassium	3.8	3.3 - 5.0 mmol/L
Chloride	111 (H)	102 - 110 mmol/L
Carbon Dioxide	20	20 - 26 mmol/L
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Glucose	116	64 - 128 mg/dL
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Alkaline Phosphatase	74	38 - 126 U/L
AST	35	16 - 40 U/L
ALT	41	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	98	mL/min/1.73m2

Drug Screen STAT, Urine

Result	Value	Ref Range
Stimulant Amines Detection	Positive (A)	Negative
Cocaine and Metabolites	Negative	Negative
Opiates, Detection	Negative	Negative
Barbiturates Detection, Urine	Negative	Negative
Methadone, Qualitative, Urine	Negative	Negative
Oxycodone, Urine, Qualitatitive	Negative	Negative
Fentanyl, Qualitative, Urine	Negative	Negative
Benzodiazepines, Qual Urine	Negative	Negative
Cannabinoids, Qual, Urine	Negative	Negative
Buprenorphine, Qual, Urine	Negative	Negative

Ethanol STAT

Result	Value	Ref Range
ETHANOL	<10	<=10 mg/dL

Salicylate, Quantitative

Result	Value	Ref Range
Salicylate	<5	2 - 10 mg/dL

Acetaminophen, Serum

Result	Value	Ref Range
Acetaminophen, Level	<3	<=30 ug/mL

Urinalysis, Complete

Result	Value	Ref Range

02/03/2025 - ED in University Hospital Emergency Department (continued)

Color, Urine	Yellow	
Appearance, Urine	Turbid (A)	Clear, Not Applicable
Leukocyte Esterase,Urine	Negative	Negative
Urobilinogen,Urine	1.0	<2.0 mg/dL
Specific Gravity, Urine	1.035 (H)	1.003 - 1.030
pH, Urine	6.5	5.0 - 7.5
Protein, Urine	30 (A)	Negative
Glucose, Urine	Negative	Negative
Ketones, Urine	Trace (A)	Negative
Bilirubin, Urine	Negative	Negative
Nitrites, Urine	Negative	Negative
Bacteria, Urine	None	Negative
Blood, Urine	Negative	Negative
RBC Auto, Urine	3	0 - 5 /HPF
WBC Auto, Urine	0	0 - 5 /HPF
EPI Auto, Urine	0	0 - 5 /HPF
Casts Auto, Urine	<4	0 - 3 /LPF

Extra Specimen Urine Gray

Result	Value	Ref Range
Extra Specimen Urine Gray	Complete	

Extra Specimen Urine

Result	Value	Ref Range
Extra Specimen Urine	Complete	

Imaging - Results Only

ECG

12 Lead ECG (Final result)

12 Lead ECG — Resulted: 02/03/25 2218, Result status: Final result

Ordering provider: Morgan Nicole Williams, MD 02/03/25 1914
Resulted by: Jason Raine Pickett, MD
Performed: 02/03/25 1914 - 02/03/25 1930
Resulting lab: MUSE

Order status: Completed
Filed by: Interface, Muse Ekg 02/03/25 2219
Accession number: 17588824
Lab Technician: KASSIDY HOOPES

Components

Component	Value	Reference Range	Flag	Lab
Ventricular Rate	86	BPM	—	188
Atrial Rate	86	BPM	—	188
P-R Interval	150	ms	—	188
QRS Duration	90	ms	—	188
Q-T Interval	372	ms	—	188
QTC Calculation (Bezet)	445	ms	—	188
Calculated P Axis	25	degrees	—	188
Calculated R Axis	98	degrees	—	188
Calculated T Axis	19	degrees	—	188
Diagnosis	--	—	—	188

Result:
Normal sinus rhythm
Right axis deviation
Borderline ECG
No previous ECGs available
Confirmed by Pickett, Jason (3576) on 2/3/2025 10:18:52 PM

02/03/2025 - ED in University Hospital Emergency Department (continued)

Imaging - Results Only (continued)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
188 - Unknown	MUSE	Unknown	Unknown	12/16/11 1027 - Present

Signed

Electronically signed by Jason Raine Pickett, MD on 2/3/25 at 2219 MST

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine

Abstract Notes

Consults

Marshall Walker Wallace, MD at 1/8/2025 2052

Attestation signed by Marta Louise McCrum, MD at 01/09/25 0536

Attending Surgeon Attestation

I provided this service on 1/8/2025

I have reviewed the note by the physician/APC above and verified its contents.
I reviewed and confirmed the HPI, PFSH, and ROS.
I examined the patient, and confirm the findings by the physician/APC above.
I have reviewed and discussed the chart, tests, labs, imaging, diagnoses, evaluation, and treatment plan with the physician/APC above. I approve the plan as noted.

Marta McCrum, MD
Associate Professor
General Surgery

General Surgery Consultation

Reason for Consult: Diarrhea, abdominal pain

Requesting Attending/Team: Emergency department

History of Present Illness:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis, who presents with diarrhea and abdominal pain. General surgery consulted for evaluation and management recommendations.

Patient reports that he was in his normal state of health until last evening, when he started having large-volume watery diarrhea. He denies blood in the diarrhea. He had 5-6 episodes of diarrhea from last night to around noon today. During that time, he denied nausea, vomiting, abdominal pain, fevers, chills. Beginning today at roughly noon, he started to have acute onset abdominal pain, progressive abdominal distention. Since that time, he has had no flatus or additional stools.

He does report a episode of axillary cellulitis, roughly 2 weeks ago, for which she was seen at the fourth Street clinic and prescribed p.o. antibiotics. He does not know what kind they were. He completed his p.o. antibiotics roughly 1 week ago. He did not have any nausea, vomiting, diarrhea while taking antibiotics.

He did recently start taking dulaglutide for weight loss. He does not have diabetes.

He denies any prior episodes of intermittent or recurrent abdominal pain, nausea, vomiting. Denies food fear. Denies unintentional weight loss. Denies bloody bowel movements, hematemesis, changes in stool caliber.

He does have a reported hx of suboxone use, but states that he never took it.

He has never had a colonoscopy.

Past Medical History:- Hyperhidrosis, depression

PastSurgical History: has a past surgical history that includes Endoscopic thoracic sympathectomy and rhinoplasty/septoplasty (Left).

Family History:
Reviewed and non -contributory, no reported bleeding, cancer disorders, no anesthesia complications

Social History:
reports that he has quit smoking. His smoking use included cigarettes. He quit smokeless tobacco use about 22 months ago. He reports that he does not currently use alcohol. He reports that he does not currently use drugs after having used the following drugs: Heroin and Cannabis (Marijuana). Reviewed and non -contributory/None, no tobacco or ETOH abuse
Daily living function: Independent
Living Status: lives alone
Frailty Assessment:
2-Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
Home Medications:

Reviewed and non -contributory

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• lidocaine (XYLOCAINE) 4 % external solution 4.5 mL	4.5 mL	Nasal	Once	Jamal Jones, MD		
• ondansetron (ZOFRAN) injection 4 mg	4 mg	Intravenous	Q15 Min PRN	Holly Smock, PA-C		4 mg at 01/08/25 1550
• oxymetazoline (AFRIN) 0.05 % nasal spray 3 spray	3 spray	Nasal	Once	Jamal Jones, MD		

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• dulaglutide (TRULICITY) 0.75 mg/0.5 mL	Inject 1 mL (1.5 mg) subcutaneously once a week.	4 mL	0
• Insulin Pen Needle (PEN NEEDLES) 32G X 4 MM miscellaneous	100 each by Does Not Apply route once a week.	4 each	5
• oxybutynin (DITROPAN) 5 mg tablet	Take 1 tablet (5 mg) by mouth 2 times a day. Indications: Excessive Sweating	60 tablet	3

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

	Disorder		
• buprenorphine-naloxone (SUBOXONE) 4-1 mg film SL film	Place 1 Film (4 mg buprenorphine) under the tongue 2 times a day. (Patient not taking: Reported on 9/23/2024)	14 Film	0
• DULoxetine (CYMBALTA) 30 mg enteric coated particles capsule	Take by mouth once daily.		
• lamoTRIgine (LAMICTAL) 100 mg tablet	Take 100 mg by mouth once daily.		
• gabapentin (NEURONTIN) 600 mg tablet	Take 600 mg by mouth 3 times daily.		
• MYDAYIS 50 MG 24 hr sustained release capsule	Take 50 mg by mouth once daily.		

Allergies: Reviewed and non -contributory

Review of Systems:

A complete 12 system ROS was reviewed and
negative except as in the HPI

Physical Exam:

Blood pressure 138/92, pulse 78, temperature 36.7 °C (98.1 °F), temperature source Temporal, resp. rate 18, SpO2 98%. There is no height or weight on file to calculate BMI.

Vital signs:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/08/25 1510	01/08/25 1631	01/08/25 1824	01/08/25 2004
BP:	134/100		137/100	138/92
Pulse:	90		87	78
Resp:	25		22	18
Temp:	36.1 °C (97 °F)		36.3 °C (97.3 °F)	36.7 °C (98.1 °F)
SpO2:	95%	98%	95%	98%

Respiratory:

Oxygen Therapy
SpO2: 98 %
O2 Device: None (Room air)
Pulse Oximetry Site: Finger

I&O:

Intake/Output Summary (Last 24 hours) at 1/8/2025 2052
Last data filed at 1/8/2025 1747

	Gross per 24 hour
Intake	999 ml

Output	—
Net	**999 ml**

General Appearance: Patient appears lying in bed in mild distress, alert and interactive
Cardiovascular: Regular rate and rhythm, hypertensive
Pulmonary: : Breathing comfortably on room air
GI: Distended, tender to palpation throughout, tympanitic. There is voluntary guarding throughout the abdomen, no signs of diffuse peritonitis. No abdominal scars.
Rectal: There are no external masses or hemorrhoids, normal digital rectal exam without palpable internal masses, no blood.
Neurologic: no focal neurological deficits are noted,Oriented To: person, place and time, GCS 15
Pysc: appropriate mood and affect
Skin: No rashes or lesions, no edema

Objective:

Patient Lines/Drains/Airways Status

Active LDAs

Name	Placement date	Placement time	Site	Days
Peripheral IV 01/08/25 Right Antecubital 18 Gauge 1.16 in	01/08/25	1546	Antecubital	less than 1

Imaging/Radiology - last 24 hrs:
CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Medications:
Infusion meds:
Scheduled meds:

• lidocaine	4.5 mL	Nasal	Once
• oxymetazoline	3 spray	Nasal	Once

Labs:
Recent Results (from the past 24 hours)
POC Glucose Fingerstick (Instrmt)

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Collection Time: 01/08/25 2:52 PM

Result	Value	Ref Range
Glucose, Finger Stick	130 (H)	64 - 128 mg/dL

CBC with Platelet Count and Automated Differential

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
WBC	9.72	4.30 - 11.30 k/uL
Hemoglobin	14.4 (L)	14.8 - 17.8 g/dL
Hematocrit	44.5	44.2 - 53.0 %
Platelet	269	159 - 439 k/uL
Red Blood Cell	4.96	4.70 - 6.14 M/uL
Mean Corpuscular Volume	89.7	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	32.4	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.2	11.5 - 15.3 %
Mean Platelet Volume	8.7	8.6 - 12.3 fL
Neutrophil %	83.1 (H)	39.4 - 72.5 %
Lymphocyte %	12.2 (L)	17.6 - 49.6 %
Monocyte %	3.6 (L)	4.1 - 12.4 %
Eosinophil %	0.4	0.4 - 6.7 %
Basophil %	0.3	0.3 - 1.4 %
Neutrophil # (ANC)	8.07 (H)	2.00 - 7.40 k/uL
Lymphocyte #	1.19 (L)	1.30 - 3.60 k/uL
Monocyte #	0.35	0.30 - 1.00 k/uL
Eosinophil #	0.04	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.04	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Collection Time: 01/08/25 3:46 PM

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Result	Value	Ref Range
Sodium S/P	141	136 - 144 mmol/L
Potassium	4.0	3.3 - 5.0 mmol/L
Chloride	115 (H)	102 - 110 mmol/L
Carbon Dioxide	18 (L)	20 - 26 mmol/L
BUN	16	8 - 24 mg/dL
Creatinine S/P	0.98	0.72 - 1.25 mg/dL
Glucose	117	64 - 128 mg/dL
Anion Gap	8	5 - 14 mmol/L
Calcium	8.9	8.4 - 10.5 mg/dL
Protein, Total, S/P	8.4	6.5 - 8.4 g/dL
Albumin	4.9	3.5 - 5.0 g/dL
Bilirubin, Total	0.4	0.2 - 1.4 mg/dL
Alkaline Phosphatase	86	38 - 126 U/L
AST	55 (H)	16 - 40 U/L
ALT	68 (H)	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	96	mL/min/1.73 m2

Lipase, Serum or Plasma

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
Lipase, S/P	43	8 - 78 U/L

Blood Gas Analysis With Electrolytes (Pulmonary Lab)

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
pH - Venous	7.262 (L)	7.310 - 7.410
pCO2 - Venous	47.9	40.0 - 52.0 mm/Hg
pO2 - Venous	25.2 (L)	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	14.4	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	26.5 (L)	>=92.0 %
Carboxyhemoglobin - Venous	0.5	<=2.0 %
Methemoglobin - Venous	0.7	<1.0 %
Oxygen Saturation (sO2) - Venous	26.8 (L)	75.0 - 100.0 %

Abstract Notes (continued)

HCO3-, Venous	20.9	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.9 (L)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	44.2	40.1 - 52.5 %
O2 Content - Venous	5.4 (L)	17 - 24 vol%
Potassium - Venous	3.9	3.5 - 5.0 mmol/L
Sodium - Venous	145 (H)	136 - 144 mmol/L
Ionized Calcium - Venous	1.32 (H)	1.11 - 1.30 mmol/L
Glucose - Venous	122 (H)	65 - 110 mg/dL
Lactate - Venous	1.50	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	0	%orFlowrate

CBC:

Lab Results

Component	Value	Date
WBC	9.72	01/08/2025
RBC	4.96	01/08/2025

CMP:

Lab Results

Component	Value	Date
SODIUM	141	01/08/2025
K	4.0	01/08/2025
CL	115 (H)	01/08/2025
CO2	18 (L)	01/08/2025
BUN	16	01/08/2025
GLUC	117	01/08/2025
CA	8.9	01/08/2025
TP	8.4	01/08/2025
ALB	4.9	01/08/2025
TBILI	0.4	01/08/2025
ALKP	86	01/08/2025
AST	55 (H)	01/08/2025
ALT	68 (H)	01/08/2025
AGAP	8	01/08/2025

ABGs: No results found for: "PH"

Imaging/Radiology - last 24 hrs:
CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025

High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

The trauma and emergency general surgery team has independently reviewed and interpreted all labs, radiology reports and images. Pertinent findings documented below.

Assessment/Plan:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and distention. On exam, patient has largely normal vital signs with the exception of hypertension, he is distended, tender throughout, tympanitic, no signs of peritonitis. Labs are notable for white blood cell count of 9, mild LFT elevation, lactate of 1.5 which is now down to 0.8 after IV fluids. CT scan with 2 notable findings, first there is diffuse colonic dilation with a max diameter of 9.2 cm in the ascending colon, separately, there is high-grade stenosis of the celiac trunk by the diaphragmatic crura, consistent with possible MALS-of note, there is no evidence of bowel ischemia, particularly in the celiac distribution. Collectively, appears most consistent with colonic ileus/pseudoobstruction, most likely secondary to gastroenteritis or infectious diarrhea given history, differential diagnosis also includes C. difficile given recent antibiotics use, medication related colonic ileus with multiple psychiatric medications or possibly related to his new dulaglutide use, low concern for mechanical obstruction given normal CT scan and digital rectal exam. At this time, given his lower GI predominance of symptoms, normal foregut midgut findings on CT scan, it is believed that the high-grade stenosis of the celiac trunk is incidental to his current complaints. There is no indication for surgical intervention at this time, however we will continue to follow closely.

-No indication for general surgical intervention at this time
-General Surgery to perform every 6 hours serial abdominal exams tonight
-Recommend admission to medicine with gastroenteritis/diarreha workup, including C diff testing given recent abx
-Recommend NGT decompression now
-Obtain AM KUB or KUB with any acute clinical change to eval for progression of colonic dilation
-NPO
-Normalize electroltyes
-Avoid opioids as able
-Can consider outpatient follow up with general surgery outpatient for possible MALS on CT, this is unlikely to be contributing to todays presentation

I have discussed the above patient with Dr. McCrum General Surgery attending.

Marshall Wallace, MD
General Surgery

I spent 45 minutes in total time for this visit including all related clinical activities before, during and after the visit.

Electronically signed by Marshall Walker Wallace, MD at 01/08/25 2248
Electronically signed by Marta Louise McCrum, MD at 01/09/25 0536

Olivia C Pearson, MD at 1/9/2025 1241

Attestation signed by Toby Merrill Enniss, MD at 01/14/25 0812

ATTENDING ATTESTATION:

I, Toby Enniss, have seen and examined Boone Cabal and confirm the findings by the resident/APC as above. I have reviewed and confirmed the HPI, PFSH, and ROS. I have independently reviewed all clinical, labarotory and radiographic data. I have reviewed the note by the physician/APC above and verified its contents. I have reviewed and discussed the chart, tests, labs, imaging, diagnoses, evaluation, and treatment plan with the physician/APC above. I agree with the assessment and plan of the Acute Care Surgery team as noted.

General Surgery Consultation

Reason for Consult: Diarrhea, abdominal pain

Requesting Attending/Team: Emergency department

History of Present Illness:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis, who presents with diarrhea and abdominal pain. General surgery consulted for evaluation and management recommendations.

Patient reports that he was in his normal state of health until last evening, when he started having large-volume watery diarrhea. He denies blood in the diarrhea. He had 5-6 episodes of diarrhea from last night to around noon today. During that time, he denied nausea, vomiting, abdominal pain, fevers, chills. Beginning today at roughly noon, he started to have acute onset abdominal pain, progressive abdominal distention. Since that time, he has had no flatus or additional stools.

He does report a episode of axillary cellulitis, roughly 2 weeks ago, for which she was seen at the fourth Street clinic and prescribed p.o. antibiotics. He does not know what kind they were. He completed his p.o. antibiotics roughly 1 week ago. He did not have any nausea, vomiting, diarrhea while taking antibiotics.

He did recently start taking dulaglutide for weight loss. He does not have diabetes.

He denies any prior episodes of intermittent or recurrent abdominal pain, nausea, vomiting. Denies food fear. Denies unintentional weight loss. Denies bloody bowel movements, hematemesis, changes in stool caliber.

He does have a reported hx of suboxone use, but states that he never took it.

He has never had a colonoscopy.

Past Medical History:- Hyperhidrosis, depression

PastSurgical History: has a past surgical history that includes Endoscopic thoracic sympathectomy and rhinoplasty/septoplasty (Left).

Family History:
Reviewed and non -contributory, no reported bleeding, cancer disorders, no anesthesia complications

Social History:
reports that he has quit smoking. His smoking use included cigarettes. He quit smokeless tobacco use about 22 months ago. He reports that he does not currently use alcohol. He reports that he does not currently use drugs after having used the following drugs: Heroin and Cannabis (Marijuana). Reviewed and non -contributory/None, no tobacco or ETOH abuse
Daily living function: Independent
Living Status: lives alone
Frailty Assessment:
2-Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
Home Medications:

Reviewed and non -contributory
Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• acetaminophen (OFIRMEV) injection 1,000 mg	1,000 mg	Intravenous	Q6H	Jackson Scott Burton, MD	400 mL/hr at 01/09/25 0629	1,000 mg at 01/09/25 0629
• ketorolac (TORADOL) injection 15 mg	15 mg	Intravenous	Q6H	Jackson Scott Burton, MD		15 mg at 01/09/25 0414
• simethicone (MYLICON) chewable tablet 80 mg	80 mg	Oral	TID PRN	Jackson Scott Burton, MD		80 mg at 01/09/25 0303
• DULoxetine (CYMBALTA) DR capsule 30 mg	30 mg	Oral	Daily	Jackson Scott Burton, MD		
• enoxaparin (LOVENOX) syringe 40 mg	40 mg	Subcutaneous	QHS	Jackson Scott Burton, MD		40 mg at 01/09/25 0101
• HYDROmorphone (DILAUDID) injection 0.2-0.4 mg	0.2-0.4 mg	Intravenous	Q4H PRN	Jackson Scott Burton, MD		0.4 mg at 01/09/25 1015
• lamoTRIgine (LaMICtal) tablet 100 mg	100 mg	Oral	Daily	Jackson Scott Burton, MD		
• melatonin tablet 3 mg	3 mg	Oral	QHS PRN	Jackson Scott Burton, MD		
• naloxone	0.1-0.4	Intravenous	PRN	Jackson Scott		

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

(NARCAN) injection 0.1-0.4 mg	mg			Burton, MD	
• ondansetron (ZOFRAN) injection 4 mg Or	4 mg	Intravenous	Q6H PRN	Jackson Scott Burton, MD	4 mg at 01/09/25 0301
• ondansetron (ZOFRAN) tablet 4 mg	4 mg	Oral	Q6H PRN	Jackson Scott Burton, MD	
• traZODone (DESYREL) tablet 50 mg	50 mg	Oral	QHS PRN	Jackson Scott Burton, MD	

Allergies: Reviewed and non -contributory

Review of Systems:

A complete 12 system ROS was reviewed and
negative except as in the HPI

Physical Exam:

Blood pressure 149/91, pulse 87, temperature 36.8 °C (98.3 °F), temperature source Temporal, resp. rate 18, height 177.8 cm (5' 10"), weight 97.3 kg (214 lb 8.1 oz), SpO2 95%. Body mass index is 30.78 kg/m².

Vital signs:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/09/25 0528	01/09/25 0701	01/09/25 0900	01/09/25 1126
BP:	142/83	145/96		149/91
Pulse:	78	88	82	87
Resp:	24	**(!) 38**		18
Temp:	36.4 °C (97.5 °F)	36.7 °C (98.1 °F)		36.8 °C (98.3 °F)
SpO2:	100%	100%		95%

Respiratory:

Volume Achieved (mL): **(!) 0**
Oxygen Therapy
SpO2: 95 %
O2 Device: Nasal cannula
Flow Rate: 1 L/min
Pulse Oximetry Site: Finger

I&O:

Intake/Output Summary (Last 24 hours) at 1/9/2025 1241
Last data filed at 1/9/2025 0725

	Gross per 24 hour
Intake	1085.16 ml
Output	—
Net	**1085.16 ml**

General Appearance: Patient appears lying in bed in mild distress, alert and interactive; NG tube in place
Cardiovascular: Regular rate and rhythm, hypertensive
Pulmonary: : Breathing comfortably on room air
GI: Distended, tender to palpation throughout, tympanitic. There is voluntary guarding throughout the abdomen, no signs of diffuse peritonitis. No abdominal scars.
Rectal: There are no external masses or hemorrhoids, normal digital rectal exam without palpable internal masses, no blood.
Neurologic: no focal neurological deficits are noted,Oriented To: person, place and time, GCS 15
Pysc: appropriate mood and affect
Skin: No rashes or lesions, no edema

Objective:

Patient Lines/Drains/Airways Status

Active LDAs

Name	Placement date	Placement time	Site	Days
Peripheral IV 01/08/25 Right Antecubital 18 Gauge 1.16 in	01/08/25	1546	Antecubital	less than 1
Peripheral IV 01/09/25 Left Forearm 20 Gauge	01/09/25	1043	Forearm	less than 1
GI Tube 01/08/25 Nostril Nasogastric Tube	01/08/25	2134	Nostril	less than 1

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Medications:
Infusion meds:
Scheduled meds:

• acetaminophen	1,000 mg	Intravenous	Q6H
• ketorolac	15 mg	Intravenous	Q6H
• DULoxetine	30 mg	Oral	Daily
• enoxaparin	40 mg	Subcutaneous	QHS
• lamoTRIgine	100 mg	Oral	Daily

Labs:
Recent Results (from the past 24 hours)
POC Glucose Fingerstick (Instrmt)
Collection Time: 01/08/25 2:52 PM

Result	Value	Ref Range
Glucose, Finger Stick	130 (H)	64 - 128 mg/dL

CBC with Platelet Count and Automated Differential
Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
WBC	9.72	4.30 - 11.30 k/uL
Hemoglobin	14.4 (L)	14.8 - 17.8 g/dL
Hematocrit	44.5	44.2 - 53.0 %
Platelet	269	159 - 439 k/uL
Red Blood Cell	4.96	4.70 - 6.14 M/uL
Mean Corpuscular Volume	89.7	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	32.4	31.9 - 35.2 g/dL

Red Cell Distribution Width	15.2	11.5 - 15.3 %
Mean Platelet Volume	8.7	8.6 - 12.3 fL
Neutrophil %	83.1 (H)	39.4 - 72.5 %
Lymphocyte %	12.2 (L)	17.6 - 49.6 %
Monocyte %	3.6 (L)	4.1 - 12.4 %
Eosinophil %	0.4	0.4 - 6.7 %
Basophil %	0.3	0.3 - 1.4 %
Neutrophil # (ANC)	8.07 (H)	2.00 - 7.40 k/uL
Lymphocyte #	1.19 (L)	1.30 - 3.60 k/uL
Monocyte #	0.35	0.30 - 1.00 k/uL
Eosinophil #	0.04	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.04	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
Sodium S/P	141	136 - 144 mmol/L
Potassium	4.0	3.3 - 5.0 mmol/L
Chloride	115 (H)	102 - 110 mmol/L
Carbon Dioxide	18 (L)	20 - 26 mmol/L
BUN	16	8 - 24 mg/dL
Creatinine S/P	0.98	0.72 - 1.25 mg/dL
Glucose	117	64 - 128 mg/dL
Anion Gap	8	5 - 14 mmol/L
Calcium	8.9	8.4 - 10.5 mg/dL
Protein, Total, S/P	8.4	6.5 - 8.4 g/dL
Albumin	4.9	3.5 - 5.0 g/dL
Bilirubin, Total	0.4	0.2 - 1.4 mg/dL
Alkaline	86	38 - 126 U/L

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Phosphatase		
AST	55 (H)	16 - 40 U/L
ALT	68 (H)	0 - 55 U/L
eGFR, CKD-EPI 2021	96	mL/min/1.73 m2

Lipase, Serum or Plasma

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
Lipase, S/P	43	8 - 78 U/L

Blood Gas Analysis With Electrolytes (Pulmonary Lab)

Collection Time: 01/08/25 3:46 PM

Result	Value	Ref Range
pH - Venous	7.262 (L)	7.310 - 7.410
pCO2 - Venous	47.9	40.0 - 52.0 mm/Hg
pO2 - Venous	25.2 (L)	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	14.4	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	26.5 (L)	>=92.0 %
Carboxyhemoglobin - Venous	0.5	<=2.0 %
Methemoglobin - Venous	0.7	<1.0 %
Oxygen Saturation (sO2) - Venous	26.8 (L)	75.0 - 100.0 %
HCO3-, Venous	20.9	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.9 (L)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	44.2	40.1 - 52.5 %
O2 Content - Venous	5.4 (L)	17 - 24 vol%
Potassium - Venous	3.9	3.5 - 5.0 mmol/L
Sodium - Venous	145 (H)	136 - 144 mmol/L
Ionized Calcium - Venous	1.32 (H)	1.11 - 1.30 mmol/L
Glucose - Venous	122 (H)	65 - 110 mg/dL
Lactate - Venous	1.50	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	0	%orFlowrate

Blood Gas Analysis With Electrolytes (Pulmonary Lab)

Collection Time: 01/08/25 10:32 PM

Result	Value	Ref Range

Abstract Notes (continued)

pH - Venous	7.293 (L)	7.310 - 7.410
pCO2 - Venous	43.4	40.0 - 52.0 mm/Hg
pO2 - Venous	39.5	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	13.1	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	65.7 (L)	>=92.0 %
Carboxyhemoglobin - Venous	1.0	<=2.0 %
Methemoglobin - Venous	0.5	<1.0 %
Oxygen Saturation (sO2) - Venous	66.7 (L)	75.0 - 100.0 %
HCO3-, Venous	20.4	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.5 (L)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	40.2	40.1 - 52.5 %
O2 Content - Venous	12.1 (L)	17 - 24 vol%
Potassium - Venous	3.8	3.5 - 5.0 mmol/L
Sodium - Venous	142	136 - 144 mmol/L
Ionized Calcium - Venous	1.26	1.11 - 1.30 mmol/L
Glucose - Venous	126 (H)	65 - 110 mg/dL
Lactate - Venous	0.80	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	1	%orFlowrate

POC Glucose Fingerstick (Instrmt)

Collection Time: 01/09/25 3:13 AM

Result	Value	Ref Range
Glucose, Finger Stick	73	64 - 128 mg/dL

CBC with Platelet Count

Collection Time: 01/09/25 7:44 AM

Result	Value	Ref Range
WBC	11.09	4.30 - 11.30 k/uL
Hemoglobin	13.4 (L)	14.8 - 17.8 g/dL
Hematocrit	39.7 (L)	44.2 - 53.0 %
Platelet	262	159 - 439 k/uL
Red Blood Cell	4.69 (L)	4.70 - 6.14 M/uL

Abstract Notes (continued)

Mean Corpuscular Volume	84.6	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	28.6	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	33.8	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.4 (H)	11.5 - 15.3 %
Mean Platelet Volume	8.6	8.6 - 12.3 fL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL

Renal Function Panel

Collection Time: 01/09/25 7:44 AM

Result	Value	Ref Range
Sodium S/P	138	136 - 144 mmol/L
Potassium	3.5	3.3 - 5.0 mmol/L
Chloride	110	102 - 110 mmol/L
Carbon Dioxide	19 (L)	20 - 26 mmol/L
BUN	15	8 - 24 mg/dL
Creatinine S/P	0.89	0.72 - 1.25 mg/dL
Glucose	103	64 - 128 mg/dL
Anion Gap	9	5 - 14 mmol/L
Calcium	8.6	8.4 - 10.5 mg/dL
Phosphorus, Inorganic, S/P	2.5	2.2 - 4.5 mg/dL
Albumin	4.5	3.5 - 5.0 g/dL
eGFR, CKD-EPI CRT 2021	107	mL/min/1.73 m2

Magnesium, Plasma or Serum

Collection Time: 01/09/25 7:44 AM

Result	Value	Ref Range
Magnesium, S/P	2.0	1.6 - 2.6 mg/dL

CBC:

Lab Results

Component	Value	Date
WBC	11.09	01/09/2025
RBC	4.69 (L)	01/09/2025

CMP:

Lab Results

Component	Value	Date
SODIUM	138	01/09/2025
K	3.5	01/09/2025
CL	110	01/09/2025
CO2	19 (L)	01/09/2025
BUN	15	01/09/2025
GLUC	103	01/09/2025
CA	8.6	01/09/2025
TP	8.4	01/08/2025
ALB	4.5	01/09/2025
TBILI	0.4	01/08/2025
ALKP	86	01/08/2025
AST	55 (H)	01/08/2025
ALT	68 (H)	01/08/2025
AGAP	9	01/09/2025

ABGs: No results found for: "PH"

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

The trauma and emergency general surgery team has independently reviewed and interpreted all labs, radiology

reports and images. Pertinent findings documented below.

Assessment/Plan:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and distention. Collectively, appears most consistent with colonic ileus/pseudoobstruction, most likely secondary to gastroenteritis or infectious diarrhea given history, differential diagnosis also includes C. difficile given recent antibiotics use, medication related colonic ileus with multiple psychiatric medications or possibly related to his new dulaglutide use, low concern for mechanical obstruction given normal CT scan and digital rectal exam. At this time, given his lower GI predominance of symptoms, normal foregut midgut findings on CT scan, it is believed that the high-grade stenosis of the celiac trunk is incidental to his current complaints. There is no indication for surgical intervention at this time, however we will continue to follow closely.

Patient endorsing continued abdominal pain today, no flatus or Bm's. Approximately 100mL gastric contents in NG tube reservoir.

-No indication for surgical intervention at this time
-NPO, continue decompression with NG tube
-Obtain AM KUB or KUB with any acute clinical change to eval for progression of colonic dilation
-Recommend PT/OT eval to encourage ambulation
-Normalize electrolytes
-F/u C. Diff testing
-Avoid opioids as able
-Can consider outpatient follow up with general surgery outpatient for possible MALS on CT, this is unlikely to be contributing to todays presentation
-If patient does not demonstrate clinical signs of improvement with conservative methods, we can consider additional adjuncts such as neostigmine
-General Surgery to continue to follow in the AM; please page with any additional questions or concerns

I have discussed the above patient with Dr. Enniss General Surgery attending.

Olivia C Pearson, MD
Emergency Medicine, PGY-1

I spent 45 minutes in total time for this visit including all related clinical activities before, during and after the visit.

Electronically signed by Olivia C Pearson, MD at 01/09/25 1249
Electronically signed by Toby Merrill Enniss, MD at 01/14/25 0812

Jade Myles Nunez, MD at 1/10/2025 0812

General Surgery Consultation

Reason for Consult: Diarrhea, abdominal pain

Requesting Attending/Team: Emergency department

History of Present Illness:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis, who presents with diarrhea and abdominal pain. General surgery consulted for evaluation and management recommendations.

Patient reports that he was in his normal state of health until last evening, when he started having large-volume watery diarrhea. He denies blood in the diarrhea. He had 5-6 episodes of diarrhea from last night to around noon today. During that time, he denied nausea, vomiting, abdominal pain, fevers, chills. Beginning today at roughly noon, he started to have acute onset abdominal pain, progressive abdominal distention. Since that time, he has had no flatus or additional stools.

He does report a episode of axillary cellulitis, roughly 2 weeks ago, for which she was seen at the fourth Street clinic and prescribed p.o. antibiotics. He does not know what kind they were. He completed his p.o. antibiotics roughly 1 week ago. He did not have any nausea, vomiting, diarrhea while taking antibiotics.

He did recently start taking dulaglutide for weight loss. He does not have diabetes.

He denies any prior episodes of intermittent or recurrent abdominal pain, nausea, vomiting. Denies food fear. Denies unintentional weight loss. Denies bloody bowel movements, hematemesis, changes in stool caliber.

He does have a reported hx of suboxone use, but states that he never took it.

He has never had a colonoscopy.

Past Medical History:- Hyperhidrosis, depression

PastSurgical History: has a past surgical history that includes Endoscopic thoracic sympathectomy and rhinoplasty/septoplasty (Left).

Family History:
Reviewed and non -contributory, no reported bleeding, cancer disorders, no anesthesia complications

Social History:
reports that he has quit smoking. His smoking use included cigarettes. He quit smokeless tobacco use about 22 months ago. He reports that he does not currently use alcohol. He reports that he does not currently use drugs after having used the following drugs: Heroin and Cannabis (Marijuana). Reviewed and non -contributory/None, no tobacco or ETOH abuse
Daily living function: Independent
Living Status: lives alone
Frailty Assessment:
2-Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
Home Medications:

Reviewed and non -contributory
Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last	Last

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

					Rate	Admin
• HYDROmorphone (DILAUDID) injection 0.2 mg	0.2 mg	Intravenous	Q4H PRN	Jenifer Hollingsworth, PA-C		
• acetaminophen (OFIRMEV) injection 1,000 mg	1,000 mg	Intravenous	Q6H	Jackson Scott Burton, MD	400 mL/hr at 01/10/25 0616	1,000 mg at 01/10/25 0616
• ketamine (KETALAR) infusion 1 mg/mL in NS	0.1 mg/kg/hr (Dosing Weight)	Intravenous	Continuous	Nwanyidirim Ahanonu-Acord, APRN	4 mL/hr at 01/09/25 1925	0.041 mg/kg/hr at 01/09/25 1925
• ketorolac (TORADOL) injection 15 mg	15 mg	Intravenous	Q6H	Jackson Scott Burton, MD		15 mg at 01/10/25 0600
• simethicone (MYLICON) chewable tablet 80 mg	80 mg	Oral	TID PRN	Jackson Scott Burton, MD		80 mg at 01/09/25 0303
• enoxaparin (LOVENOX) syringe 40 mg	40 mg	Subcutaneous	QHS	Jackson Scott Burton, MD		40 mg at 01/09/25 0101
• lamoTRIgine (LaMICtal) tablet 100 mg	100 mg	Oral	Daily	Jackson Scott Burton, MD		
• melatonin tablet 3 mg	3 mg	Oral	QHS PRN	Jackson Scott Burton, MD		
• naloxone (NARCAN) injection 0.1-0.4 mg	0.1-0.4 mg	Intravenous	PRN	Jackson Scott Burton, MD		
• ondansetron (ZOFRAN) injection 4 mg Or	4 mg	Intravenous	Q6H PRN	Jackson Scott Burton, MD		4 mg at 01/09/25 0301
• ondansetron (ZOFRAN) tablet 4 mg	4 mg	Oral	Q6H PRN	Jackson Scott Burton, MD		
• traZODone (DESYREL) tablet 50 mg	50 mg	Oral	QHS PRN	Jackson Scott Burton, MD		

Allergies: Reviewed and non -contributory

Review of Systems:

A complete 12 system ROS was reviewed and
negative except as in the HPI

Physical Exam:

Blood pressure 137/82, pulse 87, temperature 37.2 °C (99 °F), temperature source Temporal, resp. rate 24, height 177.8 cm (5' 10"), weight 97.3 kg (214 lb 8.1 oz), SpO2 92%. Body mass index is 30.78 kg/m².

Vital signs:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/09/25 1246	01/09/25 1917	01/10/25 0605	01/10/25 0747
BP:		141/72	137/82	
Pulse:		86	87	
Resp:		28	24	
Temp:		37.1 °C (98.8 °F)	37.2 °C (99 °F)	
SpO2:	90%	94%	92%	92%

Respiratory:
Volume Achieved (mL): **(!) 0**
Oxygen Therapy
SpO2: 92 %
O2 Device: None (Room air)
Flow Rate: 2 L/min
Pulse Oximetry Site: Finger

I&O:

Intake/Output Summary (Last 24 hours) at 1/10/2025 0812
Last data filed at 1/10/2025 0800

	Gross per 24 hour
Intake	355 ml
Output	—
Net	**355 ml**

General Appearance: Patient appears lying in bed in mild distress, alert and interactive; NG tube in place
Cardiovascular: Regular rate and rhythm, hypertensive
Pulmonary: : Breathing comfortably on room air
GI: Distended, tender to palpation throughout, tympanitic. There is voluntary guarding throughout the abdomen, no signs of diffuse peritonitis. No abdominal scars. NG tube in place, not hooked up to suction
Rectal: There are no external masses or hemorrhoids, normal digital rectal exam without palpable internal masses, no blood.
Neurologic: no focal neurological deficits are noted,Oriented To: person, place and time, GCS 15
Pysc: appropriate mood and affect
Skin: No rashes or lesions, no edema

Objective:

Patient Lines/Drains/Airways Status

Active LDAs

Name	Placement date	Placement time	Site	Days
Peripheral IV 01/08/25 Right Antecubital 18 Gauge 1.16 in	01/08/25	1546	Antecubital	1
Peripheral IV 01/09/25 Left Forearm 20 Gauge	01/09/25	1043	Forearm	less than 1
GI Tube 01/08/25 Nostril Nasogastric Tube	01/08/25	2134	Nostril	1

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/10/2025
Similar diffuse gaseous distention of large bowel. Multiple loops of dilated gas-filled small bowel are present, measuring up to 4.5 cm, increased in conspicuity compared to prior

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

Medications:
Infusion meds:

• ketamine (KETALAR) infusion 1 mg/mL in NS	0.041 mg/kg/hr (01/09/25 1925)	

Scheduled meds:

• acetaminophen	1,000 mg	Intravenous	Q6H
• ketorolac	15 mg	Intravenous	Q6H
• enoxaparin	40 mg	Subcutaneous	QHS
• lamoTRIgine	100 mg	Oral	Daily

Labs:
Recent Results (from the past 24 hours)
CBC with Platelet Count and Automated Differential
Collection Time: 01/10/25 5:29 AM

Result	Value	Ref Range
WBC	8.47	4.30 - 11.30 k/uL
Hemoglobin	13.1 (L)	14.8 - 17.8 g/dL

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Hematocrit	39.1 (L)	44.2 - 53.0 %
Platelet	241	159 - 439 k/uL
Red Blood Cell	4.52 (L)	4.70 - 6.14 M/uL
Mean Corpuscular Volume	86.5	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	33.5	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.1	11.5 - 15.3 %
Mean Platelet Volume	9.0	8.6 - 12.3 fL
Neutrophil %	72.8 (H)	39.4 - 72.5 %
Lymphocyte %	19.8	17.6 - 49.6 %
Monocyte %	5.2	4.1 - 12.4 %
Eosinophil %	1.4	0.4 - 6.7 %
Basophil %	0.4	0.3 - 1.4 %
Neutrophil # (ANC)	6.17	2.00 - 7.40 k/uL
Lymphocyte #	1.68	1.30 - 3.60 k/uL
Monocyte #	0.44	0.30 - 1.00 k/uL
Eosinophil #	0.12	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.03	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Collection Time: 01/10/25 5:29 AM

Result	Value	Ref Range
Sodium S/P	136	136 - 144 mmol/L
Potassium	3.5	3.3 - 5.0 mmol/L
Chloride	108	102 - 110 mmol/L
Carbon Dioxide	18 (L)	20 - 26 mmol/L
BUN	13	8 - 24 mg/dL
Creatinine S/P	0.73	0.72 - 1.25 mg/dL

Abstract Notes (continued)

Glucose	90	64 - 128 mg/dL
Anion Gap	10	5 - 14 mmol/L
Calcium	8.4	8.4 - 10.5 mg/dL
Protein, Total, S/P	7.2	6.5 - 8.4 g/dL
Albumin	4.0	3.5 - 5.0 g/dL
Bilirubin, Total	0.7	0.2 - 1.4 mg/dL
Alkaline Phosphatase	78	38 - 126 U/L
AST	40	16 - 40 U/L
ALT	50	0 - 55 U/L
eGFR, CKD-EPI 2021	114	mL/min/1.73 m2

CBC:

Lab Results

Component	Value	Date
WBC	8.47	01/10/2025
RBC	4.52 (L)	01/10/2025

CMP:

Lab Results

Component	Value	Date
SODIUM	136	01/10/2025
K	3.5	01/10/2025
CL	108	01/10/2025
CO2	18 (L)	01/10/2025
BUN	13	01/10/2025
GLUC	90	01/10/2025
CA	8.4	01/10/2025
TP	7.2	01/10/2025
ALB	4.0	01/10/2025
TBILI	0.7	01/10/2025
ALKP	78	01/10/2025
AST	40	01/10/2025
ALT	50	01/10/2025
AGAP	10	01/10/2025

ABGs: No results found for: "PH"

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/10/2025
Similar diffuse gaseous distention of large bowel. Multiple loops of dilated gas-filled small bowel are present, measuring up to 4.5 cm, increased in conspicuity compared to prior

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

The trauma and emergency general surgery team has independently reviewed and interpreted all labs, radiology reports and images. Pertinent findings documented below.

Assessment/Plan:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and distention. Collectively, appears most consistent with colonic ileus/pseudoobstruction, most likely secondary to gastroenteritis or infectious diarrhea given history, differential diagnosis also includes C. difficile given recent antibiotics use, medication related colonic ileus with multiple psychiatric medications or possibly related to his new dulaglutide use, low concern for mechanical obstruction given normal CT scan and digital rectal exam. At this time, given his lower GI predominance of symptoms, normal foregut midgut findings on CT scan, it is believed that the high-grade stenosis of the celiac trunk is incidental to his current complaints. There is no indication for surgical intervention at this time, however we will continue to follow closely.

Patient endorsing continued abdominal pain today, no flatus or Bm's. Approximately 100mL gastric contents in NG tube reservoir. Patient aware of risks of PO intake at this time but has been persistent with the primary team that he needs to eat and drink. Last night, NG tube was unhooked from suction and he was put on a clear liquid diet. Discussion was had with patient this morning and with primary team this afternoon regarding risks of pseudo-obstruction if patient continues to take in PO. Patient is aware of these risks.

-No indication for surgical intervention at this time
-NPO, continue decompression with NG tube
-Obtain AM KUB or KUB with any acute clinical change to eval for progression of colonic dilation
-Recommend PT/OT eval to encourage ambulation
-Normalize electrolytes
-F/u C. Diff testing
-Avoid opioids as able
-Can consider outpatient follow up with general surgery outpatient for possible MALS on CT, this is unlikely to be contributing to todays presentation
-If patient does not demonstrate clinical signs of improvement with conservative methods, we can consider additional adjuncts such as neostigmine
-General Surgery to continue to follow in the AM; please page with any additional questions or concerns

I have discussed the above patient with Dr. Nunez General Surgery attending.

Olivia C Pearson, MD
Emergency Medicine, PGY-1

I spent 45 minutes in total time for this visit including all related clinical activities before, during and after the visit.

ATTENDING ATTESTATION:
I have seen and examined Boone Cabal and have independently reviewed the pertinent clinical and radiographic data and agree with the assessment and plan of the Acute Care Surgery team.

Jade M Nunez, MD

Electronically signed by Jade Myles Nunez, MD at 02/16/25 0010

Jade Myles Nunez, MD at 1/11/2025 0715

General Surgery Consultation

Reason for Consult: Diarrhea, abdominal pain

Requesting Attending/Team: Emergency department

History of Present Illness:
Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis, who presents with diarrhea and abdominal pain. General surgery consulted for evaluation and management recommendations.

Patient reports that he was in his normal state of health until last evening, when he started having large-volume watery diarrhea. He denies blood in the diarrhea. He had 5-6 episodes of diarrhea from last night to around noon today. During that time, he denied nausea, vomiting, abdominal pain, fevers, chills. Beginning today at roughly noon, he started to have acute onset abdominal pain, progressive abdominal distention. Since that time, he has had no flatus or additional stools.

He does report a episode of axillary cellulitis, roughly 2 weeks ago, for which she was seen at the fourth Street clinic and prescribed p.o. antibiotics. He does not know what kind they were. He completed his p.o. antibiotics roughly 1 week ago. He did not have any nausea, vomiting, diarrhea while taking antibiotics.

He did recently start taking dulaglutide for weight loss. He does not have diabetes.

He denies any prior episodes of intermittent or recurrent abdominal pain, nausea, vomiting. Denies food fear. Denies unintentional weight loss. Denies bloody bowel movements, hematemesis, changes in stool caliber.

He does have a reported hx of suboxone use, but states that he never took it.

He has never had a colonoscopy.

24 hr events:
-Placed on strict NPO w/ NG tube to remain attached to suction.
-Unchanged KUB this morning.
-No bowel movements, but decreased abdominal discomfort, feels like he could poop
-Increased flatulence

Past Medical History:- Hyperhidrosis, depression

PastSurgical History: has a past surgical history that includes Endoscopic thoracic sympathectomy and rhinoplasty/septoplasty (Left).

Family History:
Reviewed and non -contributory, no reported bleeding, cancer disorders, no anesthesia complications

Social History:
reports that he has quit smoking. His smoking use included cigarettes. He quit smokeless tobacco use about 22 months ago. He reports that he does not currently use alcohol. He reports that he does not currently use drugs after having used the following drugs: Heroin and Cannabis (Marijuana). Reviewed and non -contributory/None, no tobacco or ETOH abuse
Daily living function: Independent
Living Status: lives alone
Frailty Assessment:
2-Well - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
Home Medications:

Reviewed and non -contributory
Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• HYDROmorphone (DILAUDID) injection 0.2 mg	0.2 mg	Intravenous	Q4H PRN	Jenifer Hollingsworth, PA-C		
• ketamine (KETALAR) infusion 1 mg/mL in NS	4 mg/hr	Intravenous	Continuous	Debra Jordan Wing, APRN	4 mL/hr at 01/10/25 1000	4 mg/hr at 01/10/25 1000
• lamoTRIgine (LaMICtal) tablet 200 mg	200 mg	Oral	Daily	Jenifer Hollingsworth, PA-C		
• acetaminophen (OFIRMEV) injection 1,000 mg	1,000 mg	Intravenous	Q6H	Jackson Scott Burton, MD	400 mL/hr at 01/10/25 0616	1,000 mg at 01/10/25 0616
• ketorolac (TORADOL) injection 15 mg	15 mg	Intravenous	Q6H	Jackson Scott Burton, MD		15 mg at 01/10/25 0600
• simethicone (MYLICON) chewable tablet 80 mg	80 mg	Oral	TID PRN	Jackson Scott Burton, MD		80 mg at 01/09/25 0303
• enoxaparin (LOVENOX) syringe 40 mg	40 mg	Subcutaneous	QHS	Jackson Scott Burton, MD		40 mg at 01/09/25 0101
• melatonin tablet 3 mg	3 mg	Oral	QHS PRN	Jackson Scott Burton, MD		
• naloxone	0.1-0.4	Intravenous	PRN	Jackson Scott		

Abstract Notes (continued)

(NARCAN) injection 0.1-0.4 mg	mg			Burton, MD	
• ondansetron (ZOFRAN) injection 4 mg Or	4 mg	Intravenous	Q6H PRN	Jackson Scott Burton, MD	4 mg at 01/09/25 0301
• ondansetron (ZOFRAN) tablet 4 mg	4 mg	Oral	Q6H PRN	Jackson Scott Burton, MD	
• traZODone (DESYREL) tablet 50 mg	50 mg	Oral	QHS PRN	Jackson Scott Burton, MD	

Allergies: Reviewed and non -contributory

Review of Systems:

A complete 12 system ROS was reviewed and
negative except as in the HPI

Physical Exam:

Blood pressure 117/69, pulse 87, temperature 36.6 °C (97.9 °F), temperature source Temporal, resp. rate 18, height 177.8 cm (5' 10"), weight 97.3 kg (214 lb 8.1 oz), SpO2 95%. Body mass index is 30.78 kg/m².

Vital signs:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/10/25 0911	01/10/25 1547	01/10/25 2100	01/11/25 0449
BP:	143/83	122/81	142/70	117/69
Pulse:	86	82	80	87
Resp:	18	18	18	18
Temp:	36.7 °C (98.1 °F)	37 °C (98.6 °F)	37 °C (98.6 °F)	36.6 °C (97.9 °F)
SpO2:	100%	98%	95%	95%

Respiratory:

Volume Achieved (mL): **(!) 0**
Oxygen Therapy
SpO2: 95 %
O2 Device: None (Room air)
Flow Rate: 2 L/min
Pulse Oximetry Site: Finger

I&O:

Intake/Output Summary (Last 24 hours) at 1/11/2025 0715
Last data filed at 1/11/2025 0532

	Gross per 24 hour
Intake	355 ml
Output	—
Net	**355 ml**

General Appearance: Patient appears lying in bed comfortably, alert and interactive; NG tube in place
Cardiovascular: Regular rate and rhythm, normotensive
Pulmonary: : Breathing comfortably on room air
GI: Improved distension from yesterday. No tenderness to light or deep palpation. No peritonitic signs. No abdominal scars. NG tube in place w/ suction
Rectal: Deferred
Neurologic: no focal neurological deficits are noted,Oriented To: person, place and time, GCS 15
Pysc: appropriate mood and affect
Skin: No rashes or lesions, no edema

Objective:

Patient Lines/Drains/Airways Status

Active LDAs

Name	Placement date	Placement time	Site	Days
Peripheral IV 01/08/25 Right Antecubital 18 Gauge 1.16 in	01/08/25	1546	Antecubital	2
Peripheral IV 01/09/25 Left Forearm 20 Gauge	01/09/25	1043	Forearm	1
GI Tube 01/08/25 Nostril Nasogastric Tube	01/08/25	2134	Nostril	2

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

Medications:
Infusion meds:

- ketamine (KETALAR) infusion 1 mg/mL in NS 4 mg/hr (01/10/25 1000)

Scheduled meds:

• lamoTRIgine	200 mg	Oral	Daily
• acetaminophen	1,000 mg	Intravenous	Q6H
• ketorolac	15 mg	Intravenous	Q6H
• enoxaparin	40 mg	Subcutaneous	QHS

Labs:

Recent Results (from the past 24 hours)

Urinalysis, Complete

Collection Time: 01/10/25 11:04 AM

Result	Value	Ref Range
Color, Urine	Yellow	
Appearance, Urine	Clear	Clear, Not Applicable
Leukocyte Esterase,Urine	Negative	Negative
Urobilinogen,Urine	1.0	<2.0 mg/dL
Specific Gravity, Urine	1.034 (H)	1.003 - 1.030
pH, Urine	6.0	5.0 - 7.5
Protein, Urine	30 (A)	Negative
Glucose, Urine	Negative	Negative
Ketones, Urine	Trace (A)	Negative
Bilirubin, Urine	Negative	Negative
Nitrites, Urine	Negative	Negative
Bacteria, Urine	None	Negative
Blood, Urine	Trace (A)	Negative
RBC Auto, Urine	7 (H)	0 - 5 /HPF
WBC Auto, Urine	2	0 - 5 /HPF
EPI Auto, Urine	1	0 - 5 /HPF
Casts Auto, Urine	<4	0 - 3 /LPF

Extra Specimen Urine Gray

Collection Time: 01/10/25 11:04 AM

Result	Value	Ref Range
Extra Specimen Urine Gray	Complete	

Extra Specimen Urine

Collection Time: 01/10/25 11:04 AM

Result	Value	Ref Range
Extra Specimen Urine	Complete	

CBC with Platelet Count

Collection Time: 01/11/25 5:43 AM

Result	Value	Ref Range
WBC	7.87	4.30 - 11.30 k/uL
Hemoglobin	14.8	14.8 - 17.8 g/dL
Hematocrit	43.9 (L)	44.2 - 53.0 %
Platelet	290	159 - 439 k/uL
Red Blood Cell	5.14	4.70 - 6.14 M/uL
Mean Corpuscular Volume	85.4	81.2 - 96.6 fL
Mean Corpuscular	28.8	25.8 - 33.1

Hemoglobin		pg
Mean Corpuscular HGB Concentration	33.7	31.9 - 35.2 g/dL
Red Cell Distribution Width	14.8	11.5 - 15.3 %
Mean Platelet Volume	8.8	8.6 - 12.3 fL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL

CBC:

Lab Results

Component	Value	Date
WBC	7.87	01/11/2025
RBC	5.14	01/11/2025

CMP:

Lab Results

Component	Value	Date
SODIUM	136	01/10/2025
K	3.5	01/10/2025
CL	108	01/10/2025
CO2	18 (L)	01/10/2025
BUN	13	01/10/2025
GLUC	90	01/10/2025
CA	8.4	01/10/2025
TP	7.2	01/10/2025
ALB	4.0	01/10/2025
TBILI	0.7	01/10/2025
ALKP	78	01/10/2025
AST	40	01/10/2025
ALT	50	01/10/2025
AGAP	10	01/10/2025

ABGs: No results found for: "PH"

Imaging/Radiology - last 24 hrs:
XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

The trauma and emergency general surgery team has independently reviewed and interpreted all labs, radiology reports and images. Pertinent findings documented below.

Assessment/Plan:

Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and

distention. Collectively, appears most consistent with colonic ileus/pseudoobstruction, most likely secondary to gastroenteritis or infectious diarrhea given history, differential diagnosis also includes C. difficile given recent antibiotics use, medication related colonic ileus with multiple psychiatric medications or possibly related to his new dulaglutide use, low concern for mechanical obstruction given normal CT scan and digital rectal exam. At this time, given his lower GI predominance of symptoms, normal foregut midgut findings on CT scan, it is believed that the high-grade stenosis of the celiac trunk is incidental to his current complaints. There is no indication for surgical intervention at this time, however we will continue to follow closely.

Boone's imaging remains mostly unchanged, however his clinical presentation has improved significantly as evidenced by decreased distension and lack of abdominal discomfort on exam. Additionally, he reports increased flatulence.

-No indication for surgical intervention at this time
-Daily bisacodyl suppository PRN
-Remove NG tube and allow clear liquid PO in small quantities.
-Obtain KUB @ 1900 or KUB with any acute clinical change to eval for progression of colonic dilation
-Continue follow-up w/ PT/OT
-Normalize electrolytes per protocol
-F/u C. Diff testing
-Avoid opioids as able
-Can consider outpatient follow up with general surgery outpatient for possible MALS on CT, this is unlikely to be contributing to todays presentation
-If patient does not demonstrate clinical signs of improvement with conservative methods, we can consider additional adjuncts such as neostigmine
-General Surgery to continue to follow in the AM; please page with any additional questions or concerns

I have discussed the above patient with Dr. Nunez General Surgery attending.

Jacob Bell MS-2

I was present with medical student who participated in patient care and documentation of this note. I personally saw and evaluated the patient and performed my own history and examination. I discussed the case with the medical student. I have reviewed, verified, and revised the note as necessary and agree with the content and plan as written by medical student.

The care plan above was formulated under the supervision of Dr. Nunez, M.D. by medical student and I oversaw the care and note as resident.

Olivia Pearson, MD
Emergency Medicine, PGY-1

I spent 45 minutes in total time for this visit including all related clinical activities before, during and after the visit.

ATTENDING ATTESTATION:
I have assessed Boone Cabal, independently reviewed the imaging and clinical data, and agree with the assessment and plan of the Acute Care Surgery team.

Jade M Nunez, MD

Electronically signed by Jade Myles Nunez, MD at 02/16/25 0010

Benjamin Joshua Gow-Lee, MD at 1/13/2025 0611

Attestation signed by Darcie Reasoner Gorman, MD at 01/13/25 1546

I have discussed the case with Dr. Gow-Lee and agree with assessment and plan.

Would stress to patient importance of proper dosing of home medications and would add bowel regimen to avoid constipation.

Please call with further questions.
Darcie Gorman, MD
Gastroenterology

GI Consult Note

Visit Information:
Unit: UH D60 INTERNAL MEDICINE

GI Attending: Darcie Gorman, MD
GI Fellow: Benjamin Joshua Gow-Lee, MD
Requesting Physician: Julie Weis, MD

This consult was done in person.

Chief Complaint/Reason for Consultation: Ogilvie's syndrome

History of Present Illness:

Mr. Boone Cabal is a 45 yo man with history of mood disorder, BMI 30, who presented with abdominal pain and found to have arcuate ligament syndrome and Ogilvie's on initial CT scan.

GI attempted to visit patient multiple times yesterday but not available for interview. Please see progress note 1/12/25 for more information. At that time, patient was passing flatus and stool. Conservative management was recommended.

Mr. Cabal is currently living in a halfway house. He reports having some abdominal pain/cramping about a month or 2 ago in the setting of starting dulaglutide for obesity. In the interim, he Using dulaglutide. Last week, he reports restarting dulaglutide at a double the dose. The next day, he began having acute diarrhea (though no nocturnal stools). The day after, he became obstipated without any bowel or flatus passage. He presented to the hospital for these concerns. Since then, he has begun having passage of flatus and bowel movements. Additionally, his crampy

abdominal pain has been improving significantly. He has been ambulating and tolerating CLD. No nausea or vomiting on my interview.

He denies any substance use currently including nicotine, alcohol, marijuana, illicit substances. No NSAIDs.

Review of Systems:

Review of systems is accurate as per admitting physician's note dated 1/8/2025 with no changes.

Problem List:

Patient Active Problem List

Diagnosis

- Mild mood disorder (HCC)
- Unspecified mood (affective) disorder (HCC)
- Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult
- Axillary abscess
- Ogilvie syndrome

Past Medical and Surgical History:

Past Medical History:

Diagnosis	Date
• Hyperhidrosis	

Past Surgical History:

Procedure	Laterality	Date
• Endoscopic thoracic sympathectomy		
• RHINOPLASTY/SEPTOPLASTY	Left	

Social History:

In the interim

Social History

Socioeconomic History

- Marital status: Single
  Spouse name: None
- Number of children: None
- Years of education: None
- Highest education level: None

Tobacco Use

- Smoking status: Former
  - Types: Cigarettes
- Smokeless tobacco: Former
  - Quit date: 03/2023

Vaping Use

- Vaping status: never used

Substance and Sexual Activity

- Alcohol use: Not Currently
- Drug use: Not Currently
  - Types: Heroin, Cannabis (Marijuana)
  - *Comment: clean 3mo (9/23/24); endorses IVDU hx*
- Sexual activity: Not Currently
  - Partners: Female

Alcohol Use: Not At Risk (10/21/2024)

Alcohol Use

- How often do you have a drink containing alcohol?: Never
- How many drinks containing alcohol do you have on a typical day when you are drinking?: 0 to 2
- How often you have six or more drinks on one occasion?: Never

Family History:

No known family history of GI luminal cancers including colon cancer, esophageal cancer, stomach cancer.

Medications and Allergies:

Medications:

Infusion meds:

Scheduled meds:

• bisacodyl	10 mg	Rectal	Daily
• lamoTRIgine	200 mg	Oral	Daily
• enoxaparin	40 mg	Subcutaneous	QHS

PRN:

• acetaminophen	975 mg	Oral	TID PRN
• HYDROmorphone	0.2 mg	Intravenous	Q4H PRN
• simethicone	80 mg	Oral	TID PRN
• melatonin	3 mg	Oral	QHS PRN
• naloxone	0.1-0.4 mg	Intravenous	PRN
• ondansetron Or	4 mg	Intravenous	Q6H PRN
• ondansetron	4 mg	Oral	Q6H PRN
• traZODone	50 mg	Oral	QHS PRN

Allergies:
No Known Allergies

Physical Exam:

Vital Signs:
BP 124/68 (BP (Cuff) Location: Right arm, Patient Position: Sitting) | Pulse 83 | Temp 36.3 °C (97.3 °F) (Temporal) | Resp 22 | Ht 177.8 cm (5' 10") | Wt 97.3 kg (214 lb 8.1 oz) | SpO2 100% | BMI 30.78 kg/m²
HR: [83-124] 83
BP: (124-148)/(68-89) 124/68
Temp: [36.3 °C (97.3 °F)-36.9 °C (98.4 °F)] 36.3 °C (97.3 °F)

Intake/Output

	01/11/25 0700 - 01/12/25 0659	01/12/25 0700 - 01/13/25 0659			
	Total	0700-1459	1500-2259	2300-0659	Total
Intake (ml)	1800	591	946	375	1912
Output (ml)	—	—	—	—	—
Net (ml)	1800	591	946	375	1912

Weight Change:
Admit Wt.Weight: 97.3 kg (214 lb 8.1 oz)
Current Wt. Weight: 97.3 kg (214 lb 8.1 oz)

Wt Readings from Last 5 Encounters:

01/08/25	97.3 kg (214 lb 8.1 oz)
01/07/25	97.7 kg (215 lb 6.4 oz)
12/13/24	97.5 kg (215 lb)
10/21/24	98.9 kg (218 lb)
09/23/24	102.1 kg (225 lb)

GENERAL: Comfortable and in no acute distress. Standing at edge of bed independently with good balance
MOOD/AFFECT: appropriate affect
EYES: Anicteric.
ENT: Neck supple, no oral ulcerations.
CARDIOVASCULAR: Regular rate and rhythm
PULMONARY: no respiratory distress on RA
ABDOMEN: soft, mild tenderness to deep palpation in LLQ, mild distension, tympany in upper quadrants, dullness lower quadrants
EXTREMITIES: No lower extremity edema.
SKIN: No rash.

Laboratory and Diagnostic Studies

Laboratory:
Laboratory data reviewed.

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 0529	01/09/25 0744	01/08/25 1546
WBC	k/uL	5.65	7.87	8.47	11.09	9.72
HGB	g/dL	14.3*	14.8	13.1*	13.4*	14.4*
PLTS	k/uL	280	290	241	262	269

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 0529	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	139	139	136	138	141
POTASSIUM	mmol/L	3.4	3.4	3.5	3.5	4.0
CHLORIDE	mmol/L	108	106	108	110	115*
CARBON DIOXIDE	mmol/L	24	21	18*	19*	18*
BUN	mg/dL	10	9	13	15	16
CREATININE	mg/dL	0.90	0.87	0.73	0.89	0.98

No results found for: "CLPRTCTNFCL", "CRPHGHSNSTVT", "CRP"

I personally reviewed the KUB. The imaging demonstrates improving colonic dilation.

Imaging:
XR Abdomen 1 View

Result Date: 1/12/2025
FINDINGS/IMPRESSION: Persistent dilation of the transverse colon, decreased dilation of the ascending colon, paucity of bowel gas seen distal to the splenic flexure consistent with slightly improved with ongoing colonic pseudoobstruction/Ogilvie syndrome.

XR Abdomen 1 View

Result Date: 1/12/2025
Similar or slightly decreased colonic gaseous distention. Attending note: Agree with the above report, which was edited for clarity.

XR Abdomen 1 View

Result Date: 1/11/2025
Similar diffuse gaseous dilation of the colon with transition at the proximal descending colon typical for Ogilvie syndrome.

XR Abdomen 1 View

Result Date: 1/11/2025
Colonic gaseous dilation is mildly improved compared to prior.

XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025

High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

IMPRESSION

Mr. Boone Cabal is a 45 yo man with history of mood disorder, BMI 30, who presented with abdominal pain and found to have arcuate ligament syndrome and Ogilvie's on initial CT scan.

#Acute colonic pseudoobstruction
Symptoms and imaging findings consistent with Ogilvie syndrome. No recent surgery or trauma, no advanced age or neurologic disorders, no severe electrolyte imbalances, no antispasmodics or other diarrheal agents. Notably, symptoms seem to begin after starting dulaglutide. Dulaglutide can affect motility and lead to ileus so conceivable that this medication may have contributed to his presentation (Faillie JL, 2022. *Clin Pharmacol Ther*. PMID: 34587280). With Sapa virus on GI PCR, this also may be contributing to motility issues. Since admission, patient has spontaneously began passing flatus and bowel movements with improvement in abdominal pain.

#Concern for median acute ligament syndrome
This concern was raised on CTA where there was inferior displacement of the proximal celiac artery with associated stenosis due to the median arcuate ligament. Unclear whether this is causing abdominal pain as Ogilvie's can also cause abdominal discomfort.

RECOMMENDATIONS

– No indication for colonic decompression currently
– Consider trial of neostigmine if colonic distention worsens
– Recommend daily KUBs
- Ogilvie's prevention:
    - aggressive electrolyte support
    - aggressive ambulation and/or movement in bed
    - lying on side or prone
    - avoid opiates and other bowel slowing medications, eg dulaglutide
– At some point can consider duplex ultrasound of the celiac artery for further workup of MALS

Assessment and recommendations to be discussed with attending physician.
Final recommendations and attending addendum to follow.
GI Service will sign off at this time. Please call with questions. . Please call with questions.
Case and above recommendations discussed with primary medicine service.

Author:
Benjamin Gow-Lee, MD
PGY-4 Fellow, Gastroenterology, Hepatology, & Nutrition

Electronically signed by Benjamin Joshua Gow-Lee, MD at 01/13/25 0829
Electronically signed by Darcie Reasoner Gorman, MD at 01/13/25 1546

Discharge Summary

Karen Michelle Hernandez-Ponce, PA-C at 1/14/2025 1822

Attestation signed by Tyler Hohnholt, MD at 01/20/25 0909

I reviewed the APC's documentation and agree with the history, exam, assessment and care plan. I made/approve the management plan for the problems addressed in the encounter and take responsibility for the plan. I personally saw and evaluated the patient on 1/14/2025, and performed my own physical examination (PE) and medical decision making (MDM). I spent 15 minutes in the care of this patient.

Tyler Hohnholt, MD
Hospitalist
University of Utah Health
Division of General Internal Medicine

Discharge Summary

Admission Date: 1/8/2025 Discharge Date:01/14/2025
Attending: No att. providers found

Discharge Diagnosis:

Diagnoses at Discharge:

#Abdominal Pain
#OgilvieSyndrome
#SapovirusInfection
#Colitis
#Diarrhea, resolving
#MedianArcuateLigamentSyndrome
#LFTElevation
#Mood
#PassiveSuicidalIdeation
#Hyperhidrosis
#Obesity

Identifying Information:

Identifying Information:Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

Reason for Hospitalization:

#Abdominal pain

#Ogilvie syndrome (Acute colonic pseudo-obstruction)

Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Home dulaglutide may also have contributed. Other etiology could be recent colitis. Patient was monitored by general surgery with serial KUBs until distension improved. He DID NOT require surgical intervention, colonic decompression with colonoscopy or neostigmine. His symptoms improved with conservative management; abdominal pain completely resolved, pt continued with 2-4 soft Bms daily, passing gas, and tolerated regular diet without issues at discharge. Dulaglutide was discontinued at discharge. Pt plans to follow up with PCP in 1-2 weeks. Referral to general surgery was also placed at discharge to address MALS as below.

#Sapovirus infection

#Colitis

#Diarrhea, improving

1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. Low concern for ischemic colitis. GI path + sapovirus. C diff test negative

#Median arcuate ligament syndrome

No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis as above. Mesenteric duplex canceled as pt high degree of bowel gas. Per general surgery and GI can follow up non-urgently outpatient to address. Referral placed.

#LFT elevation, resolved

Mild LFT derangement. No abnormality of liver on CTA.

#Mood

#Passive suicidal ideation

Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. Patient does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen. SW/Psych cleared patient from need for 1:1. Low risk. Cont home lamotrigine 200 mg

#Hyperhidrosis

- Hold oxybutynin in setting of Ogilvie syndrome
    - DC med on discharge

#Obesity

- DC home dulaglutide

Objective:

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Labs:

Recent Results (from the past 36 hours)

POC Glucose Fingerstick (Instrmt)

Collection Time: 01/13/25 11:39 AM

Result	Value	Ref Range
Glucose, Finger Stick	71	64 - 128 mg/dL

Basic Metabolic Panel

Collection Time: 01/14/25 5:50 AM

Result	Value	Ref Range
Sodium S/P	139	136 - 144 mmol/L
Potassium	3.7	3.3 - 5.0 mmol/L
Chloride	108	102 - 110 mmol/L
Carbon Dioxide	21	20 - 26 mmol/L
BUN	11	8 - 24 mg/dL
Creatinine S/P	0.94	0.72 - 1.25 mg/dL
Glucose	86	64 - 128 mg/dL
Anion Gap	10	5 - 14 mmol/L
Calcium	8.5	8.4 - 10.5 mg/dL
eGFR, CKD-EPI CRT 2021	101	mL/min/1.73m2

Diagnostic Studies (last 36 hours):

Recent Results (from the past 36 hours)

XR Abdomen 1 View

Collection Time: 01/13/25 11:07 AM

Narrative

EXAMINATION: XR ABDOMEN 1 VIEW

INDICATION: Evaluate for pseudoobstruction.

COMPARISON: Radiograph the abdomen 1/12/2024

TECHNIQUE: XR ABDOMEN 1 VIEW

FINDINGS:
Nondistended loops of colon, decreased in diameter compared to study 1/12/2025. Thumbprinting of the haustra.

Impression

Nondistended loops of colon which have decrease in diameter compared to prior. However, there is haustral thumbprinting which can be seen in the setting of C. difficile infection.

Hospital Course:

As above

Discharge Medications/Nutrition:

Medication List

START taking these medications

polyethylene glycol 3350 17 GM/SCOOP powder
Commonly known as: MIRALAX
Mix 17 grams of powder (up to line inside of measuring cap) in 4 to 8 ounces of beverage and drink daily as needed for constipation.
Start taking on: January 15, 2025

CONTINUE taking these medications

gabapentin 800 mg tablet
Commonly known as: NEURONTIN
Take 800 mg by mouth 3 times daily.

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lamoTRIgine 200 mg tablet
Commonly known as: LaMICtal
Take 200 mg by mouth every morning.

Mydayis 50 MG 24 hr sustained release capsule
Generic drug: Amphet-Dextroamphet 3-Bead ER
Take 50 mg by mouth once daily.

STOP taking these medications

dulaglutide 0.75 mg/0.5 mL
Commonly known as: TRULICITY

ASK your doctor about these medications

* DULoxetine 20 mg enteric coated particles capsule
Commonly known as: CYMBALTA
Take 20 mg by mouth daily at bedtime.
Notes to patient: ** Talk to the original prescriber of this medication about need to use it since you reported not using it at home.

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* DULoxetine 60 mg enteric coated particles capsule
Commonly known as: CYMBALTA
Take 60 mg by mouth every morning.
Notes to patient: ** Talk to the original prescriber of this medication about need to use it since you reported not using it at home.

Pen Needles 32G X 4 MM miscellaneous
100 each by Does Not Apply route once a week.
Notes to patient: ** Talk to the original prescriber of this medication about need to use it since you reported not using it at home.

* This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

Medication Instructions:

Information about your NEW discharge medication:

Polyethylene Glycol Powder (Miralax) is a laxative used to treat constipation.
- Always dissolve the powder in a full glass (8 ounces) of water or juice before swallowing it.
- Store the medicine at room temperature.
- Do not take this medication if you have loose stools (diarrhea).
- May cause mild cramps, bloating, diarrhea, or gas.
- This an over-the-counter (OTC) medication.

Abstract Notes (continued)

Where to Get Your Medications

These medications were sent to U of U Hospital Pharmacy - Salt Lake City, UT - 50 N Medical Dr
50 North Medical Drive, SALT LAKE CITY UT 84132

Hours: Pharmacy 8AM-9PM Daily, Kiosk Phone: 801-581-2276
open 24 Hours

- polyethylene glycol 3350 17 GM/SCOOP powder

Pharmacy Instructions:
Discharge medication will be delivered to patient's room by pharmacist. ** Lamotrigine (Lamictal) was not prescribed today.

Discharge Instructions:
Discharge Disposition. patient instructed to follow up with PCP and general surgery.

Condition at Discharge: hemodynamically stable (improved etc.).

Appointments Scheduled in the Next 30 Days:
No future appointments.

Author: Karen Michelle Hernnadez-Ponce, PA-C

Electronically signed by Karen Michelle Hernandez-Ponce, PA-C at 01/19/25 2329
Electronically signed by Tyler Hohnholt, MD at 01/20/25 0909

ED Provider Notes

Holly Smock, PA-C at 1/8/2025 1522

History of Present Illness
Chief complaint(s): Abdominal Pain

This note was created in part or entirely from DAX Copilot software embedded in Epic and may contain unintended transcription errors, unusual phrasing, style and ordering of medical information.

HPI: This is a 45 year old male with a history of mood disorder who comes the emergency department with a acute onset of abdominal pain.

History of Present Illness

History of Present Illness
The patient presents to the ER for evaluation of abdominal pain.

Sudden onset of severe abdominal pain at 1:00 PM and an RRT was called within the hospital. No previous episodes of similar pain. No anticoagulant therapy, no history of abdominal surgeries, hepatic disease, or thromboembolic events. Diarrhea since last night, one liquid bowel movement today, no blood. No recent antibiotic therapy. No vomiting or nausea, but reports abdominal distension. Passing gas, but this has not relieved the pain. No history of colonoscopy.

Scheduled for a neurology appointment today, during which mild abdominal discomfort rapidly escalated to severe pain.

Physical Exam
Physical Exam
Vitals and nursing note reviewed.

General: conversant, mild distress due to pain.
Head: Normocephalic, atraumatic.
Eyes: Equal, round and reactive to light. Full extraoccular movements.
ENT: Neck is supple.
Pulmonary: Clear to auscultation bilaterally. Symmetric chest rise.
Cardiovascular: Regular rate and rhythm with no murmurs, gallops, or rubs.
Abdomen: Soft, generalized tenderness worst in LLQ with rebound tenderness, distended. Bowel sounds present.
Musculoskeletal: No obvious deformities to upper or lower extremities.
Psychiatric: Alert, oriented, and appropriate to situation.
Neurologic: CN II-XII intact. No focal deficits appreciated. Moving all four extremities.

Medical Decision Making
Procedures

MDM:

Assessment & Plan
Initial Assessment: Patient presents with sudden onset abdominal pain and diarrhea since last night. No history of similar pain, blood thinners, abdominal surgery, or recent antibiotic use. No vomiting or nausea, but reports distension and minimal gas relief.

ED Course:
- CT scan reveals an ileus and median arcuate ligament syndrome due to celiac artery narrowing. No evidence of ischemia
- Administered pain medication.
- Conducted basic lab tests.
- Plan to collect a urine sample during the next bathroom visit.
- General surgery consulted with the surgical team for potential interventions.

Final Assessment: The patient has an ileus and median arcuate ligament syndrome causing severe abdominal pain. No ischemia noted. Awaiting surgical team consultation for further management.

Patient signed out to Jamal Jones, MD with surgery consult pending.

Clinical Impression:
- Ileus
- Median arcuate ligament syndrome with celiac artery stenosis

Disposition:
- Follow-Up: surgical team consultation .

Clinical Impressions as of 01/08/25 1900
Celiac artery stenosis (HCC)
Median arcuate ligament syndrome (HCC)
Ileus (HCC)

Disposition: Data Unavailable

MDM Complexity
Launch MDCalc MDM Tool
MDCalc MDM Module
Jan 08 2025 7:00 PM [Holly Smock]
Data:
- Discussed with external professional: Case discussed with General surgery. See MDM section and/or ED Course for additional details on the discussion.
- Test/documents/historian: 3+ tests ordered
Problems: Acute abdominal pain, unclear etiology
Risk: HYDROmorphone injection (Parenteral controlled substances)

Vitals and Results

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Vitals

	01/08/25 1406	01/08/25 1510	01/08/25 1631	01/08/25 1824
BP:	137/98	134/100		137/100
Pulse:	99	90		87
Temp:	36.2 °C (97.2 °F)	36.1 °C (97 °F)		36.3 °C (97.3 °F)
Resp:	28	25		22
SpO2:	97%	95%	98%	95%

CBC WITH PLATELET COUNT AND AUTOMATED DIFFERENTIAL - Abnormal

Result	Value	Ref Range
WBC	9.72	4.30 - 11.30 k/uL
Hemoglobin	14.4 (*)	14.8 - 17.8 g/dL
Hematocrit	44.5	44.2 - 53.0 %
Platelet	269	159 - 439 k/uL
Red Blood Cell	4.96	4.70 - 6.14 M/uL
Mean Corpuscular Volume	89.7	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	32.4	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.2	11.5 - 15.3 %
Mean Platelet Volume	8.7	8.6 - 12.3 fL
Neutrophil %	83.1 (*)	39.4 - 72.5 %
Lymphocyte %	12.2 (*)	17.6 - 49.6 %
Monocyte %	3.6 (*)	4.1 - 12.4 %
Eosinophil %	0.4	0.4 - 6.7 %
Basophil %	0.3	0.3 - 1.4 %
Neutrophil # (ANC)	8.07 (*)	2.00 - 7.40 k/uL
Lymphocyte #	1.19 (*)	1.30 - 3.60 k/uL

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Monocyte #	0.35	0.30 - 1.00 k/uL
Eosinophil #	0.04	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.04	0.01 - 0.09 k/uL

COMPREHENSIVE METABOLIC PANEL - Abnormal

Sodium S/P	141	136 - 144 mmol/L
Potassium	4.0	3.3 - 5.0 mmol/L
Chloride	115 (*)	102 - 110 mmol/L
Carbon Dioxide	18 (*)	20 - 26 mmol/L
BUN	16	8 - 24 mg/dL
Creatinine S/P	0.98	0.72 - 1.25 mg/dL
Glucose	117	64 - 128 mg/dL
Anion Gap	8	5 - 14 mmol/L
Calcium	8.9	8.4 - 10.5 mg/dL
Protein, Total, S/P	8.4	6.5 - 8.4 g/dL
Albumin	4.9	3.5 - 5.0 g/dL
Bilirubin, Total	0.4	0.2 - 1.4 mg/dL
Alkaline Phosphatase	86	38 - 126 U/L
AST	55 (*)	16 - 40 U/L
ALT	68 (*)	0 - 55 U/L
eGFR, CKD-EPI CRT	96	mL/min/1.

2021		73m2
POC GLUCOSE FINGERSTICK (INSTRMT) - Abnormal		
Glucose, Finger Stick	130 (*)	64 - 128 mg/dL
BLOOD GAS ANALYSIS WITH ELECTROLYTES (PULMONARY LAB) - Abnormal		
pH - Venous	7.262 (*)	7.310 - 7.410
pCO2 - Venous	47.9	40.0 - 52.0 mm/Hg
pO2 - Venous	25.2 (*)	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	14.4	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	26.5 (*)	>=92.0 %
Carboxyhemoglobin - Venous	0.5	<=2.0 %
Methemoglobin - Venous	0.7	<1.0 %
Oxygen Saturation (sO2) - Venous	26.8 (*)	75.0 - 100.0 %
HCO3-, Venous	20.9	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.9 (*)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	44.2	40.1 - 52.5 %
O2 Content - Venous	5.4 (*)	17 - 24 vol%
Potassium - Venous	3.9	3.5 - 5.0 mmol/L
Sodium - Venous	145 (*)	136 - 144 mmol/L
Ionized Calcium - Venous	1.32 (*)	1.11 - 1.30 mmol/L
Glucose - Venous	122 (*)	65 - 110 mg/dL
Lactate - Venous	1.50	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	0	%orFlowrate

LIPASE, SERUM OR PLASMA - Normal

Lipase, S/P	43	8 - 78 U/L

PERIPHERAL IV
CTA ABDOMEN PELVIS W IV CONT
POC FINGERSTICK GLUCOSE & HEELSTICK
REQUEST
URINALYSIS, COMPLETE
EXTRA SPECIMEN URINE GRAY
EXTRA SPECIMEN URINE

Imaging Results

CTA Abdomen Pelvis W IV Cont (Final result) Result time 01/08/25 17:46:00

Final result by Jeffrey D Olpin, MD (01/08/25 17:46:00)

Impression:

High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen.
Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Narrative:

EXAMINATION: CTA ABDOMEN PELVIS W IV CONT

INDICATION: Suspected mesenteric ischemia

TECHNIQUE: Helical images were obtained through the abdomen and pelvis following the protocol administration of nonionic intravenous contrast material. Because of the provided clinical history, late arterial phase images were obtained in addition to the standard portal venous phase images.

COMPARISON: None.

FINDINGS:

Lung Bases: Scattered atelectasis is noted at both lung bases.

Liver: Normal in morphology and contour. No focal abnormality. The portal veins are patent.

Gallbladder and Bile Ducts: Gallbladder is unremarkable. No bile duct dilation.

Kidneys: Symmetric nephrograms. No hydronephrosis.

Adrenal Glands: Normal in configuration. No nodule.

Spleen: Normal in size. No focal lesion.

Pancreas: Homogeneous enhancement without main duct dilation.

Bowel: The stomach is mildly distended with fluid. The small bowel loops are normal in course and caliber. There is diffuse colonic dilatation measuring up to 9.2 cm in maximum transverse diameter at the level of the proximal ascending colon. No evidence of intestinal obstruction is seen.

Pelvis: The prostate and seminal vesicles are unremarkable.

Mesentery/Peritoneum: No pneumoperitoneum. No free fluid or focal fluid collection.

Lymph Nodes: No abdominal or pelvic lymphadenopathy by size criteria.

Vasculature: The abdominal aorta is normal in course and caliber. There is no aneurysm or dissection. There is inferior displacement of the proximal celiac artery with associated stenosis due to the adjacent median arcuate ligament. The proximal celiac artery measures approximately 2 mm in maximum diameter. Mild poststenotic dilatation of the mid to distal celiac artery is noted. The hepatic and splenic arteries are widely patent. The superior and inferior mesenteric arteries are likewise normal in caliber.

Soft Tissues: Unremarkable

Bones: No acute or pathologic osseous abnormality.

Abstract Notes (continued)

Holly Smock, PA-C
01/08/25 1900

Contains text generated by DAX Copilot
Electronically signed by Holly Smock, PA-C at 01/08/25 1900

H&P

Jackson Scott Burton, MD at 1/8/2025 2223

Attestation signed by Natalie Marie Como, MD at 01/09/25 0551

I saw and evaluated the patient on 1/8/25. I reviewed the resident's documentation and agree with the history, exam, assessment and care plan with any highlights below. I spent 40 minutes in the care of this patient. Reviewed all imaging and labs.

Natalie Como, MD
Internal Medicine-Pediatrics
Assistant Professor
University of Utah, Division of General Internal Medicine

Medicine History and Physical

Chief complaint:
Abdominal pain

History of Present Illness:
Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

Patient describes being in normal state of health until last night. At this time, he began experiencing large-volume watery diarrhea. He estimates he had approximately 8 episodes of diarrhea to this morning. He came to the hospital today for a scheduled appointment with neurology for fMRI scan. While here, he experienced acute onset of severe abdominal pain which ramped up over approximately 30 minutes. Describes his pain as severe, 10 out of 10 at the time, and associated with distention in his abdomen. He presented to the emergency department where he underwent CTA with concern for mesenteric ischemia. Imaging significant for discovery of median arcuate ligament stenosis of celiac artery without signs of ischemia and dilation of large bowel up to 9 cm without obvious obstruction consistent with Ogilvie syndrome. Of note, the patient recently increased his dulaglutide dose which he received yesterday prior to onset of diarrhea. He had began this medication 3 months ago and only experienced mild gastrointestinal distress when he first began using it. Also of note, he recently completed a course of Bactrim for a subcutaneous nodule/abscess located in his left axilla. He has had several infections in his axilla and has hyperhidrosis. The patient denies any change in appetite recently or postprandial pain. He denies any hematochezia or hematemesis. Denies any recent fever or other infectious symptoms at home.

In the emergency department, the patient was hemodynamically stable saturating well on room air. Received hydromorphone 1 mg x6 for severe pain in addition to LR bolus, 20 mg ketamine injection, and had NG tube placed for decompression. Laboratory workup: No severe electrolyte derangements, no AKI, mild LFT derangement, VBG with

pH 7.26, pO2 25.2, pCO2 47.9, lactate 1.5. Repeat VBG with pH 7.29, pCO2 43.4, pO2 39.5, lactate 0.80. Nonelevated white count, Hgb 14.4. Surgery evaluated the patient and did not recommend operative intervention.

Histories:

Past Medical History:

Diagnosis	Date
• Hyperhidrosis	

Past Surgical History:

Procedure	Laterality	Date
• Endoscopic thoracic sympathectomy		
• RHINOPLASTY/SEPTOPLASTY	Left	

No family history on file.
Family history was reviewed and found noncontributory.

Social History

Tobacco History

Tobacco Use	
Smoking Status	Former
• Types:	Cigarettes
Smokeless Tobacco	Former
• Quit date:	03/2023

History

Alcohol Use	Not Currently

History

Drug Use	Unknown

Comment: clean 3mo (9/23/24); endorses IVDU hx

Medications and Allergies

Medications Prior to Admission:

No current facility-administered medications on file prior to encounter.

Current Outpatient Medications on File Prior to Encounter

Medication	Sig	Dispense	Refill
• dulaglutide (TRULICITY) 0.75 mg/0.5 mL	Inject 1 mL (1.5 mg) subcutaneously once a week.	4 mL	0
• Insulin Pen Needle (PEN NEEDLES) 32G X 4 MM miscellaneous	100 each by Does Not Apply route once a week.	4 each	5
• oxybutynin (DITROPAN) 5 mg tablet	Take 1 tablet (5 mg) by mouth 2 times a day. Indications: Excessive Sweating Disorder	60 tablet	3
• buprenorphine-naloxone (SUBOXONE) 4-1 mg film SL film	Place 1 Film (4 mg buprenorphine) under the tongue 2 times a day. (Patient not	14 Film	0

	taking: Reported on 9/23/2024)
• DULoxetine (CYMBALTA) 30 mg enteric coated particles capsule	Take by mouth once daily.
• lamoTRIgine (LAMICTAL) 100 mg tablet	Take 100 mg by mouth once daily.
• gabapentin (NEURONTIN) 600 mg tablet	Take 600 mg by mouth 3 times daily.
• MYDAYIS 50 MG 24 hr sustained release capsule	Take 50 mg by mouth once daily.

Allergies:
No Known Allergies

Review of Systems:
A 10-point ROS was performed and was otherwise negative except as per HPI.

Physical Exam:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/08/25 2004	01/08/25 2140	01/08/25 2228	01/08/25 2336
BP:	138/92	132/95	152/99	149/84
Pulse:	78	89	88	86
Resp:	18	18	18	26
Temp:	36.7 °C (98.1 °F)	36.6 °C (97.9 °F)	36.6 °C (97.9 °F)	36.2 °C (97.2 °F)
SpO2:	98%	93%	95%	99%

GEN: Moderate distress
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Severe distention, no guarding, moderate tenderness to palpation worse in epigastric area
SKIN: Dry.
NEURO: Alert.
PSYCH: Appropriate affect. Passive SI.

Studies:

Results from last 7 days

Lab	Units	01/08/25 1546
SODIUM	mmol/L	141
POTASSIUM	mmol/L	4.0
CHLORIDE	mmol/L	**115***
CARBON DIOXIDE	mmol/L	**18***
BUN	mg/dL	16
CREATININE	mg/dL	0.98
CALCIUM, S/P	mg/dL	8.9
PROTEIN, TOTAL	g/dL	8.4
BILIRUBIN, TOTAL	mg/dL	0.4
ALKALINE PHOSPHATASE	U/L	86
ALT	U/L	**68***
AST	U/L	**55***
GLUCOSE	mg/dL	117

Results from last 7 days

Lab	Units	01/08/25 1546
WBC	k/uL	9.72
HGB	g/dL	**14.4***
HCT	%	44.5
PLTS	k/uL	269

Other labs reviewed and notable for:
none

Imaging:
XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis.
- NGT placed for gastric decompression, low intermittent suction
- NPO
- Trial 72h supportive care. If no improvement consider neostigmine, GI, surg c/s
- KUB am and every 12-24h
- Pain control:
    - IV Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - 3rd line hydromorphone 0.4 mg q4h
    - avoid opiates as able
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin

#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic colitis.
- Collect GI pathogen panel, C Dif when able
- pending results of path panel, consider discontinuing dulaglutide at d/c

#Median arcuate ligament syndrome
No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- mesenteric duplex
- vascular c/s vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. In setting of obesity, most likely NASH. No abnormality of liver on CTA.
- Cont to monitor
- outpatient f/u

#Mood
#passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- defer 1:1 now given low risk of harm to self
- SW consult
- cont home duloxetine, lamotrigine
- hold home stimulant, clarify in am whether patient is taking

Abstract Notes (continued)

#Hyperhidrosis
- hold oxybutynin in setting of Ogilvie syndrome
    - consider d/c'ing med on discharge

#Obesity
- hold home dulaglutide

Diet: NPO

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Pending clinical improvement

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
none

Jackson Scott Burton, MD

Electronically signed by Jackson Scott Burton, MD at 01/09/25 0049
Electronically signed by Natalie Marie Como, MD at 01/09/25 0551

Progress Notes

Marshall Walker Wallace, MD at 1/9/2025 0312

SERIAL ABDOMINAL EXAM:

BP 149/84 (BP (Cuff) Location: Left arm, Patient Position: Supine) | Pulse 86 | Temp 36.2 °C (97.2 °F) (Temporal) | Resp 26 | Ht 177.8 cm (5' 10") | Wt 97.3 kg (214 lb 8.1 oz) | SpO2 99% | BMI 30.78 kg/m²

GEN: Sleeping comfortably, easily awoken, NAD. NGT in place, with gastric contents in tubing. Functioning properly after troubleshooting, unclogging sump port.
ABDO: Distended, somewhat softer than prior exam. Diffusely tender to deep palpation, though less tender than prior exam, no guarding, no signs of peritonitis.

Patient describes ongoing pain, though it is improved from earlier this evening. Subjective mild improvement in distension. Has not passed flatus or BM.

Marshall Wallace, MD
1/9/2025 3:12 AM

Electronically signed by Marshall Walker Wallace, MD at 01/09/25 0440

Electronically signed by Marta Louise McCrum, MD at 01/09/25 0554

Jenifer Hollingsworth, PA-C at 1/9/2025 0716

Attestation signed by Julie Frances Weis, MD at 01/11/25 1331

I saw and evaluated the patient on 1/09. I reviewed the APC's documentation and agree with the history, exam, assessment and care plan. I performed the substantive portion of the medical decision making (MDM). I made/approve the management plan for the problems addressed in the encounter and take responsibility for the plan. I spent 40 minutes in the care of this patient.

Julie Weis, MD MPH
Assistant Professor / Hospitalist
General Internal Medicine

Medicine Daily Progress Note

Admission Date: 1/8/2025
Hospital Day: 1
Service: Internal Medicine

Patient ID:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

24h Events/Subjective:

- Patient felt pain was uncontrolled. APS consulted and started on ketamine drip (0.1 to 0.2. mg/kg/hr)
- Repeat Xray this AM with unchanged colonic distension.
- General Surgery following: No indication for surgical intervention at this time.
- SW reports high risk SI: Psych consulted. Will 1:1 until cleared by Psych

Objective:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/09/25 0701	01/09/25 0900	01/09/25 1126	01/09/25 1246
BP:	145/96		149/91	
Pulse:	88	82	87	
Resp:	**(!) 38**		18	
Temp:	36.7 °C (98.1 °F)		36.8 °C (98.3 °F)	
SpO2:	100%		95%	90%

I/O last 3 completed shifts:
In: 1085.2 [I.V.:999; IV Piggyback:86.2]
Out: -

Exam:

GEN: No acute distress.
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Soft. Distended. Diffusely TTP. No guarding or peritonitic signs.
SKIN: Dry.
NEURO: Alert. CN II - XII grossly intact
PSYCH: Appropriate affect.

Results from last 7 days

Lab	Units	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	138	141
POTASSIUM	mmol/L	3.5	4.0
CHLORIDE	mmol/L	110	**115***
CARBON DIOXIDE	mmol/L	**19***	**18***
BUN	mg/dL	15	16
CREATININE	mg/dL	0.89	0.98
CALCIUM, S/P	mg/dL	8.6	8.9
PROTEIN, TOTAL	g/dL	--	8.4
BILIRUBIN, TOTAL	mg/dL	--	0.4
ALKALINE PHOSPHATASE	U/L	--	86
ALT	U/L	--	**68***
AST	U/L	--	**55***
GLUCOSE	mg/dL	103	117

Results from last 7 days

Lab	Units	01/09/25 0744	01/08/25 1546
WBC	k/uL	11.09	9.72
HGB	g/dL	**13.4***	**14.4***
HCT	%	**39.7***	44.5
PLTS	k/uL	262	269

Radiology reviewed and notable for:
XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome (Acute colonic pseudo-obstruction)
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis. The risk of colonic perforation increases when cecal diameter exceeds 10 to 12 cm and when the distension has been present for greater than six days.
- NGT placed for gastric decompression, low intermittent suction
- NPO
- Trial 72h supportive care. If no improvement will consider cholinergic tx with neostigmine vs Gen Surg
- KUB am and every 24h to monitor for acute change or increasing cecal diameter
- Pain control:
    - IV Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - 3rd line hydromorphone 0.4 mg q4h
    - Avoid opiates as able
- PT/OT: Encourage ambulation
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin

#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic colitis.
- Collect GI pathogen panel, C Dif when able
- Pending results of path panel, consider discontinuing dulaglutide at d/c

#Median arcuate ligament syndrome

No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- Mesenteric duplex canceled as pt high degree of bowel gas
- Vascular consult vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. In setting of obesity, most likely NASH. No abnormality of liver on CTA.
- Cont to monitor
- outpatient f/u

#Mood
#Passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- SW consult feels pt is high risk SI
- Psych consulted, appreciate recs
- 1:1 close supervision until evaluated and cleared by Psych
- Cont home lamotrigine 100 mg

#Hyperhidrosis
- Hold oxybutynin in setting of Ogilvie syndrome
    - consider d/c'ing med on discharge

#Obesity
- Hold home dulaglutide

Diet Orders (From admission, onward)

Ordered		Start
01/08/25 2300	**NPO except for medications** Continuous	01/08/25 2300

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Medicine Team 6

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
General Surgery
Acute Pain Service

I spent 70 minutes in the care of this patient >50% of which was counseling and coordination of care.

Jenifer Hollingsworth, PA-C

Abstract Notes (continued)

Hospitalist
Department of General Internal Medicine
University of Utah Hospital

Electronically signed by Jenifer Hollingsworth, PA-C at 01/09/25 1546
Electronically signed by Julie Frances Weis, MD at 01/11/25 1331

Asif Ghouri at 1/9/2025 0859

Utilization Review Follow Up

The visit has been reviewed by a Utilization Review Nurse and meets criteria for Inpatient Status:

Date of Admission Order: 1/8/2025
Date of Review: 1/9/2025

Review >24 hrs from admit due to: No

InterQual Criteria:
Reference CERME for review

Medicare Inpatient Flag done per Epic: na

Funding: UT Medicaid

Utilization Review will continue to follow with interdisciplinary team.

Geri RN, BS
Utilization Review
University of Utah Health Science Center
Page through SmartWeb
Ext 7-5424
1/9/2025 9:00 AM

Case Management Initial Assessment

Initial Assessment
Interview Completed By: Asif G, RNCM
Information Obtained From: Patient
Information Obtained: Face to face
Patient Admitted From: Home
Admitted type: ED/Urgent (U of U)
Demographics Verbally Confirmed: Yes (1747 S 900 W, Salt Lake City, UT 84104)

Contact Person: None
Verified Designated Caregiver: No (self)
Support Systems: None (Half way house)
Other Household Members: Friend/Roommate (1 roommate)
Funding Confirmed: Yes (Primary Insurance: MEDICAID UT TRADITIONAL)
PCP Confirmed: None
Anticipated Discharge Transportation: Family, Private vehicle
Home Assessment: Multiple story (comment - how many)
Stairs or Elevator: Stairs
Number stairs inside: 10
Number stairs outside: 0
ADL Prior to Admission: Independent
DME Prior to Admission: BIPAP/CPAP, Shower chair (own cpap, tub shower,grab bars)
Home Health Prior to Admission: None
Infusion Prior to Admission: None
Dialysis Prior to Admission: None
Funding Barriers Prior To Admission: Insured

Patient came to ED with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus. and have h/o mood disorder, obesity, hyperhidrosis . Interviewed patient in pt's hospital room. Pt participated in conversation. Pt's unemployed. Pt uses public transport to go to Dr's office or groceries.CM introduced himself & CM's role to pt & spouse. PT/OT pending. Pt does not has any support. Pt doesn't need anything from CM or have any question for case management at this point. Pt e mentioned that have room reserved at half way house. Case manager will continue to co-ordinate & collaborate with multi - disciplinary team member and will provide resources & referral as needed.

Asif G, RN, BSN
Case Manager
Available via smartweb
1/10/2025 9:51 AM

Case Management Discharge Plan

Discharge Planning
Patient Verbalized Discharge Plan: Fortitude Treatment Center
CM Anticipated Plan: Fortitude Treatment Center
Specific Needs Identified: Psych consulted for SI
Decision Points (Barriers to Discharge): Medical recs
Anticipated Discharge Transportation: Family, Private vehicle
DC Hospitality Suite Candidate: No
Reason Why Not DHS Candidate: Contact precaution
Case Manager has reviewed the discharge plan: Yes
Plan Discussed with: Patient, Family

Expected Discharge Date: 01/14/25

Asif G, RN, BSN
Case Manager
Available via smartweb
1/10/2025 9:51 AM

Case Management Follow Up

Sergeant Ward, Half Way house 801-888-7732 called & said they'll provide ride once pt DC home.
Asif G, RN, BSN
Case Manager
Available via smartweb
1/13/2025 4:34 PM

Case Management Final Discharge Services

Final Discharge Services
Final Discharge Services: No Needs Identified
Final Discharge Transport: Public Transport

Expected Discharge Date: 01/14/25

Patient has a bus pass

Lily V.
Case Management Assistant
Available via SmartWeb
1/14/2025 4:19 PM

Case Management Follow Up

Final Discharge Services
Final Discharge Services: Yes
Final Discharge Detail: Halfway house
Final Patient DME:None
O2 need: RA
Final DC Documents Faxed: Yes
DC with lines/drain: NA
Wounds & Care: NA
DC on antibiotic: NA
Confirmed destination: Halfway house
Final Discharge Transport confirmed: pt have a bus pass
Follow up appointment with: PCP & U of U
Provider put amb PCP referral order

Abstract Notes (continued)

Preservice discharge plan met?: N/A

Asif G, RN, BSN
Case Manager
Available via smartweb
1/14/2025 4:24 PM

Electronically signed by Asif Ghouri at 01/14/25 1651

Nwanyidirim Ahanonu-Acord, APRN at 1/9/2025 1500

ACUTE PAIN SERVICE (APS) INITIAL CONSULT NOTE **- TIER 1: KETAMINE INFUSION**

Referring Team: Treatment Team:
Attending Provider: Julie Frances Weis, MD

SUBJECTIVE

History of Present Illness:
Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus. APS Consulted for consideration of ketamine infusion for uncontrolled pain.

Home Pain Regimen: Gabapentin 600 mg TID

Home Daily OME: None

Interval History:

Patient reports pain is lessening with the addition of ketamine. He reports pain sensation similar to "having a side ache, but the pain is in the front of his abdomen. He continues with feeling of tightness in the abdomen, but the sharp stabbing pain is mostly gone.

Associated symptoms
Sedation: None
Respiratory Depression: None
Nausea/Vomiting: None
Pruritis: None
Weakness: None
Bowel Function: pseudo-obstruction
Hallucinations: None

Function: Patient reports pain contributing to limited function

OBJECTIVE

Current Opioid Therapy: IV dilaudid 0.2-0.4 mg Q 4 hours prn

Total OME Last 24 Hours: 96

Current Non-Opioid Therapy: IV tylenol 1000 mg Q6 hrs
-toradol 15 mg 6 hrs

Current Ketamine Infusion Dose: 0.1 mg/kg/hr (97.3 kg)

Current Anticoagulant/Antiplatelet: enoxaparin

Allergies:
No Known Allergies

Home Medications
No current facility-administered medications on file prior to encounter.

Current Outpatient Medications on File Prior to Encounter

Medication	Sig	Dispense	Refill
• DULoxetine (CYMBALTA) 20 mg enteric coated particles capsule	Take 20 mg by mouth daily at bedtime. (Patient not taking: Reported on 1/9/2025)		
• DULoxetine (CYMBALTA) 60 mg enteric coated particles capsule	Take 60 mg by mouth every morning. (Patient not taking: Reported on 1/9/2025)		
• gabapentin (NEURONTIN) 800 mg tablet	Take 800 mg by mouth 3 times daily.		
• lamoTRIgine (LAMICTAL) 200 mg tablet	Take 200 mg by mouth every morning.		
• dulaglutide (TRULICITY) 0.75 mg/0.5 mL	Inject 1 mL (1.5 mg) subcutaneously once a week.	4 mL	0
• Insulin Pen Needle (PEN NEEDLES) 32G X 4 MM miscellaneous	100 each by Does Not Apply route once a week. (Patient not taking: Reported on 1/9/2025)	4 each	5
• MYDAYIS 50 MG 24 hr sustained release capsule	Take 50 mg by mouth once daily.		
• [DISCONTINUED] oxybutynin (DITROPAN) 5 mg tablet	Take 1 tablet (5 mg) by mouth 2 times a day. Indications: Excessive Sweating Disorder	60 tablet	3
• [DISCONTINUED]	Place 1 Film (4 mg	14 Film	0

buprenorphine-naloxone (SUBOXONE) 4-1 mg film SL film	buprenorphine) under the tongue 2 times a day. (Patient not taking: Reported on 9/23/2024)
• [DISCONTINUED] DULoxetine (CYMBALTA) 30 mg enteric coated particles capsule	Take by mouth once daily.
• [DISCONTINUED] lamoTRIgine (LAMICTAL) 100 mg tablet	Take 100 mg by mouth once daily.
• [DISCONTINUED] gabapentin (NEURONTIN) 600 mg tablet	Take 600 mg by mouth 3 times daily.

Current Medications
acetaminophen (OFIRMEV) injection 1,000 mg, Q6H
ketamine (KETALAR) infusion 1 mg/mL in NS, Continuous
ketorolac (TORADOL) injection 15 mg, Q6H
simethicone (MYLICON) chewable tablet 80 mg, TID PRN
enoxaparin (LOVENOX) syringe 40 mg, QHS
HYDROmorphone (DILAUDID) injection 0.2-0.4 mg, Q4H PRN
lamoTRIgine (LaMICtal) tablet 100 mg, Daily
melatonin tablet 3 mg, QHS PRN
naloxone (NARCAN) injection 0.1-0.4 mg, PRN
ondansetron (ZOFRAN) injection 4 mg, Q6H PRN
Or
ondansetron (ZOFRAN) tablet 4 mg, Q6H PRN
traZODone (DESYREL) tablet 50 mg, QHS PRN

Past Medical History
Patient Active Problem List

Diagnosis

- Mild mood disorder (HCC)
- Unspecified mood (affective) disorder (HCC)
- Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult
- Axillary abscess
- Ogilvie syndrome

Past Surgical History:
Past Surgical History:

Procedure	Laterality	Date
• Endoscopic thoracic sympathectomy		
• RHINOPLASTY/SEPTOPLASTY	Left	

Social History:
Social History

Tobacco Use

- Smoking status: Former
  - Types: Cigarettes
- Smokeless tobacco: Former
  - Quit date: 03/2023

Vaping Use

- Vaping status: never used

Substance Use Topics

- Alcohol use: Not Currently
- Drug use: Not Currently
  - Types: Heroin, Cannabis (Marijuana)
  - *Comment: clean 3mo (9/23/24); endorses IVDU hx*

Physical Exam

BP 141/72 (BP (Cuff) Location: Left arm, Patient Position: Supine) | Pulse 86 | Temp 37.1 °C (98.8 °F) (Temporal) | Resp 28 | Ht 177.8 cm (5' 10") | Wt 97.3 kg (214 lb 8.1 oz) | SpO2 94% | BMI 30.78 kg/m²

Physical Exam

Vitals reviewed.

Constitutional:

Appearance: Normal appearance. He is diaphoretic.

HENT:

Head: Normocephalic.

Nose:

Comments: NG tube taped to nose

Eyes:

Extraocular Movements: Extraocular movements intact.

Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:

Rate and Rhythm: Normal rate.

Pulmonary:

Effort: Pulmonary effort is normal.

Abdominal:

General: There is distension.

Skin:

General: Skin is warm.

Neurological:

General: No focal deficit present.

Mental Status: He is alert and oriented to person, place, and time.

Psychiatric:

Mood and Affect: Mood normal.

Behavior: Behavior normal.

Laboratory Studies Reviewed
Results from last 7 days

Lab	Units	01/09/25 0744
WBC	k/uL	11.09
HGB	g/dL	**13.4***
HCT	%	**39.7***
PLTS	k/uL	262

Lab Results

Component	Value	Date
SODIUM	138	01/09/2025
K	3.5	01/09/2025
CL	110	01/09/2025
CO2	19 (L)	01/09/2025
AGAP	9	01/09/2025
GLUC	103	01/09/2025
BUN	15	01/09/2025
CREAT	0.89	01/09/2025
CA	8.6	01/09/2025

No results found for: "INR"

Medical Decision Making
- Laboratory test(s) independently reviewed and notable for: N/A
- External record review:Reviewed most recent inpatient medicine note for treatment details
- Additional independent history obtained: None
- Discussed management of patient's care: with inpatient medical team

ASSESSMENT

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus and currently requires intensive monitoring with increased risk for adverse effect due to parenteral ketamine or lidocaine infusion

PLAN

Ketamine Therapy:
- Will continue intensive monitoring as ordered due increased risk for adverse effect associated with need for parenteral ketamine infusion.
-Ketamine 0.1 mg/kg/hr (97.3 kg). Dose will be adjusted for pain control and minimization of adverse side effects.

Medication Recommendations:
-Multimodal pain management
-Optimize non-opioid medications for pain control
-Avoid escalating opioids

Pain Medications other than Ketamine to be ordered by Primary team.

Thank you for the consult, APS will continue to follow.

Advanced Practice Clinician Statement:
I spent 20 minutes in total time today, 01/09/25, for this visit including all related clinical activities before, during, and after the visit on the date of service, excluding any procedure time.

Electronically signed by Nwanyidirim Ahanonu-Acord, APRN at 01/09/25 2255

Lucinda Wilmshurst, CSW at 1/9/2025 1559

Social Work Consult Note C-SSRS:
Social Work (SW) received a consult for a C-SSRS. The patient was sitting up in his hospital bed; affect and mood were congruent. SW introduced self, role and the reason for the visit. The patient engaged in the visit and the assessment. He shared that he has been sent to prison 3 times and that he violated parole 2 times. The patient said he is addicted to Adderall and that he has been diagnosed by a mental health provider at Valley Behavioral Health with Disassociative Disorder (Amnesia Type). Patient said he cannot maintain employment. He said he has been denied SSD and has reapplied for SSD.

The patient presently resides at the Fortitude Treatment Center Utah Department of Corrections. He described Fortitude as "horrible" and that the people there are not safe people. He has a Case Manager, Taufa, at the Halfway House that he doesn't feel support from. He also has a Case Manager, Kylee, at Valley Behavioral Health. He sees a mental health provider, Heidi, at Fortitude form time to time. He also sees a therapist, Stephanie Larson, virtually at Valley Behavioral Health every two weeks.

The patient scored High Risk on the C-SSRS. He said he plans to overdose on Fentanyl because he can't find a way out of the situation he is in. He verbally commits to keeping himself safe at UUH. The patient said he "needs to be removed from the Fortitude Halfway House" and be in a supportive psychiatric environment. SW consulted with Case Management (CM) about the patient and shared the patient's "High Risk" Stratification score. CM said they would request a Psychiatry Consult for the patient. SW concurs that a Psychiatry Consult is needed. SW also shared the patient's score with the Charge RN. The Charge RN assigned a 1:1 to the patient and confirmed that Psychiatry will be seeing the patient.

SW provided encouragement and emotional support. SW gave the patient the Good Deed Revolution Mental Health Resources in Utah handout and specifically recommended the Utah Warm Line. The patient said he has called the Utah Crisis Line multiple times and that all it does is end up placing him on a 72-hour hold. The patient said he will sometimes turn to online AI support. SW provided information on the mental health AI Woebot.

The patient engaged with SW in completing a Safety Plan. SW asked the patient what he would wish for his future and he said to work in software engineering and that he has a Masters Degree in Software Engineering. SW shared that the Department of Vocational Rehabilitation would be a helpful resource for the patient; the patient said he would have to follow through on making an appointment. SW also provided the patient with contact information to VocRehab.

The patient was responsive to the interpersonal interaction and emotional support provided during this consult. SW spent some time walking on the unit with the patient, which appeared therapeutic for the patient.

C-SSRS

SAFE-T Protocol with C-SSRS
Wish to be Dead: Yes
Describe: Patient endorsed wish to be dead in the past month. Patient said he resides at the Halfway House "Fortitude" and that it is "horrible."
Non-Specific Active Suicidal Thoughts: Yes
Describe: Patient endorsed non-specific active suicial thoughts in the past month.
Suicidal thoughts w/ Method (with no specific plan or intent to act): Yes
Describe: Patient endorsed suicidal thoughts with method (with no specific plan or intent to act) in the past month.
Suicidal Intent without Specific Plan: Yes
Describe: Patient endorsed suicidal intent without specific plan in the past month.
Intent with Plan: Yes
Describe: Patient endorsed intent with plan in the past month. Patient said he plans to get Fentanyl and overdose in a room somewhere.
Risk Stratification: High Risk

Suicidal Behavior
Have you ever done anything, started to do anything, or prepared to do anything to end your life, in your lifetime?: Yes
Was it within the past 3 months?: No
Activating Events: : Current or pending isolation or feeling alone (Patient has a hard time connecting to people. He doesn't feel safe at the Halfway House Fortitude.)
Treatment History: : Previous psychiatric diagnosis and treatments (Patient stated he has been diagnosed with Disassociative Disorder. The patient also stated he is addicted to Adderall.)
Clinical Status:: Hopelessness, Substance abuse or dependence
Access to lethal methods: : Denied

Protective Factors
Internal:: Identifies reasons for living (Patient struggled to find a reason, he offered, "To see the evolution of AI." The patient has a Master's Degree in Software Engineering.)

Safety Plan

Patient Name: Boone Cabal
Date: 01/09/25

Warning Signs:
Rapid dissociation
Severe Anxiety
Repeated depressed episodes
Become emotional (cry)
Become apathetic "don't really care too much"

Coping Strategies:
Meditation
Use mental health AI

People that provide distraction:

Social settings that provide distraction: Sorenson Center

People whom I can ask for help:

Abstract Notes (continued)

Professionals/agencies I can contact during a crisis: Stephan Larson, therapist at Valley Behavioral Health,Heidi, mental health support person at Fortitude Treatment Center Utah Dept. of Corrections

Patient said the people who live at Fortitude are "not safe" for someone with mental health problems to be around.

One thing that is important to me and worth living for is:
"See the evolution of AI."

Person completing plan with patient: Cindy Wilmshurst, CSW

If you are in a mental health crisis, or need crisis support, please dial 988 to reach the Suicide and Crisis Lifeline.

Electronically signed by Lucinda Wilmshurst, CSW at 01/09/25 1730
Electronically signed by Joanna Brooks, LCSW at 01/16/25 1149

Jenifer Hollingsworth, PA-C at 1/10/2025 0728

Attestation signed by Julie Frances Weis, MD at 01/11/25 1334

I saw and evaluated the patient on 1/10. I reviewed the APC's documentation and agree with the history, exam, assessment and care plan. I performed the substantive portion of the medical decision making (MDM). I made/approve the management plan for the problems addressed in the encounter and take responsibility for the plan. I spent 30 minutes in the care of this patient.

Julie Weis, MD MPH
Assistant Professor / Hospitalist
General Internal Medicine

Medicine Daily Progress Note

Admission Date: 1/8/2025
Hospital Day: 2
Service: Internal Medicine

Patient ID:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

24h Events/Subjective:

Abstract Notes (continued)

- KUB today with similar diffuse gaseous distention of large bowel. Multiple loops of dilated gas-filled small bowel are present, measuring up to 4.5 cm
- Resume NPO and low intermittent suction of NG tube
- Remains on ketamine drip

Objective:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/09/25 1126	01/09/25 1246	01/09/25 1917	01/10/25 0605
BP:	149/91		141/72	137/82
Pulse:	87		86	87
Resp:	18		28	24
Temp:	36.8 °C (98.3 °F)		37.1 °C (98.8 °F)	37.2 °C (99 °F)
SpO2:	95%	90%	94%	92%

I/O last 3 completed shifts:
In: 86.2 [IV Piggyback:86.2]
Out: -

Exam:
GEN: No acute distress.
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Soft. Distended. Diffusely TTP. No guarding or peritonitic signs.
SKIN: Dry.
NEURO: Alert. CN II - XII grossly intact
PSYCH: Appropriate affect.

Results from last 7 days

Lab	Units	01/10/25 0529	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	136	138	141
POTASSIUM	mmol/L	3.5	3.5	4.0
CHLORIDE	mmol/L	108	110	**115***
CARBON DIOXIDE	mmol/L	**18***	**19***	**18***
BUN	mg/dL	13	15	16
CREATININE	mg/dL	0.73	0.89	0.98
CALCIUM, S/P	mg/dL	8.4	8.6	8.9
PROTEIN, TOTAL	g/dL	7.2	--	8.4
BILIRUBIN, TOTAL	mg/dL	0.7	--	0.4
ALKALINE PHOSPHATASE	U/L	78	--	86
ALT	U/L	50	--	**68***
AST	U/L	40	--	**55***
GLUCOSE	mg/dL	90	103	117

Results from last 7 days

Lab	Units	01/10/25 0529	01/09/25 0744	01/08/25 1546
WBC	k/uL	8.47	11.09	9.72
HGB	g/dL	**13.1***	**13.4***	**14.4***
HCT	%	**39.1***	**39.7***	44.5
PLTS	k/uL	241	262	269

Radiology reviewed and notable for:
XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:
Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome (Acute colonic pseudo-obstruction)
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis. The risk of colonic perforation increases when cecal diameter exceeds 10 to 12 cm and when the distension has been present for greater than six days.
- General Surgery following

- NGT placed for gastric decompression, low intermittent suction
- NPO
- Trial 72h supportive care. If no improvement will consider cholinergic tx with neostigmine vs Gen Surg
- KUB am and every 24h to monitor for acute change or increasing cecal diameter
- Pain control:
    - IV ketamine drip as managed by APS
    - Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - 3rd line hydromorphone 0.2 mg q4h
    - Avoid opiates as able
- PT/OT: Encourage ambulation
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin

#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic colitis.
- Collect GI pathogen panel, C Dif when able
- Pending results of path panel, consider discontinuing dulaglutide at d/c

#Median arcuate ligament syndrome
No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- Mesenteric duplex canceled as pt high degree of bowel gas
- Vascular consult vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. In setting of obesity, most likely NASH. No abnormality of liver on CTA.
- Cont to monitor
- outpatient f/u

#Mood
#Passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- SW consult feels pt is high risk SI
- Psych consulted, appreciate recs
- 1:1 close supervision until evaluated and cleared by Psych
- Cont home lamotrigine 100 mg

#Hyperhidrosis
- Hold oxybutynin in setting of Ogilvie syndrome
    - consider d/c'ing med on discharge

#Obesity
- Hold home dulaglutide

Diet Orders (From admission, onward)

Ordered			Start
01/09/25 1718	**Clear Liquid Diet**	Continuous	01/09/25 1715

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Medicine Team 6

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
General Surgery
Acute Pain Service

I spent 70 minutes in the care of this patient >50% of which was counseling and coordination of care.

Jenifer Hollingsworth, PA-C
Hospitalist
Department of General Internal Medicine
University of Utah Hospital

Electronically signed by Jenifer Hollingsworth, PA-C at 01/10/25 1455
Electronically signed by Julie Frances Weis, MD at 01/11/25 1334

Alexis Doutt, PT at 1/10/2025 0846

Acute Care Physical Therapy Evaluation

Admission Date: 1/8/2025
Attending: Julie Frances Weis, MD

Past Medical History:

Diagnosis	Date
• Hyperhidrosis	

Subjective

PT Last Visit
PT Received On: 01/10/25

Subjective: Pt greeted in supine. Reports pain is better and willing to particiapte in PT evaluation.
PT Diagnosis: abd pain, median arcuate ligament syndrome and ogilvie ileus PMH mood disorder, obesity, hyperhidrosis
Floor Location: D60/Internal Medicine
Patient received: in bed with the call light within reach;with 1:1 aide present
Patient returned: in bed with the call light within reach;with 1:1 aide present;with pulse-ox on

Cognition
Cognitive Functioning: Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions
Affect: Alert;Cooperative
Safety/Judgment: No safety issues observed
Command Following: Inconsistent;Follows one step commands consistently;Follows one step commands with repetition;Improved success with visual cues
Comprehension: Auditory
Communication: Verbal

Precautions
Activity Orders: Up with assistance
Lines/Tubes: IV, NGT
O2 Requirement: None/Room air
Psych/Social Precautions: 1:1 aide
Is there a language barrier?: No
Comment: 1:1 for SI

Objective

Home Living
Info obtained from: Patient
Does the patient live in-state?: Yes (Fortitude Treatment Center)
Available Assistance: Full time physical assistance;Full time supervision
Type of Home: Other
Other: (Fortitude Treatment Center)
Home Layout: Stairs inside the living setting
Stairs Inside: 2 flights+ (from bedroom to daily activites)
Rails stairs inside: 1 rail
Bathroom Layout: Walk-in shower
Comment: dorm walk in showers, pod style rooms. Been at fortitude treatment center (halfway house) for 1 year.

Prior Function
PLOF: Independent
Help Used: Paid assistance
Services in Last Two Months: Psychiatric hospital/unit
Mobility Devices: Does not use equipment
History of Falls: No
Patient's Responsibilities: Basic self care;Laundry;Leisure/play/hobbies
Comment: facility provides food, med mgmt. Pt does own laundry.

LLE Assessment
LLE Assessment: Within Functional Limits (limited hip flexion d/t abd pain)
RLE Assessment

RLE Assessment: Within Functional Limits (limited hip flexion d/t abd pain)

Bed Mobility
Supine to Sit: Supervision or touching assist
Supine to Sit details: One person assist;Left
Sit to Supine: Supervision or touching assist
Sit to Supine details: One person assist;Logroll;Right
Education/comment: VC for logroll technique

Transfers
Sit to Stand: Supervision or touching assist
Sit to Stand details: One person assist

Gait
Gait Assistance Level: Supervision or touching assist
Distance ambulated: 160 feet
Assistive device: None;FWW
Gait Multi-person Assist: One person
Gait Terrain: Even surfaces;Straight hallways;Hallways with turns;Through doorways;Tight spaces
Gait Deviations: Slow cadence;Wide base of support;Inconsistent step length/height;Inconsistent foot placement
Gait Training Provided: Upright posture;Safety;Route finding
Gait education/comment: Pt ambulates with slow cadence and unsteady inconsistent steps. Needs VC to avoid obstacles in hallway. Initially amb with FWW, but reports not using and and it seems to be getting in the pt's way, so left in the room prior to amb in the hallway.

AM-PAC 6 Clicks Basic Mobility
Turning over in bed: None
Moving from lying on back to sitting: A little
Moving to and from a bed to a chair: A little
Standing up from a chair: A little
Walk in a hospital room: A little
Climb 3-5 steps with rail: A little
AMPAC Mobility Raw Score: 19

Mobility Tests
Johns Hopkins Highest Level of Mobility: Walk 25+ feet

Assessment

Assessment
Participation: Good
Assessment Comments: Boone is a 45 year old male admitted for abd pain, median arcuate ligament syndrome and ogilvie ileus. PMH mood disorder, obesity, hyperhidrosis. He is currently requiring supA for all aspects of functional mobility. Required VC for routefinding and avoiding obstacles in the hallway. Pt to continue to benefit from skilled PT in order to safely progress functional mobility and perform stair negotiation prior to discharge.
Physical Therapy Progress: Would benefit from continued PT
Prognosis: Good
Barriers to Discharge Comments: 2 flights of stairs performed multiple times per day when at facility

Impairments

Musculoskeletal: Pain
Cardiovascular: Endurance/Activity tolerance
Barriers
Mobility: Bed mobility deficits;Transfer deficits;Gait deficits;Stair deficits;Balance deficits
Barriers to Discharge Comments: 2 flights of stairs performed multiple times per day when at facility

Goals

Bed Mobility Goal
Patient will perform supine to sit independently.

Transfers Goal
Patient will perform sit to stand transfer without assistive device independently.

Gait Goal
Patient will ambulate 500 feet without assistive device independently.

Additional Goal 1: Pt to complete 2 flights of stairs with single HR with independence.

Plan

Plan
Treatment/Interventions: Balance training, Patient education, Transfer training, Bed mobility training, Stair training, Therapeutic exercises, Neuromuscular reeducaton, Gait training, Equipment training, Pain management, Caregiver training
PT Frequency: 1-3x/wk
PT Duration: Current admission
Plan for Next Visit: stairs

Discharge Recommendations

Recommendation
New Equipment Recommended (PT): None/Has all DME
Requires PT Follow Up?: Yes
Location/Services: Home;Pending Progress/Med Status
Recommendation: likely back to previous

Evaluation

This evaluation was a **Moderate Complexity** evaluation based on the following factors:

History: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care
Examination: An examination of body systems using standardized test and measures in addressing a total of 4 or more elements from any of the following: body structures and function, activity limitations, and/or participation restrictions
Clinical Presentation: An evolving clinical presentation with changing characteristics
Decision Making: Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome

Time/Charges

Total duration of timed treatments: 0 minutes
Total duration of treatment session: 24 minutes

Electronically signed by Alexis Doutt, PT at 01/10/25 0959

Jessica Zamias, OT at 1/10/2025 0846

Acute Care Occupational Therapy Evaluation

Admission Date: 1/8/2025
Attending: Julie Frances Weis, MD

Past Medical History:

Diagnosis	Date
• Hyperhidrosis	

Subjective

OT Received On: 01/10/25, Time Seen: 0846, Floor Location: D60/Internal Medicine

OT Diagnosis: median arcuate ligament syndrome and ogilvie ileus, Abdominal pain, Ogilvie syndrome (Acute colonic pseudo-obstruction)
Pertinent Past Medical Hx: mood disorder, obesity, hyperhidrosis

Subjective
General Presentation: Agreeable;Impulsive
Patient Upon Arrival: Lying in bed;Awake;Communicated with nursing prior to session;1:1 present
Patient Upon Departure: Lying in bed;1:1 present;Call light accessible;Tray table accessible
Comment: Handed pt off to 1:1.

Precautions
Activity Orders: Up with assistance
Lines/Tubes: IV;NGT
O2 Requirement: None/Room air
Med/Surg Precautions: Fall;Logroll;No BLT (for comfort)
Infection Precautions: Contact precautions
Psych/Social Precautions: 1:1 aide
Is there a language barrier?: No

Objective

Home Living

Info obtained from: Patient;Chart
Does the patient live in-state?: Yes
Available Assistance: Full time physical assistance;Full time supervision
Type of Home: Other
Home Layout: Stairs inside the living setting
Stairs Inside: 2 flights+
Rails stairs inside: 1 rail
Bathroom Layout: Walk-in shower
Comment: SLC, UT lives at Fortitude Treatment Facility with multiple stairs to navigate from bedroom to daily activites throughout the day.

Prior Function
PLOF: Needed some help
Needed help with: Community mobility
Help Used: Paid assistance
Services in Last Two Months: Psychiatric hospital/unit
Mobility Devices: Does not use equipment
History of Falls: No
Patient's Responsibilities: Basic self care;Laundry;Leisure/play/hobbies;Social participation;Home management
Vocational/Community: Unknown
Comment: Facility assist with meals, and med mgt. Pt does own laundry.

Basic ADL
Self-feeding: Independent
Position: Supported sitting
Grooming: Supervision or touching assist
Position: Supported sitting
Upper Body Dressing: Supervision or touching assist
Position: Supported sitting
Lower Body Dressing: Partial/moderate assist
Patient needed assist for: Donning/doffing footwear;Obtaining/selecting clothing
Position: Edge of bed;Standing;Unsupported sitting
Toileting: Supervision or touching assist
Patient needed assist for: Obtaining supplies
Position: Toilet
Bathing: Partial/moderate assist
Patient needed assist for: Soaping, rinsing, and/or drying body parts;Obtaining/using supplies
Position: Shower chair

AM-PAC 6 Clicks Daily Activity
Don/Doff LB Clothing: A little
Bathing: A lot
Toileting: A little
Don/Doff UB clothing: A little
Personal grooming: A little
Eating meals: None
AM-PAC Activity Raw Score: 18

Bed mobility to complete ADLs
Supine to Sit: Supervision or touching assist
Sit to Supine: Supervision or touching assist

Details: Logroll
Functional transfers to complete ADLs
Sit to Stand: Supervision or touching assist
Stand to Sit: Supervision or touching assist
Functional mobility to complete ADLs
Ambulation to/from activity: Supervision or touching assist
Functional Mobility Comment: Pt required cues for safety.

Functional Cognition
Task Errors: Attending to multiple aspects of task or directions;Sequencing/shifting between steps/activities;Generating alternative strategies;Self-monitoring performance;Organizing task;Using efficient strategies;Keeping track of information
Cognitive Cues: Verbal directive
Accuracy: Partially accurate and inefficient
Insight: Demonstrates vague awareness of limitations, unable to generalize the impact on activity performance
Safety: Risks to safety were observed and assistance given to prevent potential harm

AM-PAC 6 Clicks Cognitive
Following a speech or presentation: A little
Understanding conversations: None
Recall of medications: A lot
Recall of items placed: A little
Recall of a list: A lot
Taking care of complicated tasks: A lot
AM-PAC Cognitive Raw Score: 16

Hand Dominance: Right
LUE Assessment AROM: Within Functional Limits
RUE Assessment AROM: Within Functional Limits

Vision/Perception
Comment: Pt reports no vision changes.

Activity Tolerance
Activity Tolerance: Fair

Education/Training
Participants: Patient
Subject Matter: Plan of care;Role of OT;Safety protocols;ADL management
Response to Training: Verbalizes understanding;Needs review/reinforcement;Needs continued practice

No special assessments completed

Assessment

Assessment
Barriers to ADL independence include: Balance;Cognition/safety;Activity tolerance;Self management

Pt is a 45 year old male who was admitted due to median arcuate ligament syndrome and ogilvie ileus, Abdominal pain, Ogilvie syndrome (Acute colonic pseudo-obstruction). Pt PMH includes mood disorder, obesity, hyperhidrosis. Pt

performs dynamic BADLs with partial assist. Pt performs functional mobility with SBA/touch assist. Pt was impulsive. Pt required cues for safety and line mgt. Pt is limited by the above mentioned deficits. Pt will benefit from skilled OT services to promote functional performance independence.

AM-PAC Activity Raw Score: 18
AM-PAC Cognitive Raw Score: 16
Range: 6 (low function) - 24 (high function)

Plan

OT Duration: Ongoing OT during admission
Frequency: 1-3x/wk
Interventions: BADL retraining;Compensatory strategies;Functional mobility/balance;Patient/caregiver training;Self care transfers;Therapeutic activity;Therapeutic exercise

SHORT TERM GOALS (STG)
STG 1: Pt will independently complete TB dressing including item retrevial tasks
Progress: New
STG 2: Pt will independently complete g/h tasks standing sinkside for 10 minutes
Progress: New
STG 3: Pt will independently complete all aspects of toilet rouitne
Progress: New

Discharge Recommendations

Location/Services: Home, with Caregiver Supervision-/Assistance
Recommendation: 1/10: Back to previous living situation.
Equipment Recommended (OT): Shower chair, Tub transfer bench

Time/Charges

Total duration of billed timed treatments: 0 minutes
Total duration of treatment session: 35 minutes

This evaluation was a **Moderate Complexity** evaluation based on the following factors:

History: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review physical, cognitive, or psychosocial history related to current functional performance
Examination: An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions
Decision Making: Clinical decision making of moderate complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessments(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable completion of evaluation component

Electronically signed by Jessica Zamias, OT at 01/10/25 1335

Sarah A Lucero, RD at 1/10/2025 1227

Nutrition Assessment: Initial

Admit
Boone Cabal is a 45 year old male admitted with ogilvie syndrome and sudden onset abd px w/ large-volume diarrhea.

PMH See H&P for full history
Depression, axillary cellulitis, hyperhidrosis, Class I obesity (recently started on dulaglutide)

Events this Admission
01/08: NG placed for decompression

Labs
01/07: A1c 5.3%
01/08: AST 55 (H), ALT 68 (H)
01/09: Phos 2.5, Mg 2.0
01/10: Na 136, K+ 3.5, BUN 13, Crea 0.73, BG 90, LFTs WNL

Medications
Reviewed

Diet | GI
Current Diet: Clear Liquid
PO intake: 100%

Allergies/Int: NKFA

GI: +BS/-flatus/+BM on 1/8

Anthropometrics
Ht: 177.8 cm
Admit Wt: 97.3 kg (standing)
Admit BMI: 30.7

Ideal body weight: 73 kg (160 lb 15 oz)
Adjusted ideal body weight: 82.7 kg (182 lb 5.8 oz)

Weight Hx | Daily Wt
08/02/24: 101.3 kg
10/21/24: 98.8 kg

Edema: WNL

Malnutrition
1/10/25: No evidence of malnutrition at this time.

-Weight loss: Per EMR 4% x 6 months. Patient reports recently starting dulaglutide for weight loss (not diabetic).
-Intake changes: none reported by patient.

Assessment
Patient with sufficient intake the past two days, consuming 100% of all meals recorded. However, current diet order provides minimal nutrition. Continues with abdominal pain and nausea. No reported weight loss or significant intake changes prior to admission. Though, not considered clinically significant weight loss, patient's weight has been down-trending since August. A clear liquid diet order remains appropriate at this time. Nutrition care representatives will continue to visit daily to assist with menu selections and to encourage PO intake.

Patient was NPO until diet advanced to CLD on 1/9. If unable to advance diet in the next few days alternative nutrition will need to be considered.

Recommendations/Plan
- Continue current diet order
    -ADAT to regular; when medically indicated
- Ensure Clear while on clear liquid diet
    **advance to Ensure Plus when diet advances*
- Weekly weight
- Consider outpatient RD referral to aid in weight management
- RD available for consult

Will monitor patient's nutritional status and needs per RD policy.

Sarah Lucero, RDN CSG CD
Clinical Dietitian
SmartWeb | Spok (M-F)
Weekends: page "Dietitian (weekend & holidays)"

Electronically signed by Sarah A Lucero, RD at 01/10/25 1403

Debra Jordan Wing, APRN at 1/10/2025 1410

ACUTE PAIN SERVICE (APS) PROGRESS NOTE **- TIER 1: KETAMINE INFUSION**

Referring Team: Treatment Team:
Attending Provider: Julie Frances Weis, MD

SUBJECTIVE

History of Present Illness:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus. APS Consulted for consideration of ketamine infusion for uncontrolled pain.

Home Pain Regimen: Gabapentin 600 mg TID

Home Daily OME: None

Interval History:

Patient reports pain improved. NG tube is not to suction. He says that the NG tube is his main complaint, wants to have it removed. His abd pain has improved. Ketamine infusion was decreased last night due to hallucinations. Patient reports that he does not remember hallucinating.

Associated symptoms
Sedation: None
Respiratory Depression: None
Nausea/Vomiting: None
Pruritis: None
Weakness: None
Bowel Function: pseudo-obstruction
Hallucinations: None

Function: Patient reports pain contributing to limited function

OBJECTIVE

Current Opioid Therapy: IV dilaudid 0.2-0.4 mg Q 4 hours prn

Total OME Last 24 Hours: 33

Current Non-Opioid Therapy: IV tylenol 1000 mg Q6 hrs
-toradol 15 mg 6 hrs

Current Ketamine Infusion Dose: 0.04 mg/kg/hr (97.3 kg)

Current Anticoagulant/Antiplatelet: enoxaparin

Allergies:
No Known Allergies

Home Medications
No current facility-administered medications on file prior to encounter.

Current Outpatient Medications on File Prior to Encounter

Medication	Sig	Dispense	Refill
• DULoxetine (CYMBALTA) 20	Take 20 mg by		

mg enteric coated particles capsule	mouth daily at bedtime. (Patient not taking: Reported on 1/9/2025)		
• DULoxetine (CYMBALTA) 60 mg enteric coated particles capsule	Take 60 mg by mouth every morning. (Patient not taking: Reported on 1/9/2025)		
• gabapentin (NEURONTIN) 800 mg tablet	Take 800 mg by mouth 3 times daily.		
• lamoTRIgine (LAMICTAL) 200 mg tablet	Take 200 mg by mouth every morning.		
• dulaglutide (TRULICITY) 0.75 mg/0.5 mL	Inject 1 mL (1.5 mg) subcutaneously once a week.	4 mL	0
• Insulin Pen Needle (PEN NEEDLES) 32G X 4 MM miscellaneous	100 each by Does Not Apply route once a week. (Patient not taking: Reported on 1/9/2025)	4 each	5
• MYDAYIS 50 MG 24 hr sustained release capsule	Take 50 mg by mouth once daily.		

Current Medications

HYDROmorphone (DILAUDID) injection 0.2 mg, Q4H PRN
ketamine (KETALAR) infusion 1 mg/mL in NS, Continuous
[START ON 1/11/2025] lamoTRIgine (LaMICtal) tablet 200 mg, Daily
acetaminophen (OFIRMEV) injection 1,000 mg, Q6H
ketorolac (TORADOL) injection 15 mg, Q6H
simethicone (MYLICON) chewable tablet 80 mg, TID PRN
enoxaparin (LOVENOX) syringe 40 mg, QHS
melatonin tablet 3 mg, QHS PRN
naloxone (NARCAN) injection 0.1-0.4 mg, PRN
ondansetron (ZOFRAN) injection 4 mg, Q6H PRN
Or
ondansetron (ZOFRAN) tablet 4 mg, Q6H PRN
traZODone (DESYREL) tablet 50 mg, QHS PRN

Past Medical History

Patient Active Problem List

Diagnosis

- Mild mood disorder (HCC)
- Unspecified mood (affective) disorder (HCC)
- Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult
- Axillary abscess

- Ogilvie syndrome

Past Surgical History:

Past Surgical History:

Procedure	Laterality	Date
• Endoscopic thoracic sympathectomy		
• RHINOPLASTY/SEPTOPLASTY	Left	

Social History:

Social History

Tobacco Use	
• Smoking status:	Former
Types:	Cigarettes
• Smokeless tobacco:	Former
Quit date:	03/2023
Vaping Use	
• Vaping status:	never used
Substance Use Topics	
• Alcohol use:	Not Currently
• Drug use:	Not Currently
Types:	Heroin, Cannabis (Marijuana)
Comment: clean 3mo (9/23/24); endorses IVDU hx	

Physical Exam

BP 143/83 (BP (Cuff) Location: Right arm, Patient Position: Supine) | Pulse 86 | Temp 36.7 °C (98.1 °F) (Temporal) | Resp 18 | Ht 177.8 cm (5' 10") | Wt 97.3 kg (214 lb 8.1 oz) | SpO2 100% | BMI 30.78 kg/m²

Well appearing, no acute distress. Patient is awake, alert, and oriented. Responds to questions appropriately. Sitting up in bed. 1:1 aide at the bedside.

Laboratory Studies Reviewed

Results from last 7 days

Lab	Units	01/10/25 0529
WBC	k/uL	8.47
HGB	g/dL	**13.1***
HCT	%	**39.1***
PLTS	k/uL	241

Lab Results

Component	Value	Date
SODIUM	136	01/10/2025
K	3.5	01/10/2025
CL	108	01/10/2025
CO2	18 (L)	01/10/2025
AGAP	10	01/10/2025
GLUC	90	01/10/2025
BUN	13	01/10/2025
CREAT	0.73	01/10/2025

CA	8.4	01/10/2025

No results found for: "INR"

Medical Decision Making
- Laboratory test(s) independently reviewed and notable for: N/A
- External record review:Reviewed most recent inpatient medicine note for treatment details
- Additional independent history obtained: None
- Discussed management of patient's care: with inpatient medical team

ASSESSMENT

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus and currently requires intensive monitoring with increased risk for adverse effect due to parenteral ketamine or lidocaine infusion

PLAN

Ketamine Therapy:
- Will continue intensive monitoring as ordered due increased risk for adverse effect associated with need for parenteral ketamine infusion.
-Ketamine 0.04 mg/kg/hr (97.3 kg). Decreased due to side effects. Will plan to stop ketamine infusion on 1/11.

Medication Recommendations:
-Multimodal pain management
-Optimize non-opioid medications for pain control
-Avoid escalating opioids

Pain Medications other than Ketamine to be ordered by Primary team.

Thank you for the consult, APS will continue to follow.

Advanced Practice Clinician Statement:
I spent 20 minutes in total time today, 01/10/25, for this visit including all related clinical activities before, during, and after the visit on the date of service, excluding any procedure time.

Electronically signed by Debra Jordan Wing, APRN at 01/10/25 1527
Electronically signed by Kevin M Conrad, MD at 01/10/25 1706

Julio Portillo, CSW at 1/10/2025 1437

Abstract Notes (continued)

Description of patient and diagnosis: Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.
Emergency Contact: No data recorded
Next of Kin: No data recorded
AD/POLST: Not on file

Social Work Encounter

Narrative

Social work met with patient re: complex social situation. Social work reviewed patient chart, met pt at bedside, introduced self, and explained social work role. Pt was currently standing up and in a 1:1. Sw spoke with previous Sw who evaluated pt previously. Sw was informed pt had made a comment regarding SI which led to C-SSRS/Safety Plan. Sw was informed that pt had been told they had Dissociation disorder per pt's statement from a different institution. Pt noted when inquired about SI thoughts/behavior they noted I made a comment related to Suicide given their present situation and related it to a person who would jump and commit suicide. Pt noted they felt okay at the moment without a 1:1 and requested if their ketamine could be increased. Refer to previous Sw note on 1/09/25 regarding C-SSRS.

Sw noted if pt would like resources as a safety plan had been created to which pt declined. Pt noted they have a team from fortitude to help pt. Pt noted Stephanie Book assists pt in the social/mental health aspect. Sw passed along messaged to floor staff. Pt would benefit from visit of addiction services. Sw will remain available to pt.

Plan

Intervention: -Patient/Family/Caregiver contact
-Normalized and validated feelings/emotions
-Processed feelings, questions, and concerns
-Provided emotional support through empathetic/active listening
-Explored and assessed mood, resources and coping
-Interpersonal interaction

Plan: -Social Work to remain available to patient and family as needed for ongoing psychosocial support and intervention

Julio Portillo CSW
Inpatient Medical Social Worker
Smart Web

Electronically signed by Julio Portillo, CSW at 01/15/25 1722
Electronically signed by Michael S Jacobs, LCSW at 01/16/25 0937

Jenifer Hollingsworth, PA-C at 1/11/2025 0813

Attestation signed by Julie Frances Weis, MD at 01/12/25 1725

I saw and evaluated the patient on 1/11. I reviewed the APC's documentation and agree with the history, exam, assessment and care plan. I performed the substantive portion of the medical decision making (MDM). I made/approve the management plan for the problems addressed in the encounter and take responsibility for the plan. I spent 30 minutes in the care of this patient.

Julie Weis, MD MPH
Assistant Professor / Hospitalist
General Internal Medicine

Medicine Daily Progress Note

Admission Date: 1/8/2025
Hospital Day: 3
Service: Internal Medicine

Patient ID:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

24h Events/Subjective:

- KUB: Colonic gaseous dilation is mildly improved compared to prior
- Trial removal of NG tube. Net negative 1L
- Trial on clears.
- UTES continuing to follow and will reassess, and follow KUB at 1900

Objective:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/10/25 1547	01/10/25 2100	01/11/25 0449	01/11/25 0811
BP:	122/81	142/70	117/69	130/73
Pulse:	82	80	87	85
Resp:	18	18	18	18
Temp:	37 °C (98.6 °F)	37 °C (98.6 °F)	36.6 °C (97.9 °F)	36.4 °C (97.5 °F)
SpO2:	98%	95%	95%	97%

I/O last 3 completed shifts:
In: 355 [P.O.:355]
Out: -

Exam:
GEN: No acute distress.
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Soft. Distension improved compared to previous serial exam. Mild TTP. No guarding or peritonitic signs.
SKIN: Dry.
NEURO: Alert. CN II - XII grossly intact
PSYCH: Appropriate affect.

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Results from last 7 days

Lab	Units	01/11/25 0543	01/10/25 0529	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	139	136	138	141
POTASSIUM	mmol/L	3.4	3.5	3.5	4.0
CHLORIDE	mmol/L	106	108	110	**115***
CARBON DIOXIDE	mmol/L	21	**18***	**19***	**18***
BUN	mg/dL	9	13	15	16
CREATININE	mg/dL	0.87	0.73	0.89	0.98
CALCIUM, S/P	mg/dL	9.0	8.4	8.6	8.9
PROTEIN, TOTAL	g/dL	--	7.2	--	8.4
BILIRUBIN, TOTAL	mg/dL	--	0.7	--	0.4
ALKALINE PHOSPHATASE	U/L	--	78	--	86
ALT	U/L	--	50	--	**68***
AST	U/L	--	40	--	**55***
GLUCOSE	mg/dL	83	90	103	117

Results from last 7 days

Lab	Units	01/11/25 0543	01/10/25 0529	01/09/25 0744
WBC	k/uL	7.87	8.47	11.09
HGB	g/dL	14.8	**13.1***	**13.4***
HCT	%	**43.9***	**39.1***	**39.7***
PLTS	k/uL	290	241	262

Radiology reviewed and notable for:
XR Abdomen 1 View

Result Date: 1/11/2025
Colonic gaseous dilation is mildly improved compared to prior.

XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome (Acute colonic pseudo-obstruction)
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis. The risk of colonic perforation increases when cecal diameter exceeds 10 to 12 cm and when the distension has been present for greater than six days.
- General Surgery following
- KUB: Colonic gaseous dilation is mildly improved compared to prior
- Trial removal of NG tube. Net negative 1L
- Trial on clears.
- Continue 72h supportive care. If no improvement will consider cholinergic tx with neostigmine vs Gen Surg
- KUB am and every 24h to monitor for acute change or increasing cecal diameter
- Pain control:
    - IV ketamine drip as managed by APS
    - Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - 3rd line hydromorphone 0.2 mg q4h
    - Avoid opiates as able
- PT/OT: Encourage ambulation
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin

#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic

colitis.
- Collect GI pathogen panel, C Dif when able
- Pending results of path panel, consider discontinuing dulaglutide at d/c

#Median arcuate ligament syndrome
No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- Mesenteric duplex canceled as pt high degree of bowel gas
- Vascular consult vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. No abnormality of liver on CTA.
- Cont to monitor

#Mood
#Passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- SW/Psych cleared patient from need for 1:1. Low risk
- Cont home lamotrigine 200 mg

#Hyperhidrosis
- Hold oxybutynin in setting of Ogilvie syndrome
    - DC med on discharge

#Obesity
- Hold home dulaglutide

Diet Orders (From admission, onward)

Ordered			Start
01/11/25 0812	**NPO except for medications**	Continuous	01/11/25 0813

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Medicine Team 6

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
General Surgery
Acute Pain Service

I spent 70 minutes in the care of this patient >50% of which was counseling and coordination of care.

Jenifer Hollingsworth, PA-C
Hospitalist
Department of General Internal Medicine
University of Utah Hospital

Electronically signed by Jenifer Hollingsworth, PA-C at 01/11/25 1420
Electronically signed by Julie Frances Weis, MD at 01/12/25 1725

Debra Jordan Wing, APRN at 1/11/2025 0825

ACUTE PAIN SERVICE (APS) PROGRESS NOTE **- TIER 1: KETAMINE INFUSION**

Referring Team: Treatment Team:
Attending Provider: Julie Frances Weis, MD

SUBJECTIVE

History of Present Illness:
Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus. APS Consulted for consideration of ketamine infusion for uncontrolled pain.

Home Pain Regimen: Gabapentin 600 mg TID

Home Daily OME: None

Interval History:

Patient reports pain improved. NG tube to suction. He is NPO today and wants to continue the ketamine to distract him from the hunger pains. He says that the NG tube is his main complaint, wants to have it removed. His abd pain has improved. Tolerating the ketamine infusion, denies hallucinations or bothersome dreams.

Associated symptoms
Sedation: None
Respiratory Depression: None
Nausea/Vomiting: None
Pruritis: None
Weakness: None
Bowel Function: pseudo-obstruction
Hallucinations: None

Function: Patient reports pain contributing to limited function

OBJECTIVE

Current Opioid Therapy: IV dilaudid 0.2-0.4 mg Q 4 hours prn

Total OME Last 24 Hours: 0

Current Non-Opioid Therapy: IV tylenol 1000 mg Q6 hrs
-toradol 15 mg 6 hrs

Current Ketamine Infusion Dose: 0.04 mg/kg/hr (97.3 kg)

Current Anticoagulant/Antiplatelet: enoxaparin

Allergies:
No Known Allergies

Home Medications
No current facility-administered medications on file prior to encounter.

Current Outpatient Medications on File Prior to Encounter

Medication	Sig	Dispense	Refill
• DULoxetine (CYMBALTA) 20 mg enteric coated particles capsule	Take 20 mg by mouth daily at bedtime. (Patient not taking: Reported on 1/9/2025)		
• DULoxetine (CYMBALTA) 60 mg enteric coated particles capsule	Take 60 mg by mouth every morning. (Patient not taking: Reported on 1/9/2025)		
• gabapentin (NEURONTIN) 800 mg tablet	Take 800 mg by mouth 3 times daily.		
• lamoTRIgine (LAMICTAL) 200 mg tablet	Take 200 mg by mouth every morning.		
• dulaglutide (TRULICITY) 0.75 mg/0.5 mL	Inject 1 mL (1.5 mg) subcutaneously once a week.	4 mL	0
• Insulin Pen Needle (PEN NEEDLES) 32G X 4 MM miscellaneous	100 each by Does Not Apply route once a week. (Patient not taking: Reported on 1/9/2025)	4 each	5
• MYDAYIS 50 MG 24 hr sustained release capsule	Take 50 mg by mouth once daily.		

Current Medications
bisacodyl (DULCOLAX) 10 MG rectal suppository 10 mg, Daily
ketamine (KETALAR) infusion 1 mg/mL in NS, Continuous
HYDROmorphone (DILAUDID) injection 0.2 mg, Q4H PRN

lamoTRIgine (LaMICtal) tablet 200 mg, Daily
acetaminophen (OFIRMEV) injection 1,000 mg, Q6H
ketorolac (TORADOL) injection 15 mg, Q6H
simethicone (MYLICON) chewable tablet 80 mg, TID PRN
enoxaparin (LOVENOX) syringe 40 mg, QHS
melatonin tablet 3 mg, QHS PRN
naloxone (NARCAN) injection 0.1-0.4 mg, PRN
ondansetron (ZOFRAN) injection 4 mg, Q6H PRN
Or
ondansetron (ZOFRAN) tablet 4 mg, Q6H PRN
traZODone (DESYREL) tablet 50 mg, QHS PRN

Past Medical History

Patient Active Problem List

Diagnosis

- Mild mood disorder (HCC)
- Unspecified mood (affective) disorder (HCC)
- Class 1 obesity due to excess calories without serious comorbidity with body mass index (BMI) of 32.0 to 32.9 in adult
- Axillary abscess
- Ogilvie syndrome

Past Surgical History:

Past Surgical History:

Procedure	Laterality	Date
• Endoscopic thoracic sympathectomy		
• RHINOPLASTY/SEPTOPLASTY	Left	

Social History:

Social History

Tobacco Use

- Smoking status: Former
  - Types: Cigarettes
- Smokeless tobacco: Former
  - Quit date: 03/2023

Vaping Use

- Vaping status: never used

Substance Use Topics

- Alcohol use: Not Currently
- Drug use: Not Currently
  - Types: Heroin, Cannabis (Marijuana)
  - *Comment: clean 3mo (9/23/24); endorses IVDU hx*

Physical Exam

BP 130/73 (BP (Cuff) Location: Right arm, Patient Position: Supine) | Pulse 85 | Temp 36.4 °C (97.5 °F) (Temporal) | Resp 18 | Ht 177.8 cm (5' 10") | Wt 97.3 kg (214 lb 8.1 oz) | SpO2 97% | BMI 30.78 kg/m²

Well appearing, no acute distress. Patient is awake, alert, and oriented. Responds to questions appropriately.

Sitting up in bed.

Laboratory Studies Reviewed
Results from last 7 days

Lab	Units	01/11/25 0543
WBC	k/uL	7.87
HGB	g/dL	14.8
HCT	%	**43.9***
PLTS	k/uL	290

Lab Results

Component	Value	Date
SODIUM	139	01/11/2025
K	3.4	01/11/2025
CL	106	01/11/2025
CO2	21	01/11/2025
AGAP	12	01/11/2025
GLUC	83	01/11/2025
BUN	9	01/11/2025
CREAT	0.87	01/11/2025
CA	9.0	01/11/2025

No results found for: "INR"

Medical Decision Making
- Laboratory test(s) independently reviewed and notable for: N/A
- External record review:Reviewed most recent inpatient medicine note for treatment details
- Additional independent history obtained: None
- Discussed management of patient's care: with inpatient medical team

ASSESSMENT
Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus and currently requires intensive monitoring with increased risk for adverse effect due to parenteral ketamine or lidocaine infusion

PLAN

Ketamine Therapy:
- Will continue intensive monitoring as ordered due increased risk for adverse effect associated with need for parenteral ketamine infusion.
-Ketamine 0.04 mg/kg/hr (97.3 kg). Will plan to stop ketamine infusion on 1/12.

Medication Recommendations:
-Multimodal pain management
-Optimize non-opioid medications for pain control

Abstract Notes (continued)

-Avoid escalating opioids

Pain Medications other than Ketamine to be ordered by Primary team.

Thank you for the consult, APS will continue to follow.

Advanced Practice Clinician Statement:
I spent 20 minutes in total time today, 01/11/25, for this visit including all related clinical activities before, during, and after the visit on the date of service, excluding any procedure time.

Electronically signed by Debra Jordan Wing, APRN at 01/11/25 1150

Karen Michelle Hernandez-Ponce, PA-C at 1/12/2025 1334

Attestation signed by Julie Frances Weis, MD at 01/12/25 1731

I saw and evaluated the patient on 1/12. I reviewed the APC's documentation and agree with the history, exam, assessment and care plan. I performed the substantive portion of the medical decision making (MDM). I made/approve the management plan for the problems addressed in the encounter and take responsibility for the plan. I spent 30 minutes in the care of this patient.

Julie Weis, MD MPH
Assistant Professor / Hospitalist
General Internal Medicine

Medicine Daily Progress Note

Admission Date: 1/8/2025
Hospital Day: 4
Service: Internal Medicine

Patient ID:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

24h Events/Subjective:

- KUB: Colonic gaseous dilation is mildly improved compared to prior
- Tolerating CLD well , no nausea or vomiting, having 2-4 Bms per day, abdominal pain has also improved.
- UTES continuing to follow and will reassess, and follow KUB from this morning.

Objective:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

01/11/25 1534	01/11/25 2145	01/12/25 0512	01/12/25 0845

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

BP:	137/77	112/66	134/73	148/87
Pulse:	84	83	72	95
Resp:	18	16	18	18
Temp:	36.8 °C (98.2 °F)	36.6 °C (97.9 °F)	36.5 °C (97.7 °F)	36.3 °C (97.3 °F)
SpO2:	100%	96%	95%	97%

I/O last 3 completed shifts:
In: 1800 [P.O.:1800]
Out: -

Exam:
GEN: No acute distress.
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Soft. Distension improved compared to previous serial exam. Mild TTP. No guarding or peritonitic signs.
SKIN: Dry.
NEURO: Alert. CN II - XII grossly intact
PSYCH: Appropriate affect.

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 0529	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	139	139	136	< >	141
POTASSIUM	mmol/L	3.4	3.4	3.5	< >	4.0
CHLORIDE	mmol/L	108	106	108	< >	**115***
CARBON DIOXIDE	mmol/L	24	21	**18***	< >	**18***
BUN	mg/dL	10	9	13	< >	16
CREATININE	mg/dL	0.90	0.87	0.73	< >	0.98
CALCIUM, S/P	mg/dL	8.5	9.0	8.4	< >	8.9
PROTEIN, TOTAL	g/dL	7.0	--	7.2	--	8.4
BILIRUBIN, TOTAL	mg/dL	0.5	--	0.7	--	0.4
ALKALINE PHOSPHATASE	U/L	68	--	78	--	86
ALT	U/L	48	--	50	--	**68***
AST	U/L	35	--	40	--	**55***
GLUCOSE	mg/dL	88	83	90	< >	117

< > = values in this interval not displayed.

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 0529
WBC	k/uL	5.65	7.87	8.47
HGB	g/dL	**14.3***	14.8	**13.1***
HCT	%	**42.0***	**43.9***	**39.1***
PLTS	k/uL	280	290	241

Radiology reviewed and notable for:
XR Abdomen 1 View

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

Result Date: 1/12/2025
Similar or slightly decreased colonic gaseous distention. Attending note: Agree with the above report, which was edited for clarity.

XR Abdomen 1 View

Result Date: 1/11/2025
Similar diffuse gaseous dilation of the colon with transition at the proximal descending colon typical for Ogilvie syndrome.

XR Abdomen 1 View

Result Date: 1/11/2025
Colonic gaseous dilation is mildly improved compared to prior.

XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome (Acute colonic pseudo-obstruction)
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis. The risk of colonic perforation increases when cecal diameter exceeds 10 to 12 cm and when the distension has been present for greater than six days.
- General Surgery following
- KUB: Colonic gaseous dilation is mildly improved compared to prior
- Trial on clears, advance pending general surgery review of KUBs
- Continue 72h supportive care. If no improvement will consider cholinergic tx with neostigmine vs Gen Surg
- KUB am and every 24h to monitor for acute change or increasing cecal diameter
- Pain control:
    - IV ketamine drip discontinued 1/11
    - Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - 3rd line hydromorphone 0.2 mg q4h
    - Avoid opiates as able
- PT/OT: Encourage ambulation
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin

#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic colitis.
- Collect GI pathogen panel, C Dif when able
- Pending results of path panel, consider discontinuing dulaglutide at d/c

#Median arcuate ligament syndrome
No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- Mesenteric duplex canceled as pt high degree of bowel gas
- Vascular consult vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. No abnormality of liver on CTA.
- Cont to monitor

#Mood
#Passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- SW/Psych cleared patient from need for 1:1. Low risk
- Cont home lamotrigine 200 mg

#Hyperhidrosis
- Hold oxybutynin in setting of Ogilvie syndrome
    - DC med on discharge

#Obesity
- Hold home dulaglutide

Diet Orders (From admission, onward)

Ordered		Start
01/11/25 1027	**Clear Liquid Diet** Continuous	01/11/25 1028

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Medicine Team 6

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
General Surgery
Acute Pain Service

I spent 70 minutes in the care of this patient >50% of which was counseling and coordination of care.

Karen Michelle Hernnadez-Ponce, PA-C
Hospitalist
Department of General Internal Medicine
University of Utah Hospital

Electronically signed by Karen Michelle Hernandez-Ponce, PA-C at 01/12/25 1344
Electronically signed by Julie Frances Weis, MD at 01/12/25 1731

Alan Robert Brinkerhoff, PT at 1/12/2025 1409

Acute Care Physical Therapy Daily Progress Note

Admission Date: 1/8/2025
Attending: Julie Frances Weis, MD

Subjective

PT Last Visit

PT Received On: 01/12/25
Subjective: Pt is seated EOB upon therapy arrival, agreeable to participate in therapy session at this time.
PT Diagnosis: abd pain, median arcuate ligament syndrome and ogilvie ileus PMH mood disorder, obesity, hyperhidrosis
Floor Location: D60/Internal Medicine
Patient received: in bed with the call light within reach
Patient returned: in bed with the call light within reach

Cognition
Cognitive Functioning: Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently
Affect: Alert;Cooperative
Safety/Judgment: No safety issues observed
Command Following: Follows all commands without difficulty
Comprehension: Auditory
Communication: Verbal

Precautions
Activity Orders: Up with assistance
Lines/Tubes: IV
O2 Requirement: None/Room air
Infection Precautions: Contact precautions
Is there a language barrier?: No

Objective

Mobility Tests
Johns Hopkins Highest Level of Mobility: Walk 250+ feet

AM-PAC 6 Clicks Basic Mobility
Turning over in bed: None
Moving from lying on back to sitting: None
Moving to and from a bed to a chair: None
Standing up from a chair: None
Walk in a hospital room: None
Climb 3-5 steps with rail: None
AMPAC Mobility Raw Score: 24

Barriers
Barriers to Discharge Comments: 2 flights of stairs performed multiple times per day when at facility

Bed Mobility
Rolling: Independent
Supine to Sit: Independent
Supine to Sit details: Left
Supine Scooting: Independent
Sit to Supine: Independent

Transfers
Sit to Stand: Independent

Gait
Gait Assistance Level: Independent
Distance ambulated: 1000 feet
Assistive device: None
Gait education/comment: improved gait cadence today, no loss of balance, cues for pathfinding only

Stairs
Stair Management Assistance: Independent
Assistive device/detail: None
Number of Stairs: 48

Assessment

Assessment
Participation: Good

Assessment Comments: Boone is a 45 year old male admitted for abd pain, median arcuate ligament syndrome and ogilvie ileus. PMH mood disorder, obesity, hyperhidrosis. He performs all functional mobility independently today, he is on track for safe DC back to prior housing, no ongoing IP PT needs at this time. Pt is safe to ambulate with staff SBA during remainder of admission.

Physical Therapy Progress: On track for safe DC home
Prognosis: Good
Barriers to Discharge Comments: 2 flights of stairs performed multiple times per day when at facility

Goals

Bed Mobility Goal
Patient will perform supine to sit independently.
Progress: Met
Transfers Goal
Patient will perform sit to stand transfer without assistive device independently.
Progress: Met
Gait Goal
Patient will ambulate 500 feet without assistive device independently.
Progress: Met
Additional Goal 1: Pt to complete 2 flights of stairs with single HR with independence.
Progress: Met

Plan

Plan
Treatment/Interventions: Balance training, Patient education, Transfer training, Bed mobility training, Stair training, Therapeutic exercises, Neuromuscular reeducaton, Gait training, Equipment training, Pain management, Caregiver training
PT Duration: Discontinue skilled PT

Discharge Recommendations

Recommendation
New Equipment Recommended (PT): None/Has all DME
Location/Services: Home;with Caregiver Supervision-/Assistance
Recommendation: 01/12: Back to previous living situation.

Time/Charges

Total duration of billed timed treatments: 19 minutes
Total duration of treatment session: 25 minutes

Electronically signed by Alan Robert Brinkerhoff, PT at 01/12/25 1435

Alla Zinger, PA-C at 1/12/2025 1642

Attestation signed by Jason Bryan Young, MD at 01/12/25 1951

Attending Surgeon Attestation

I provided this service on 1/12/2025.

I have reviewed the note by the physician/APC above and verified its contents.
I reviewed and confirmed the HPI, PFSH, and ROS.
I examined the patient, and confirm the findings by the physician/APC above.
I have reviewed, independently interpreted, and discussed the chart, tests, labs, imaging, diagnoses, evaluation, and treatment plan with the physician/APC above. I approve the plan as noted.

Jason B. Young, MD, PharmD
Associate Professor
Department of Surgery
949-278-0466

Surgery Progress Note

Hospital Day: 5
Current Unit: UH D60 INTERNAL MEDICINE

ID:
Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and distention. General Surgery consulted to evaluate for Ogilvie's.

Subjective:
KUB with persistent colonic dilation
NGT discontinued,
Patient started and tolerating clears,
denied N/V/abdominal pain, c/o ongoing diarrhea, passing flatus

Physical Exam:
Vital Signs:
Temp: [36.3 °C (97.3 °F)-36.8 °C (98.2 °F)] 36.8 °C (98.2 °F)
HR: [72-124] 124

Abstract Notes (continued)

Resp: [16-18] 18
BP: (112-148)/(66-89) 133/89
SpO2: [95 %-97 %] 97 %
BMI: Body mass index is 30.78 kg/m².

General appearance: in no apparent distress, alert and oriented .
Cardiovascular: RRR
Respiratory: Respiratory Effort: Unlabored, regular
Abdomen: soft, not distended, NT, not tympanic,

Data:

Intake/Output

	01/10/25 0700 - 01/11/25 0659	01/11/25 0700 - 01/12/25 0659				01/12/25 0700 - 01/13/25 0659			
	Total	0700-1459	1500-2259	2300-0659	Total	0700-1459	1500-2259	2300-0659	Total
Intake (ml)	**355**	800	1000	0	**1800**	591	472	—	**1063**
Output (ml)	**—**	—	—	—	**—**	—	—	—	**—**
Net (ml)	**355**	800	1000	0	**1800**	591	472	—	**1063**

Results from last 7 days

Lab	Units	01/12/25 0546
SODIUM	mmol/L	139
POTASSIUM	mmol/L	3.4
CHLORIDE	mmol/L	108
CARBON DIOXIDE	mmol/L	24
BUN	mg/dL	10
CREATININE	mg/dL	0.90
GLUCOSE	mg/dL	88
CALCIUM, S/P	mg/dL	8.5

Results from last 7 days

Lab	Units	01/12/25 0546
WBC	k/uL	5.65
HGB	g/dL	**14.3***
HCT	%	**42.0***
PLTS	k/uL	280

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 1104
SODIUM	mmol/L	139	< >	--
POTASSIUM	mmol/L	3.4	< >	--
CHLORIDE	mmol/L	108	< >	--
CARBON DIOXIDE	mmol/L	24	< >	--
BUN	mg/dL	10	< >	--
CREATININE	mg/dL	0.90	< >	--
CALCIUM, S/P	mg/dL	8.5	< >	--
UA PROTEIN		--	--	**30***
BILIRUBIN, TOTAL	mg/dL	0.5	--	--
ALKALINE PHOSPHATASE	U/L	68	--	--
ALT	U/L	48	--	--
AST	U/L	35	--	--
GLUCOSE	mg/dL	88	< >	--

< > = values in this interval not displayed.

Imaging: Reviewed

Assessment:

Boone Cabal is an 45 year old male, admitted to medicine due to abdominal pain, diarrhea in the setting of the recent treatment of cellulitis of the axilla treated with the course of antibiotics and ongoing diarrhea since (about 2-3 weeks). General surgery following for colonic pseudoobstruction.

Plan:

MANAGEMENT PER PRIMARY TEAM

General Surgery recommendations:
-no surgical intervention indicated
-in the setting of ongoing watery diarrhea would r/o C. Diff , GI panel-pending to r/o other infectious w/u
-concern about giving Neostigmine at this time until infectious sources, incl C. Dif ruled out.
-recommend consulting GI as patient may need colonoscopic decompression sooner rather then later and to look for mucosal ischemia while GI panel is in process
-daily KUB, recommend repeating KUB later tonight
-daily BMP, lytes, replace PRN
-UA is negative and no SSx of UTI per pt
-General surgery, UTES B team, will continue to follow

Alla Zinger, PA-C , UTES B
Attending; Dr. Young

Electronically signed by Alla Zinger, PA-C at 01/12/25 1935
Electronically signed by Jason Bryan Young, MD at 01/12/25 1951

Michael James Walker, MD at 1/12/2025 1642

Brief GI Progress Note

2 attempts were made to see the patient this afternoon/evening but he was not in his room. History is thus obtained from primary team and chart review

Subjective

45-year-old man PMH mood disorder, BMI 30, hyperhidrosis who presented with abdominal pain and was found to have median arcuate ligament syndrome and Ogilvie on initial CT scan. He had a GI PCR collected and he is starting to have bowel movements

Per chart review:
– Admitted at IMC 9/28 till 9/29. This was for abdominal pain/bloating and nausea vomiting. Records are somewhat limited in our system

Objective

Afebrile. HR 70s to 90s. Most recent was 124. Good blood pressure. Room air
CMP WNL. Potassium 3.4
WBC 5.6 Hgb 14.3 platelets 280

CT abdomen pelvis 1/8/2025
– High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome without evidence of ischemia
– Colonic dilation to the level of the rectum

Multiple KUBs which show colonic distention. This morning his transverse colon measures 12 cm. It is somewhat similar to 1/11 although there appears to be improvement in dilation of the left colon.

Impression

#Ogilvie's
Patient presenting with abdominal pain and found to have a dilated colon that is consistent with Ogilvie's. There does not appear to be a clear cause (no) apparent recent surgery, no recent trauma, not no advanced age, no apparent neurologic disorders, no severe electrolyte imbalances, no classic offending medications). He is currently receiving a bisacodyl suppository. It appears he is tolerating clear liquids.

Concern for median arcuate ligament syndrome
This concern was raised on CTA where there was inferior displacement of the proximal celiac artery with associated stenosis due to the median arcuate ligament. Unclear whether this is causing abdominal pain as Ogilvie's can also cause abdominal discomfort.

Recommendations

–At this time there does not appear to be clear indication for colonic decompression with a colonoscopy. Our general protocol is to trial neostigmine first if he continues to have colonic distention despite conservative treatment.
– Recommend daily KUB.
– If patient develops abdominal pain would repeat imaging and if colonic distention is getting worse consider neostigmine.

Abstract Notes (continued)

– Additionally would check twice daily BMP, magnesium, phosphorus. With target K>4, Mg>2, Phos>3.
–If patient is comfortable, tolerating oral intake, and is having bowel movements he can start doing daily MiraLAX daily
– Otherwise no clear indication for urgent colonoscopy at this time unless patient fails neostigmine (which at this time it is not clear he needs).
–At some point can consider duplex ultrasound of the celiac artery for further workup of MALS

Andrew Kent Fuller, MD
PGY-5 Fellow Division of Gastroenterology & Hepatology

I performed chart review for evaluation of this patient. This patient was not seen in person. This consultation required greater than 5 minutes of attending time. I have reviewed the medical chart, history, physical examination, laboratory data, pertinent radiological studies, and the assessment and plan with the fellow. The assessment and care plan are appropriate as written.

Electronically signed by Michael James Walker, MD at 01/13/25 0830

Karen Michelle Hernandez-Ponce, PA-C at 1/13/2025 0759

Attestation signed by Tyler Hohnholt, MD at 01/14/25 0818

I did not see the patient on the day of this encounter, but reviewed the chart, discussed the assessment and plan with the APC, and amended the above documentation as indicated. I spent 15 minutes in the care of this patient.

Tyler Hohnholt, MD
Hospitalist
University of Utah Health
Division of General Internal Medicine

Medicine Daily Progress Note

Admission Date: 1/8/2025
Hospital Day: 5
Service: Internal Medicine

Patient ID:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

24h Events/Subjective:

- KUB 1/13:Nondistended loops of colon which have decrease in diameter compared to prior. However, there is haustral thumbprinting which can be seen in the setting of C. difficile infection.
- Continues tolerating CLD well, no nausea or vomiting, having 2-4 Bms per day, abdominal pain has also improved. Requesting advancement of diet.
- C diff testing panel negative

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

- GI consulted, no indication for decompressive colonoscopy, Neostigmine trial would be first-line treatment per protocol which patient does not clearly need at this time per general surgery.

Objective:

Vitals - Last 4 B/P,Pulse,Temp,Resp,SpO2

	01/12/25 1615	01/12/25 1700	01/12/25 1916	01/13/25 0533
BP:	133/89		128/82	124/68
Pulse:	**(!) 124**	93	114	83
Resp:	18		18	22
Temp:	36.8 °C (98.2 °F)		36.9 °C (98.4 °F)	36.3 °C (97.3 °F)
SpO2:	97%		98%	100%

I/O last 3 completed shifts:
In: 1912 [P.O.:1912]
Out: -

Exam:
GEN: No acute distress.
EYES: Normal conjunctivae.
CV: Regular rate and rhythm.
PULM/CHEST: Normal respiratory effort. Clear to auscultation bilaterally.
GI/ABD: Soft. Distension improved compared to previous serial exam. Mild TTP. No guarding or peritonitic signs.
SKIN: Dry.
NEURO: Alert. CN II - XII grossly intact
PSYCH: Appropriate affect.

Results from last 7 days

Lab	Units	01/13/25 0531	01/12/25 0546	01/11/25 0543	01/10/25 0529	01/09/25 0744	01/08/25 1546
SODIUM	mmol/L	138	139	139	136	< >	141
POTASSIUM	mmol/L	--	3.4	3.4	3.5	< >	4.0
CHLORIDE	mmol/L	110	108	106	108	< >	**115***
CARBON DIOXIDE	mmol/L	**15***	24	21	**18***	< >	**18***
BUN	mg/dL	8	10	9	13	< >	16
CREATININE	mg/dL	1.00	0.90	0.87	0.73	< >	0.98
CALCIUM, S/P	mg/dL	8.9	8.5	9.0	8.4	< >	8.9
PROTEIN, TOTAL	g/dL	--	7.0	--	7.2	--	8.4
BILIRUBIN, TOTAL	mg/dL	--	0.5	--	0.7	--	0.4
ALKALINE PHOSPHATASE	U/L	--	68	--	78	--	86
ALT	U/L	--	48	--	50	--	**68***
AST	U/L	--	35	--	40	--	**55***
GLUCOSE	mg/dL	81	88	83	90	< >	117

< > = values in this interval not displayed.

Results from last 7 days

Lab	Units	01/12/25 0546	01/11/25 0543	01/10/25 0529
WBC	k/uL	5.65	7.87	8.47
HGB	g/dL	**14.3***	14.8	**13.1***
HCT	%	**42.0***	**43.9***	**39.1***
PLTS	k/uL	280	290	241

Radiology reviewed and notable for:
XR Abdomen 1 View

Result Date: 1/12/2025
FINDINGS/IMPRESSION: Persistent dilation of the transverse colon, decreased dilation of the ascending colon, paucity of bowel gas seen distal to the splenic flexure consistent with slightly improved with ongoing colonic pseudoobstruction/Ogilvie syndrome.

XR Abdomen 1 View

Result Date: 1/12/2025
Similar or slightly decreased colonic gaseous distention. Attending note: Agree with the above report, which was edited for clarity.

XR Abdomen 1 View

Result Date: 1/11/2025
Similar diffuse gaseous dilation of the colon with transition at the proximal descending colon typical for Ogilvie syndrome.

XR Abdomen 1 View

Result Date: 1/11/2025
Colonic gaseous dilation is mildly improved compared to prior.

XR Abdomen 1 View

Result Date: 1/10/2025
Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

XR Abdomen 1 View

Result Date: 1/9/2025
Unchanged diffuse gaseous distention of the colon.

XR Chest 1 View

Result Date: 1/9/2025
1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded. 2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

XR Abdomen 1 View

Result Date: 1/9/2025
Similar gaseous distention of the colon.

XR Abdomen 1 View

Result Date: 1/8/2025
1. Appropriately positioned gastric tube. 2. Similar appearance of multiple air-filled mildly dilated colonic loops.

CTA Abdomen Pelvis W IV Cont

Result Date: 1/8/2025
High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen. Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Assessment/Plan:

Boone Cabal is a 45 year old male with mood disorder, obesity, hyperhidrosis who presents with acute onset abdominal pain discovered to have median arcuate ligament syndrome and ogilvie ileus.

#Abdominal pain
#Ogilvie syndrome (Acute colonic pseudo-obstruction)
Patient with acute onset abdominal pain characterized by abdominal distention preceded by 12 to 24 hours of profuse diarrhea. CT with 9 cm distension of colon w/o obstruction. No severe electrolyte derangements. Patient takes oxybutynin for hyperhidrosis which has been reported to cause ileus in patients with IBS. Other etiology could be recent colitis. The risk of colonic perforation increases when cecal diameter exceeds 10 to 12 cm and when the distension has been present for greater than six days.
- General Surgery signing off
- Ok to advance diet to regular
- Continue 72h supportive care. If no improvement will consider cholinergic tx with neostigmine vs Gen Surg
- Pain control:
    - Tylenol 1g q6h x 5d scheduled
    - Ketorolac 15 mg q6h x 5d scheduled
    - Avoid opiates as able
- PT/OT: Encourage ambulation
- PRN ondansetron 4 mg IV
- PRN simethicone
- Hold home oxybutynin
- bowel regimen

#Sapovirus infection
#Colitis
#Diarrhea
1d history profuse watery diarrhea. He did receive recent course of bactrim though this medication is low risk for C. Dif infection. More likely viral gastroenteritis vs side effect from recent GLP1 dose increase. Low concern for ischemic colitis. GI path + sapovirus. C diff test negative
- CTM

#Median arcuate ligament syndrome

No obvious symptoms of intermittent or critical mesenteric ischemia. Less likely than Ogilvie syndrome to be source of abdominal pain. No ischemia on CTA. No post prandial pain. Diarrhea can be 2/2 ischemic colitis.
- Mesenteric duplex canceled as pt high degree of bowel gas
- Vascular consult vs outpatient referral if hemodynamically significant stenosis on duplex

#LFT elevation
Mild LFT derangement. No abnormality of liver on CTA.
- Cont to monitor

#Mood
#Passive suicidal ideation
Reported past suicide attempt in 2015 and current passive SI w plan to overdose on fentanyl. He has not actively thought about how he would do this. As patient has no access to fentanyl here and does not threaten imminent self-harm, he does not require 1:1 although he scored highly on nursing suicidality screen.
- SW/Psych cleared patient from need for 1:1. Low risk
- Cont home lamotrigine 200 mg

#Hyperhidrosis
- Hold oxybutynin in setting of Ogilvie syndrome
    - DC med on discharge

#Obesity
- Hold home dulaglutide

Diet Orders (From admission, onward)

Ordered		Start
01/11/25 1027	**Clear Liquid Diet** Continuous	01/11/25 1028

DVT Prophylaxis: Enoxaparin

Code status: Full Code

Dispo: Medicine Team 6

Outpatient providers:
PCP: No Assignment Pt Req
Specialists:
General Surgery
Acute Pain Service

I spent 50 minutes in the care of this patient >50% of which was counseling and coordination of care.

Karen Michelle Hernnadez-Ponce, PA-C
Hospitalist
Department of General Internal Medicine
University of Utah Hospital

Electronically signed by Karen Michelle Hernandez-Ponce, PA-C at 01/13/25 1730
Electronically signed by Tyler Hohnholt, MD at 01/14/25 0818

Jade Myles Nunez, MD at 1/13/2025 1025

Surgery Progress Note

Hospital Day: 6
Current Unit: UH D60 INTERNAL MEDICINE

ID:
Boone Cabal is an 45 year old male with past medical history of depression, recent axillary cellulitis for which he received antibiotics, who presents with 1 day of diarrhea, roughly 8 hours of progressive abdominal pain and distention. General Surgery consulted to evaluate for Ogilvie's.

Subjective:
- Repeat 01/12 PM revealed persistent dilation of the transverse colon measuring approximately 11.5cm, decreased dilation of the ascending colon, paucity of bowel gas seen distal to the splenic flexure consistent with slightly improved with ongoing colonic pseudoobstruction/Ogilvie syndrome.
- GI consulted, no indication for decompressive colonoscopy, Neostigmine trial would be first-line treatment per protocol (which patient does not clearly need at this time)
- tolerating CLD
- diarrhea x2, passing flatus
- denied N/V, abdominal pain

Physical Exam:
Vital Signs:
Temp: [36.3 °C (97.3 °F)-36.9 °C (98.4 °F)] 36.9 °C (98.4 °F)
HR: [83-124] 114
Resp: [18-24] 24
BP: (124-152)/(68-89) 152/85
SpO2: [95 %-100 %] 95 %
BMI: Body mass index is 30.78 kg/m².

General appearance: in no apparent distress, alert and oriented .
Cardiovascular: RRR.
Respiratory: Respiratory Effort unlabored, regular.
Abdomen: soft, not distended, NT, not tympanic.

Data:

Intake/Output

01/11/25 0700 - 01/12/25 0659	01/12/25 0700 - 01/13/25 0659	01/13/25 0700 - 01/14/25 0659

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Abstract Notes (continued)

	Total	0700-1459	1500-2259	2300-0659	Total	0700-1459	1500-2259	2300-0659	Total
Intake (ml)	**1800**	591	946	375	**1912**	105	—	—	**105**
Output (ml)	**—**	—	—	—	**—**	—	—	—	**—**
Net (ml)	**1800**	591	946	375	**1912**	105	—	—	**105**

Results from last 7 days

Lab	Units	01/13/25 0531	01/12/25 0546
SODIUM	mmol/L	138	139
POTASSIUM	mmol/L	--	3.4
CHLORIDE	mmol/L	110	108
CARBON DIOXIDE	mmol/L	**15***	24
BUN	mg/dL	8	10
CREATININE	mg/dL	1.00	0.90
GLUCOSE	mg/dL	81	88
CALCIUM, S/P	mg/dL	8.9	8.5

Results from last 7 days

Lab	Units	01/12/25 0546
WBC	k/uL	5.65
HGB	g/dL	**14.3***
HCT	%	**42.0***
PLTS	k/uL	280

Results from last 7 days

Lab	Units	01/13/25 0531	01/12/25 0546	01/11/25 0543	01/10/25 1104
SODIUM	mmol/L	138	139	< >	--
POTASSIUM	mmol/L	--	3.4	< >	--
CHLORIDE	mmol/L	110	108	< >	--
CARBON DIOXIDE	mmol/L	**15***	24	< >	--
BUN	mg/dL	8	10	< >	--
CREATININE	mg/dL	1.00	0.90	< >	--
CALCIUM, S/P	mg/dL	8.9	8.5	< >	--
UA PROTEIN		--	--	--	**30***
BILIRUBIN, TOTAL	mg/dL	--	0.5	--	--
ALKALINE PHOSPHATASE	U/L	--	68	--	--
ALT	U/L	--	48	--	--
AST	U/L	--	35	--	--
GLUCOSE	mg/dL	81	88	< >	--

< > = values in this interval not displayed.

Imaging:

EXAMINATION: XR ABDOMEN 1 VIEW

INDICATION: Evaluate for pseudoobstruction.

COMPARISON: Radiograph the abdomen 1/12/2024

TECHNIQUE: XR ABDOMEN 1 VIEW

FINDINGS:
Nondistended loops of colon, decreased in diameter compared to study 1/12/2025. Thumbprinting of the haustra.

IMPRESSION:

Nondistended loops of colon which have decrease in diameter compared to prior. However, there is haustral thumbprinting which can be seen in the setting of C. difficile infection.

Assessment:

Boone Cabal is an 45 year old male, admitted to medicine due to abdominal pain, diarrhea in the setting of the recent treatment of cellulitis of the axilla treated with the course of antibiotics and ongoing diarrhea since (about 2-3 weeks). General surgery consulted 2/2 concerns for colonic pseudoobstruction.

Plan:

MANAGEMENT PER PRIMARY TEAM
General Surgery recommendations:
- GI panel positive for Sapovirus
- c.diff pending
- repeat XR KUB 1/13 AM demonstrated nondistended loops of colon, decreased in diameter compared to yesterday's study
- no surgical intervention indicated
- daily BMP, lytes, replace PRN
- GI consulted, appreciate recommendations
- General surgery, UTES B team, plan to sign off at this time. Please reach out with any questions or concerns.

Paige Casil, MD Emergency Medicine PGY-1
Attending: Dr. Nunez

ATTENDING ATTESTATION:
I have seen and examined Boone Cabal and have independently reviewed the pertinent clinical and radiographic data and agree with the assessment and plan of the Acute Care Surgery team.

Jade M Nunez, MD

Electronically signed by Jade Myles Nunez, MD at 02/16/25 0013

Abstract Notes (continued)

Breanna Caudle, OT at 1/13/2025 1503

Pt up ad lib in room. Denies concerns about ADls at this time, reports ind w/ dressing and showering
OT to d/c orders

Electronically signed by Breanna Caudle, OT at 01/13/25 1507

Results for orders placed or performed during the hospital encounter of 01/08/25

CBC with Platelet Count and Automated Differential

Result	Value	Ref Range
WBC	9.72	4.30 - 11.30 k/uL
Hemoglobin	14.4 (L)	14.8 - 17.8 g/dL
Hematocrit	44.5	44.2 - 53.0 %
Platelet	269	159 - 439 k/uL
Red Blood Cell	4.96	4.70 - 6.14 M/uL
Mean Corpuscular Volume	89.7	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	32.4	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.2	11.5 - 15.3 %
Mean Platelet Volume	8.7	8.6 - 12.3 fL
Neutrophil %	83.1 (H)	39.4 - 72.5 %
Lymphocyte %	12.2 (L)	17.6 - 49.6 %
Monocyte %	3.6 (L)	4.1 - 12.4 %
Eosinophil %	0.4	0.4 - 6.7 %
Basophil %	0.3	0.3 - 1.4 %
Neutrophil # (ANC)	8.07 (H)	2.00 - 7.40 k/uL
Lymphocyte #	1.19 (L)	1.30 - 3.60 k/uL
Monocyte #	0.35	0.30 - 1.00 k/uL
Eosinophil #	0.04	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.04	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Result	Value	Ref Range
Sodium S/P	141	136 - 144 mmol/L
Potassium	4.0	3.3 - 5.0 mmol/L
Chloride	115 (H)	102 - 110 mmol/L
Carbon Dioxide	18 (L)	20 - 26 mmol/L
BUN	16	8 - 24 mg/dL
Creatinine S/P	0.98	0.72 - 1.25 mg/dL
Glucose	117	64 - 128 mg/dL
Anion Gap	8	5 - 14 mmol/L
Calcium	8.9	8.4 - 10.5 mg/dL

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Protein, Total, S/P	8.4	6.5 - 8.4 g/dL
Albumin	4.9	3.5 - 5.0 g/dL
Bilirubin, Total	0.4	0.2 - 1.4 mg/dL
Alkaline Phosphatase	86	38 - 126 U/L
AST	55 (H)	16 - 40 U/L
ALT	68 (H)	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	96	mL/min/1.73m2

Lipase, Serum or Plasma

Result	Value	Ref Range
Lipase, S/P	43	8 - 78 U/L

Urinalysis, Complete

Result	Value	Ref Range
Color, Urine	Yellow	
Appearance, Urine	Clear	Clear, Not Applicable
Leukocyte Esterase,Urine	Negative	Negative
Urobilinogen,Urine	1.0	<2.0 mg/dL
Specific Gravity, Urine	1.034 (H)	1.003 - 1.030
pH, Urine	6.0	5.0 - 7.5
Protein, Urine	30 (A)	Negative
Glucose, Urine	Negative	Negative
Ketones, Urine	Trace (A)	Negative
Bilirubin, Urine	Negative	Negative
Nitrites, Urine	Negative	Negative
Bacteria, Urine	None	Negative
Blood, Urine	Trace (A)	Negative
RBC Auto, Urine	7 (H)	0 - 5 /HPF
WBC Auto, Urine	2	0 - 5 /HPF
EPI Auto, Urine	1	0 - 5 /HPF
Casts Auto, Urine	<4	0 - 3 /LPF

Extra Specimen Urine Gray

Result	Value	Ref Range
Extra Specimen Urine Gray	Complete	

Extra Specimen Urine

Result	Value	Ref Range
Extra Specimen Urine	Complete	

CBC with Platelet Count

Result	Value	Ref Range
WBC	11.09	4.30 - 11.30 k/uL
Hemoglobin	13.4 (L)	14.8 - 17.8 g/dL
Hematocrit	39.7 (L)	44.2 - 53.0 %
Platelet	262	159 - 439 k/uL
Red Blood Cell	4.69 (L)	4.70 - 6.14 M/uL
Mean Corpuscular Volume	84.6	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	28.6	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	33.8	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.4 (H)	11.5 - 15.3 %
Mean Platelet Volume	8.6	8.6 - 12.3 fL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL

Renal Function Panel

Result	Value	Ref Range
Sodium S/P	138	136 - 144 mmol/L

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Potassium	3.5	3.3 - 5.0 mmol/L
Chloride	110	102 - 110 mmol/L
Carbon Dioxide	19 (L)	20 - 26 mmol/L
BUN	15	8 - 24 mg/dL
Creatinine S/P	0.89	0.72 - 1.25 mg/dL
Glucose	103	64 - 128 mg/dL
Anion Gap	9	5 - 14 mmol/L
Calcium	8.6	8.4 - 10.5 mg/dL
Phosphorus, Inorganic, S/P	2.5	2.2 - 4.5 mg/dL
Albumin	4.5	3.5 - 5.0 g/dL
eGFR, CKD-EPI CRT 2021	107	mL/min/1.73m2

Magnesium, Plasma or Serum

Result	Value	Ref Range
Magnesium, S/P	2.0	1.6 - 2.6 mg/dL

CBC with Platelet Count and Automated Differential

Result	Value	Ref Range
WBC	8.47	4.30 - 11.30 k/uL
Hemoglobin	13.1 (L)	14.8 - 17.8 g/dL
Hematocrit	39.1 (L)	44.2 - 53.0 %
Platelet	241	159 - 439 k/uL
Red Blood Cell	4.52 (L)	4.70 - 6.14 M/uL
Mean Corpuscular Volume	86.5	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	29.0	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	33.5	31.9 - 35.2 g/dL
Red Cell Distribution Width	15.1	11.5 - 15.3 %
Mean Platelet Volume	9.0	8.6 - 12.3 fL
Neutrophil %	72.8 (H)	39.4 - 72.5 %
Lymphocyte %	19.8	17.6 - 49.6 %
Monocyte %	5.2	4.1 - 12.4 %
Eosinophil %	1.4	0.4 - 6.7 %
Basophil %	0.4	0.3 - 1.4 %
Neutrophil # (ANC)	6.17	2.00 - 7.40 k/uL
Lymphocyte #	1.68	1.30 - 3.60 k/uL
Monocyte #	0.44	0.30 - 1.00 k/uL
Eosinophil #	0.12	0.00 - 0.50 k/uL
Basophil #	0.03	0.00 - 0.10 k/uL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL
Immature Granulocytes %	0.4	0.2 - 0.9 %
Immature Granulocytes #	0.03	0.01 - 0.09 k/uL

Comprehensive Metabolic Panel

Result	Value	Ref Range
Sodium S/P	136	136 - 144 mmol/L
Potassium	3.5	3.3 - 5.0 mmol/L
Chloride	108	102 - 110 mmol/L
Carbon Dioxide	18 (L)	20 - 26 mmol/L
BUN	13	8 - 24 mg/dL
Creatinine S/P	0.73	0.72 - 1.25 mg/dL
Glucose	90	64 - 128 mg/dL
Anion Gap	10	5 - 14 mmol/L
Calcium	8.4	8.4 - 10.5 mg/dL
Protein, Total, S/P	7.2	6.5 - 8.4 g/dL

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Albumin	4.0	3.5 - 5.0 g/dL
Bilirubin, Total	0.7	0.2 - 1.4 mg/dL
Alkaline Phosphatase	78	38 - 126 U/L
AST	40	16 - 40 U/L
ALT	50	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	114	mL/min/1.73m2

CBC with Platelet Count

Result	Value	Ref Range
WBC	7.87	4.30 - 11.30 k/uL
Hemoglobin	14.8	14.8 - 17.8 g/dL
Hematocrit	43.9 (L)	44.2 - 53.0 %
Platelet	290	159 - 439 k/uL
Red Blood Cell	5.14	4.70 - 6.14 M/uL
Mean Corpuscular Volume	85.4	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	28.8	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	33.7	31.9 - 35.2 g/dL
Red Cell Distribution Width	14.8	11.5 - 15.3 %
Mean Platelet Volume	8.8	8.6 - 12.3 fL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL

Basic Metabolic Panel

Result	Value	Ref Range
Sodium S/P	139	136 - 144 mmol/L
Potassium	3.4	3.3 - 5.0 mmol/L
Chloride	106	102 - 110 mmol/L
Carbon Dioxide	21	20 - 26 mmol/L
BUN	9	8 - 24 mg/dL
Creatinine S/P	0.87	0.72 - 1.25 mg/dL
Glucose	83	64 - 128 mg/dL
Anion Gap	12	5 - 14 mmol/L
Calcium	9.0	8.4 - 10.5 mg/dL
eGFR, CKD-EPI CRT 2021	108	mL/min/1.73m2

CBC with Platelet Count

Result	Value	Ref Range
WBC	5.65	4.30 - 11.30 k/uL
Hemoglobin	14.3 (L)	14.8 - 17.8 g/dL
Hematocrit	42.0 (L)	44.2 - 53.0 %
Platelet	280	159 - 439 k/uL
Red Blood Cell	5.04	4.70 - 6.14 M/uL
Mean Corpuscular Volume	83.3	81.2 - 96.6 fL
Mean Corpuscular Hemoglobin	28.4	25.8 - 33.1 pg
Mean Corpuscular HGB Concentration	34.0	31.9 - 35.2 g/dL
Red Cell Distribution Width	14.7	11.5 - 15.3 %
Mean Platelet Volume	8.7	8.6 - 12.3 fL
NRBC %	0.0	0.0 - 0.0 %
NRBC #	<0.01	0.00 - 0.01 k/uL

Comprehensive Metabolic Panel

Result	Value	Ref Range
Sodium S/P	139	136 - 144 mmol/L
Potassium	3.4	3.3 - 5.0 mmol/L
Chloride	108	102 - 110 mmol/L
Carbon Dioxide	24	20 - 26 mmol/L

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

BUN	10	8 - 24 mg/dL
Creatinine S/P	0.90	0.72 - 1.25 mg/dL
Glucose	88	64 - 128 mg/dL
Anion Gap	7	5 - 14 mmol/L
Calcium	8.5	8.4 - 10.5 mg/dL
Protein, Total, S/P	7.0	6.5 - 8.4 g/dL
Albumin	3.9	3.5 - 5.0 g/dL
Bilirubin, Total	0.5	0.2 - 1.4 mg/dL
Alkaline Phosphatase	68	38 - 126 U/L
AST	35	16 - 40 U/L
ALT	48	0 - 55 U/L
eGFR, CKD-EPI CRT 2021	107	mL/min/1.73m2

Basic Metabolic Panel

Result	Value	Ref Range
Sodium S/P	138	136 - 144 mmol/L
Potassium		
Chloride	110	102 - 110 mmol/L
Carbon Dioxide	15 (L)	20 - 26 mmol/L
BUN	8	8 - 24 mg/dL
Creatinine S/P	1.00	0.72 - 1.25 mg/dL
Glucose	81	64 - 128 mg/dL
Anion Gap	13	5 - 14 mmol/L
Calcium	8.9	8.4 - 10.5 mg/dL
eGFR, CKD-EPI CRT 2021	94	mL/min/1.73m2

Magnesium, Plasma or Serum

Result	Value	Ref Range
Magnesium, S/P	2.1	1.6 - 2.6 mg/dL

Phosphorus, Inorganic, Plasma or Serum

Result	Value	Ref Range
Phosphorus, Inorganic, S/P	3.5	2.2 - 4.5 mg/dL

Thyroid Stimulating Hormone with reflex to Free Thyroxine

Result	Value	Ref Range
TSH	5.82 (H)	0.27 - 4.20 mU/L

Thyroxine, Free (Free T4)

Result	Value	Ref Range
Thyroxine Free	1.2	0.9 - 1.7 ng/dL

Basic Metabolic Panel

Result	Value	Ref Range
Sodium S/P	139	136 - 144 mmol/L
Potassium	3.7	3.3 - 5.0 mmol/L
Chloride	108	102 - 110 mmol/L
Carbon Dioxide	21	20 - 26 mmol/L
BUN	11	8 - 24 mg/dL
Creatinine S/P	0.94	0.72 - 1.25 mg/dL
Glucose	86	64 - 128 mg/dL
Anion Gap	10	5 - 14 mmol/L
Calcium	8.5	8.4 - 10.5 mg/dL
eGFR, CKD-EPI CRT 2021	101	mL/min/1.73m2

Gastrointestinal Pathogens Panel by PCR

Specimen: Stool

Result	Value	Ref Range
Campylobacter PCR	Not Detected	

Plesiomonas shigelloides PCR	Not Detected
Salmonella PCR	Not Detected
Vibrio PCR	Not Detected
Vibrio cholerae PCR	Not Detected
Yersinia enterocolitica PCR	Not Detected
Enteroaggregative E. coli (EAEC) PCR	Not Detected
Enteropathogenic E. coli (EPEC) PCR	Not Detected
Enterotoxigenic E. coli (ETEC) PCR	Not Detected
Shiga toxin-producing E. coli (STEC) PCR	Not Detected
E. coli O157 PCR	N/A
Shigella/Enteroinvasive E. coli PCR	Not Detected
Cryptosporidium PCR	Not Detected
Cyclospora cayetanensis PCR	Not Detected
Entamoeba histolytica PCR	Not Detected
Giardia lamblia PCR	Not Detected
Adenovirus 40/41 PCR	Not Detected
Astrovirus PCR	Not Detected
Norovirus GI/GII PCR	Not Detected
Rotavirus A PCR	Not Detected
Sapovirus PCR	Detected (A)

Toxigenic Clostridioides difficile by LFA with Reflex to PCR, Stool

Specimen: Stool

Result	Value	Ref Range
Toxigenic C. difficile Interpretation	Not Detected	

POC Glucose Fingerstick (Instrmt)

Result	Value	Ref Range
Glucose, Finger Stick	130 (H)	64 - 128 mg/dL

Blood Gas Analysis With Electrolytes (Pulmonary Lab)

Result	Value	Ref Range
pH - Venous	7.262 (L)	7.310 - 7.410
pCO2 - Venous	47.9	40.0 - 52.0 mm/Hg
pO2 - Venous	25.2 (L)	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	14.4	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	26.5 (L)	>=92.0 %
Carboxyhemoglobin - Venous	0.5	<=2.0 %
Methemoglobin - Venous	0.7	<1.0 %
Oxygen Saturation (sO2) - Venous	26.8 (L)	75.0 - 100.0 %
HCO3-, Venous	20.9	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.9 (L)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	44.2	40.1 - 52.5 %
O2 Content - Venous	5.4 (L)	17 - 24 vol%
Potassium - Venous	3.9	3.5 - 5.0 mmol/L
Sodium - Venous	145 (H)	136 - 144 mmol/L
Ionized Calcium - Venous	1.32 (H)	1.11 - 1.30 mmol/L
Glucose - Venous	122 (H)	65 - 110 mg/dL
Lactate - Venous	1.50	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	0	%orFlowrate

Blood Gas Analysis With Electrolytes (Pulmonary Lab)

Result	Value	Ref Range
pH - Venous	7.293 (L)	7.310 - 7.410
pCO2 - Venous	43.4	40.0 - 52.0 mm/Hg

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

pO2 - Venous	39.5	30.0 - 50.0 mm/Hg
Hemoglobin (HGB) - Venous	13.1	13.0 - 17.0 g/dL
Oxyhemoglobin - Venous	65.7 (L)	>=92.0 %
Carboxyhemoglobin - Venous	1.0	<=2.0 %
Methemoglobin - Venous	0.5	<1.0 %
Oxygen Saturation (sO2) - Venous	66.7 (L)	75.0 - 100.0 %
HCO3-, Venous	20.4	19.0 - 25.0 mmol/L
Base Excess (ECF) - Venous	-5.5 (L)	-2.5 - 2.5 mmol/L
Hematocrit (HCT) - Venous	40.2	40.1 - 52.5 %
O2 Content - Venous	12.1 (L)	17 - 24 vol%
Potassium - Venous	3.8	3.5 - 5.0 mmol/L
Sodium - Venous	142	136 - 144 mmol/L
Ionized Calcium - Venous	1.26	1.11 - 1.30 mmol/L
Glucose - Venous	126 (H)	65 - 110 mg/dL
Lactate - Venous	0.80	0.70 - 2.10 mmol/L
FIO2 or LPM	LPM	
FIO2 or LPM Amount	1	%orFlowrate

POC Glucose Fingerstick (Instrmt)

Result	Value	Ref Range
Glucose, Finger Stick	73	64 - 128 mg/dL

POC Glucose Fingerstick (Instrmt)

Result	Value	Ref Range
Glucose, Finger Stick	92	64 - 128 mg/dL

POC Glucose Fingerstick (Instrmt)

Result	Value	Ref Range
Glucose, Finger Stick	80	64 - 128 mg/dL

POC Glucose Fingerstick (Instrmt)

Result	Value	Ref Range
Glucose, Finger Stick	71	64 - 128 mg/dL

01/08/2025 - ED to Hosp-Admission (Discharged) in University Hospital Internal Medicine (continued)

Imaging - Results Only

MEDICAL IMAGING

CTA Abdomen Pelvis W IV Cont (Final result)

CTA Abdomen Pelvis W IV Cont Resulted: 01/08/25 1746, Result status: Final result

Ordering provider: Holly Smock, PA-C 01/08/25 1527
Resulted by: Jeffrey D Olpin, MD
Performed: 01/08/25 1710 - 01/08/25 1735
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/08/25 1747
Accession number: 17484548

Narrative:

EXAMINATION: CTA ABDOMEN PELVIS W IV CONT

INDICATION: Suspected mesenteric ischemia

TECHNIQUE: Helical images were obtained through the abdomen and pelvis following the protocol administration of nonionic intravenous contrast material. Because of the provided clinical history, late arterial phase images were obtained in addition to the standard portal venous phase images.

COMPARISON: None.

FINDINGS:

Lung Bases: Scattered atelectasis is noted at both lung bases.

Liver: Normal in morphology and contour. No focal abnormality. The portal veins are patent.

Gallbladder and Bile Ducts: Gallbladder is unremarkable. No bile duct dilation.

Kidneys: Symmetric nephrograms. No hydronephrosis.

Adrenal Glands: Normal in configuration. No nodule.

Spleen: Normal in size. No focal lesion.

Pancreas: Homogeneous enhancement without main duct dilation.

Bowel: The stomach is mildly distended with fluid. The small bowel loops are normal in course and caliber. There is diffuse colonic dilatation measuring up to 9.2 cm in maximum transverse diameter at the level of the proximal ascending colon. No evidence of intestinal obstruction is seen.

Pelvis: The prostate and seminal vesicles are unremarkable.

Mesentery/Peritoneum: No pneumoperitoneum. No free fluid or focal fluid collection.

Lymph Nodes: No abdominal or pelvic lymphadenopathy by size criteria.

Vasculature: The abdominal aorta is normal in course and caliber. There is no aneurysm or dissection. There is inferior displacement of the proximal celiac artery with associated stenosis due to the adjacent median arcuate ligament. The proximal celiac artery measures approximately 2 mm in maximum diameter. Mild poststenotic dilatation of the mid to distal celiac artery is noted. The hepatic and splenic arteries are widely patent. The superior and inferior mesenteric arteries are likewise normal in caliber.

Soft Tissues: Unremarkable

Bones: No acute or pathologic osseous abnormality.

Impression:

High-grade stenosis of the proximal celiac artery due to median arcuate ligament syndrome. No evidence of mesenteric ischemia seen.
Diffuse colonic dilatation to the level of the rectum, suggestive of underlying colonic ileus. No evidence of intestinal obstruction.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Jeffrey D Olpin, MD on 1/8/25 at 1746 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/08/25 2311, Result status: Final result

Ordering provider: Jamal Jones, MD 01/08/25 2123
Resulted by:
Eric Martin Christiansen, MD
Paulo Miro, MD
Performed: 01/08/25 2206 - 01/08/25 2213
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/08/25 2312
Accession number: 17485061

Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Evaluate nasogastric tube placement.

TECHNIQUE: Portable supine views of the abdomen and pelvis, 2 images.

COMPARISON: CTA abdomen and pelvis 1/8/2025.

FINDINGS:
Gastric tube tip and side fenestration project over the gastric body. Similar appearance of multiple air-filled mildly dilated colonic loops. No abnormally dilated loops of small bowel.

Impression:

1. Appropriately positioned gastric tube.

2. Similar appearance of multiple air-filled mildly dilated colonic loops.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Eric Martin Christiansen, MD on 1/8/25 at 2311 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/09/25 0232, Result status: Final result

Ordering provider: Natalie Marie Como, MD 01/08/25 2358
Resulted by: Eric Martin Christiansen, MD
Performed: 01/09/25 0130 - 01/09/25 0141
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/09/25 0233
Accession number: 17485192

Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Colonic distention

TECHNIQUE: Portable supine view of the abdomen

COMPARISON: Radiograph 1/8/2025

FINDINGS:
Nasogastric tube terminates in the stomach.
Similar diffuse gaseous distention of the colon. Posterior small bowel gas. Contrast within the right renal collecting system. No free air, pneumatosis or portal venous gas.

Impression:

Similar gaseous distention of the colon.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Eric Martin Christiansen, MD on 1/9/25 at 0232 MST

XR Chest 1 View (Final result)

XR Chest 1 View Resulted: 01/09/25 0749, Result status: Final result

Ordering provider: Lucas J Waddoups, PA-C 01/09/25 0651
Order status: Completed
Resulted by:
Jeremy Robert Burt, MD
David Riesberg, MD
Filed by: Interface, Powerscribe Magresults 01/09/25 0750
Performed: 01/09/25 0701 - 01/09/25 0701
Accession number: 17485410
Resulting lab: RADIANT AND CUPID PROCEDURES
Narrative:
EXAMINATION: BEDSIDE CHEST RADIOGRAPHY (One -view)

INDICATIONS: Shortness of breath.

COMPARISON EXAMINATION(S): CT abdomen and pelvis 1/8/2025.

FINDINGS:

CATHETERS, TUBES AND MEDICAL DEVICES: Partially visualized gastric tube, the tip of which terminates outside the field of view.

AIRWAYS, LUNGS AND PLEURA: No focal consolidation. No large pleural effusion. No pneumothorax. Bibasilar opacities, left greater than right. Low lung volumes.

HEART, MEDIASTINUM AND HILA : The cardiomediastinal silhouette is within normal limits, given radiographic technique.

SKELETAL STRUCTURES: No acute osseus abnormalities.

OTHER: Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm.

Impression:

1.Bibasilar opacities, left greater than right, compatible with atelectasis, however, superimposed infection is not excluded.

2.Multiple loops of gas-filled large bowel are present, measuring up to 7.2 cm, better characterized on prior CT abdomen and pelvis.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Jeremy Robert Burt, MD on 1/9/25 at 0749 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/09/25 0949, Result status: Final result

Ordering provider: Marissa Weeks, PA-C 01/09/25 0733
Order status: Completed
Resulted by:
Rebekah Leonila Cruz Aquino, MD
Samantha Salmon, MD
Filed by: Interface, Powerscribe Magresults 01/09/25 0950
Performed: 01/09/25 0839 - 01/09/25 0851
Accession number: 17485725
Resulting lab: RADIANT AND CUPID PROCEDURES
Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Surveillance of Ogilvie syndrome

COMPARISON: Abdominal radiographs 1/9/2025 at 0139 hours

FINDINGS:
Tubes, Lines and Other Devices: Gastric tube tip and side-port project over the stomach.

Bowel Gas Pattern: Diffuse gaseous distention of the colon, similar to prior.

Bones: No acute osseous abnormality.

Lung bases: Bibasilar subsegmental opacities.

Other Comments: Contrast material is present within the bladder.

Impression:

Unchanged diffuse gaseous distention of the colon.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Rebekah Leonila Cruz Aquino, MD on 1/9/25 at 0949 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/10/25 1704, Result status: Final result

Imaging - Results Only (continued)

Ordering provider: Olivia C Pearson, MD 01/10/25 0715
Resulted by:
Douglas Michael Rogers, MD
David Riesberg, MD
Performed: 01/10/25 0734 - 01/10/25 0740
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/10/25 1705
Accession number: 17490837

Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Colonic pseudoobstruction.

TECHNIQUE: Portable supine view of the abdomen

COMPARISON: Radiographs 1/9/2025.

FINDINGS:

Tubes, Lines and Other Devices: Gastric tube tip projects over the gastric antrum, the sidehole distal to the gastroesophageal junction.

Bowel Gas Pattern: Diffuse gaseous dilation of the colon, similar to prior. Similar gaseous distention of small bowel.

Bones: Degenerative changes but no acute osseous abnormalities.

Lung bases: Bibasilar opacities.

Impression:

Colonic dilation and distention of small bowel appears slightly increased; there is large stool burden in the right colon.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Douglas Michael Rogers, MD on 1/10/25 at 1704 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/11/25 0742, Result status: Final result

Ordering provider: Jenifer Hollingsworth, PA-C 01/10/25 1451
Resulted by:
Grace Zhu, MD
David Riesberg, MD
Performed: 01/11/25 0537 - 01/11/25 0537
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/11/25 0743
Accession number: 17495725

Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Colonic pseudoobstruction.

TECHNIQUE: Portable supine view of the abdomen

COMPARISON: Radiographs 1/10/2025.

FINDINGS:
Tubes, Lines and Other Devices: Gastric tube tip projects over the antrum, with the sidehole distal to the gastroesophageal

junction.

Bowel Gas Pattern: Diffuse gaseous distention of the colon, slightly decreased compared to prior.

Bones: Degenerative changes in the hips.

Lung bases: Bibasilar atelectasis.

Impression:

Colonic gaseous dilation is mildly improved compared to prior.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Grace Zhu, MD on 1/11/25 at 0742 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/11/25 2217, Result status: Final result

Ordering provider: Jenifer Hollingsworth, PA-C 01/11/25 1027
Order status: Completed
Resulted by:
Dell Petersen Dunn, MD
William Zachery Paden
Filed by: Interface, Powerscribe Magresults 01/11/25 2218
Performed: 01/11/25 2048 - 01/11/25 2049
Accession number: 17496771
Resulting lab: RADIANT AND CUPID PROCEDURES
Narrative:
EXAM: XR ABDOMEN 1 VIEW

INDICATIONS: Serial exam for Ogilvie's

COMPARISON: Abdominal radiograph 1/11/2025

FINDINGS:

Tubes, Lines and Other Devices: Interval removal of gastric tube.

Bowel Gas Pattern: Similar diffuse gaseous dilation of the colon with a few nondilated loops of small bowel.

Impression:

Similar diffuse gaseous dilation of the colon with transition at the proximal descending colon typical for Ogilvie syndrome.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Dell Petersen Dunn, MD on 1/11/25 at 2217 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/12/25 0839, Result status: Final result

Ordering provider: Jenifer Hollingsworth, PA-C 01/11/25 0848
Order status: Completed
Resulted by:
Grace Zhu, MD
Moataz Soliman, MD
Filed by: Interface, Powerscribe Magresults 01/12/25 0840
Performed: 01/12/25 0602 - 01/12/25 0602
Accession number: 17497105
Resulting lab: RADIANT AND CUPID PROCEDURES
Narrative:
EXAM: XR ABDOMEN 1 VIEW

HISTORY: Colonic pseudoobstruction follow-up.

COMPARISON: Abdominal radiograph 1/11/2025

TECHNIQUE: Supine radiograph of the abdomen.

FINDINGS:
Again noted diffuse colonic gaseous distention with other nondilated gas-filled small bowel loops. Of note, the descending colon is now decompressed compared to prior.

Left basilar patchy opacity. likely increasing atelectasis.

Degenerative changes of bilateral hips and lower lumbar spine.

Impression:

Similar or slightly decreased colonic gaseous distention.

Attending note: Agree with the above report, which was edited for clarity.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Grace Zhu, MD on 1/12/25 at 0839 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/12/25 2159, Result status: Final result

Ordering provider: Lauren Kay McCulloch, APRN 01/12/25 1951
Order status: Completed
Resulted by: Dell Petersen Dunn, MD
Filed by: Interface, Powerscribe Magresults 01/12/25 2200
Performed: 01/12/25 2109 - 01/12/25 2109
Accession number: 17498099
Resulting lab: RADIANT AND CUPID PROCEDURES
Narrative:
EXAM/TECHNIQUE: XR ABDOMEN 1 VIEW

INDICATIONS: Pt with colonic psuedo-obstruction, monitor cecal diameter.

COMPARISON: 1/12/2025 at 0602 hours

Imaging - Results Only (continued)

Impression:
FINDINGS/IMPRESSION:

Persistent dilation of the transverse colon, decreased dilation of the ascending colon, paucity of bowel gas seen distal to the splenic flexure consistent with slightly improved with ongoing colonic pseudoobstruction/Ogilvie syndrome.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by Dell Petersen Dunn, MD on 1/12/25 at 2159 MST

XR Abdomen 1 View (Final result)

XR Abdomen 1 View Resulted: 01/13/25 1211, Result status: Final result

Ordering provider: Glelynn Paige Casil, MD 01/13/25 1021
Resulted by: April Griffith, MD
Performed: 01/13/25 1106 - 01/13/25 1107
Resulting lab: RADIANT AND CUPID PROCEDURES
Order status: Completed
Filed by: Interface, Powerscribe Magresults 01/13/25 1212
Accession number: 17500057

Narrative:
EXAMINATION: XR ABDOMEN 1 VIEW

INDICATION: Evaluate for pseudoobstruction.

COMPARISON: Radiograph the abdomen 1/12/2024

TECHNIQUE: XR ABDOMEN 1 VIEW

FINDINGS:
Nondistended loops of colon, decreased in diameter compared to study 1/12/2025. Thumbprinting of the haustra.

Impression:

Nondistended loops of colon which have decrease in diameter compared to prior. However, there is haustral thumbprinting which can be seen in the setting of C. difficile infection.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
273 - Unknown	RADIANT AND CUPID PROCEDURES	Unknown	Unknown	09/27/13 1445 - Present

Signed

Electronically signed by April Griffith, MD on 1/13/25 at 1211 MST