TYPE OF CONSULTATION:, Wound care consult.,HISTORY OF PRESENT ILLNESS:, The patient is a 62-year-old woman with a past medical history significant for prior ileojejunal bypass for weight loss (1980) and then subsequent gastric banding (2002 Dr. X) who was transferred to this facility following a complicated surgical and postoperative course after takedown of the prior gastroplasty and bypass (07/08/2008, Dr. Y). The patient has been followed by Cardiothoracic Surgery (Dr. Z) as an outpatient. She had a history of daily postprandial vomiting, regurgitation, and heartburn. She underwent a preop assessment of her GERD and postprandial vomiting including nuclear gastric emptying studies, which showed increased esophageal retention with normal gastric emptying. Preoperative barium swallow demonstrated moderated esophageal dysmotility with incomplete emptying and a small hiatal hernia. It was recommended that she undergo an exploratory laparotomy and possible redo fundoplication and possible gastrectomy. She had already undergone multiple EGDs with dilatations without success. She continued to have abdominal discomfort.,On 07/07/2008, she was admitted to hospital. She underwent an exploratory laparotomy with esophagogastrectomy with esophagogastric anastomosis and Dor fundoplication, repair of hiatal hernia, small bowel resection x2 with primary anastomosis, extensive lysis of adhesions, insertion of a red-rubber J tube, and esophagogastroduodenoscopy. She also had her ileojejunal bypass reversed. Postoperatively, she was able to be

extubated. She was started on TPN, given the risk of not being able to tolerate enteral nutrition. Her operative note confirmed that the stomach pouch was enlarged with outlet obstruction where the band was. There was 2 hours of extensive lysis of adhesions. It took 2 hours to identify the colon. A defect was repaired in the transverse colon. The bypass segment of the anastomosis was seen between the proximal jejunum and the distal ileum, which was divided and the proximal jejunum was reconnected to the atretic blind limb of the small bowel. A red feeding tube was placed proximal to the anastomosis then tended to cross the anastomosis into the distal atretic small bowel for enteral feeds. The hiatal hernia was repaired as noted. The obstructed proximal gastric segment was resected. An anastomosis was made between the proximal intestine and the stomach and distal esophagus with Dor fundoplication. Omentectomy was performed due to devascularization. The wound was able to be closed with staples.,Postoperatively, the patient was started on IV antibiotics. She was able to be extubated. However, on 07/14/2008, she coded with shortness of breath and chest pain. She had respiratory failure, required endotracheal intubation and ICU management. CT scan of the abdomen and the pelvis confirmed that she had an anastomotic leak. Sputum cultures were positive ESBL Klebsiella. Blood cultures were negative. She was managed closely for sepsis with an elevated white cell count. She was also febrile. Her chest x-ray also showed left lower lobe consolidation. She had scattered contrast material in the anterior abdomen and

left upper quadrant due to the anastomotic leak. Her antibiotics were adjusted. Of note, the patient did have a JP drain placed out to the surface during her initial surgery. Followup CT scan on 07/16/2008 confirmed the anastomosis as the likely site of a fistula, as there was continued extraluminal enteric contrast seen within anterior abdomen just beneath the peritoneum as well as the left upper quadrant adjacent to the spleen. No enteric contrast was seen surrounding the patient's known GE junction leak. A JP drain was noted at the posterior aspect of the fundoplication. There was only a small amount of pelvic fluid. Follow up scan again on 07/25/2008 showed no abscess formation. On 08/05/2008, she did underwent an advancement of the #14 French red-rubber catheter feeding tube distal to the dehiscence of fistula into the distal small bowel. At the beginning of the procedure, the catheter did appear to traverse through an anastomotic suture line in the wound dehiscence. At some point during her course, the patient did undergo a second operative procedure, but I do not have any operative note at this time. She subsequently was left with a large open abdominal defect, which was being managed by the wound care nurses, which at the time of her transfer to this facility was being managed with a ""wound manager system."" to low-continuous wall suction. She was also transferred on tube feedings via the red rubber catheter 20 mL per hour. She is only to have her tube feeds increased by 10 mL a week to ensure tolerance. During her course, she was started on TPN. She was transferred on TPN here.,At the time of her transfer,

the patient was no longer on IV antibiotics. She is on Fragmin for DVT prophylaxis. During her course, she did have to undergo a tracheostomy. This has subsequently been removed and this site is healing. The tracheostomy was removed on 08/06/2008, I believe. At the time of her tracheostomy (on 07/22/2008), the patient also underwent a flexible bronchoscopy, which showed some secretions in the left airway (right was clear), which did not appear to be purulent. Of note also, pathology of her partial stomach resection showed Helicobacter pylori gastritis. There were no other significant abnormalities noted in the small intestine or omentum. On 08/11/2008, the patient was transferred to HealthSouth Monroeville LTAC for continued medical management, wound care, and rehab therapies.1,PAST MEDICAL HISTORY: ,History of diabetes with peripheral neuropathy - on Lyrica and Cymbalta preoperatively. History of hypothyroidism, history of B12 deficiency related to prior gastric surgeries, history of osteoarthritis, history of valvular disease (no details available), and cardiac arrhythmias.,PAST SURGICAL HISTORY:, Status post bilateral total knee replacements, status post right rotator cuff repair, status post sigmoid colectomy - no further details available, status post right breast lumpectomy for benign lesion, history of bladder repair, status post hysterectomy/tonsillectomy/appendectomy, history of lumbar spinal fusion - no further details available. History of MRSA in knees (previous surgery).,ALLERGIES:, MULTIPLE INCLUDING TETRACYCLINE, ERYTHROMYCIN, MORPHINE, SULFA DRUGS,

BETADINE, ADHESIVE TAPES, AND BANDAGE.,SOCIAL HISTORY:, Prior to admission, the patient lived alone in a one storied dwelling. She does have some equipment at home including a powered wheelchair, which she uses for longer distance. She does have some ambulatory devices also. She used to smoke, but quit about 10 years ago. She smoked 1 to 2 packs a day from age 18 to 54. She does not smoke.,FAMILY HISTORY:, Remarkable for cardiac disease with early death of her father at age 43 and mother had Alzheimer.,REVIEW OF SYSTEMS: , According to her notes, the patient's weight 07/10/2008 was 256 pounds. She has a BMI of 44 indicating morbid obesity. She had had a significant weight loss in the 6 months prior to this of 7%. As noted, she is on TPN and enteral feeds. Her prealbumin level noted on 07/10/2008 was low at 7. Prior to admission, the patient ate a regular diet, but had most likely weight loss and inadequate intake due to her chronic postprandial vomiting and esophageal dysmotility. She is currently NPO with NG to suction. The patient has no complaints of abdominal pain or discomfort at the time of this exam. She was awake and alert. MRSA screen on 07/14/2008 was negative.,PHYSICAL EXAMINATION:,General: The patient is a morbidly obese woman, who is in no acute distress at the time of this exam. She is lying comfortably on a low air loss mattress. She had just been assisted with cleaning up and had no complaints of pain or discomfort.,Vital Signs: Temperature is 98.9, pulse is 95, blood pressure is 123/69, and weight is 239 pounds.,HEENT: Normocephalic/atraumatic. Extraocular

muscles intact. Her mentation is good.,Neck: Stout. There is good range of motion.,Cor: Regular rate and rhythm. No murmurs appreciated.,Lungs: Fairly clear anteriorly.,Abdomen: Remarkable for a large open abdominal wound with a collection system in place covering the entire wound in midline. There is a JP drain and a red rubber catheter present. At present, the wound manager system is somewhat collapsed. She had just been on her side. It is connected to low continuous wall suction and removing fluid.,Musculoskeletal: There is PICC line present in the right upper extremity. No significant pedal edema. Bilateral knee scars from prior surgeries.,Skin: Reported intact at this time (not seen by me).,Neurological: Cranial nerves II through XII grossly intact. She is able to answer questions appropriately. She is able to raise both arms over head. She is able to raise her legs, but does need assistance. She has fair bed mobility and requires much assistance for any turning. Gait and transfers not tested.,SUMMARY: , In summary, the patient is a 62-year-old woman with a remote history of ileojejunal bypass followed by gastric banding to facilitate weight loss. However, she subsequently developed reflux associated with postprandial vomiting, which was found to be secondary to esophageal retention. On 07/08/2008, she underwent exploratory laparotomy with esophagogastrectomy with esophagogastric anastomosis and Dor fundoplication, hiatal hernia repair, small bowel resection, and lysis of adhesions. She has had a fairly rocky postoperative course and has subsequently underwent some type of re-exploration after she

was noted to have enteric contents draining from her JP drain with confirmed anastomotic leak. She has undergone placement on an NG tube. At present, she is on enteral feeds as well as TPN. During all these, she also coded and had respiratory failure, requiring vent management, but this has improved. Her trach has been removed and this site is healing. From the wound standpoint, her largest problem at this point is the abdominal wound, which is open. A wound manager system is currently in place, which is connected to low intermittent wall suction for drainage of the enteral contents still present. At present, the drainage is quite yellow in appearance. She has no significant complaints of pain at this time. At some point in her notes, there was mention of a negative pressure wound therapy being used to this wound, but this cannot be confirmed at this time. I will plan to contact Dr. Z's office to see whether or not they wanted to resume a wound VAC system to this wound. For now, we will continue with wound manager system. We will need to keep track of in's and out's of drainage from this site. Her fluid status will need to be monitored. In an attempt to get her mobilized, we will need extra care to be sure that this wound dressing/management system stays in place. She is eager and motivated to get mobilized. We will plan to ask Plastic (Dr. A) to be involved in following this wound also. Again, I will plan to call the surgeon's office for further directions. She is to follow up with Dr. Z in 2 weeks.,Later in afternoon, I was able to reach Dr. Z's office. I was called back by one of his nurses, who advised me that a wound VAC (negative pressure wound

therapy) was not to be used on this wound. They are using the wound manager system. She did report that the confusion came about with the inability during her discharge summary dictation that she was only able to cite a ""wound VAC"" when describing the system that was in place on the patient. She was using a formatted discharge summary program. At present, the patient has had some leakage from the system. According to my discussion with our wound care coordinator at this time, this system has been removed, with leakage repaired, and replaced with another wound manager system with suctioning continuing. Pictures were also taken of the wound bed. There were several staples apparently in place. I was not present at the time that this system had to be changed.