"Admission Date: [**2181-11-18**] Discharge Date: [**2181-11-28**]

Date of Birth: [**2127-12-6**] Sex: M

Service: NEUROSURGERY

Allergies:

Penicillins

Attending:[**First Name3 (LF) 1854**]

Chief Complaint:

CSF Rhinorrhea

Major Surgical or Invasive Procedure:

[**2181-11-21**]: Right Crani for dural repair and lumbar drain

placement

History of Present Illness:

53M with a recent discharge from the neurosurgical service on

[**2181-11-16**]. Underwent R temp craniotomy for metastatic

adenocarcinoma on [**2181-10-5**] followed by XRT 10 sessions finishing

mid [**Month (only) **]. Presented to [**Hospital1 18**] [**2181-11-7**] with post nasal salty

drainage and clear drainage from nose; admitted with lumbar

drain

placement for 1wk, was removed and had no nasal drainage.

Discharged [**2181-11-16**] and called back on [**11-18**] am stating salty

drainage from previous night back of throat and this morning

several

episodes ""gushes of clear fluid"" out his right nare. He also

complains of left calf pain beginning yesterday that is exquisitly tender. Pt has only mild headache. Pt denies fever, chills, weakness, neuro changes.

Past Medical History:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

[**2181-10-5**] - s/p Right craniotomy for resection of mass

Social History:

Social Hx: married, 50pk yr tobacco hx, occas EtOH

Physical Exam:

Upon Admission:

PHYSICAL EXAM:

O: T:98 BP:118/ 66 HR: 76 R16 O2Sats 95RA

Gen: WD/WN, comfortable, NAD.

HEENT: Pupils:3->2 EOMs full

Neck: Supple.

Extrem: Warm and well-perfused. Left calf non erythematous, no swelling, very tender to light touch posterior cald below knee, +[**Last Name (un) 5813**] sign on left, neg on right

Neuro:

Mental status: Awake and alert, cooperative with exam, normal affect.

Orientation: Oriented to person, place, and date.

Language: Speech fluent with good comprehension and repetition.

Naming intact. No dysarthria or paraphasic errors.

Cranial Nerves:

I: Not tested

II: Pupils equally round and reactive to light, 3to2

mm bilaterally.

III, IV, VI: Extraocular movements intact bilaterally without

nystagmus.

V, VII: Facial strength and sensation intact and symmetric.

VIII: Hearing intact to voice.

IX, X: Palatal elevation symmetrical.

[**Doctor First Name 81**]: Sternocleidomastoid and trapezius normal bilaterally.

XII: Tongue midline without fasciculations.

Motor: Normal bulk and tone bilaterally. No abnormal movements,

tremors. Strength full power [**6-12**] throughout. No pronator drift

Sensation: Intact to light touch bilaterally.

Toes downgoing bilaterally

Pertinent Results:

[**2181-11-18**] 03:10PM WBC-10.3 RBC-4.42* HGB-13.6* HCT-40.4 MCV-91

MCH-30.7 MCHC-33.6 RDW-14.8

[**2181-11-18**] 03:10PM NEUTS-70 BANDS-1 LYMPHS-17* MONOS-7 EOS-2

BASOS-0 ATYPS-2* METAS-1* MYELOS-0

Brief Hospital Course:

Mr. [**Known lastname 78957**] is a 53 yo Male readmitted to Nsurg on [**2181-11-18**] with CSF rhinorrhea. He had underwent a right craniotomy for mass resection on [**2181-10-5**]. The pathology was Metastatic adenocarcinoma. He was readmitted for CSF leak from [**2181-11-7**] to [**2181-11-16**] and had a lumbar drain from [**2181-11-9**] to [**2181-11-16**]. He had a recurrance of CSF rhinorrhea and was admitted on [**2181-11-18**].

Upon admission he also reported left calf tenderness with a positive [**Doctor Last Name **] sign. Lower extremity doppler study was negative on [**11-18**]. Repeat studies showed LLE thrombosis involving superficial calf veins. He was kept on bedrest until being taken to surgery on [**2181-11-21**] for a right craniotomy for dural repair and lumbar drain placement with Dr. [**Last Name (STitle) **]. He was extubated and transfered to the SICU after the procedure. The lumbar drain parameters were 15cc/CSF as goal.

Post-op CT imaging showed mild pneumocephalus and post-surgical changes. He was trasnfered to the [**Hospital Ward Name **] 11 floor. On [**11-22**] his HOB was at 25 degress max and he had no sign of CSF leak. On [**11-23**] he had a temp of 102. Fever work up was initiated which included CSF sample from lumbar drain. He became disoriented and agitated later that day. His CSF studies showed WBC 380. Peripheral WBC was 19.

He was transfered to the SICU. ID was consulted and Vancomycin and Cefipime were ordered. They recommended that the LD be removed. The tip was sent for culture which had no growth. The

patient improved clincally within 24 hours and had a normal neurological exam. He was transferred to surgical floor 48 hours later and remained afebrile. ID recommended 14 days of IV antibiotics and one week further treatment for C-Diff. He had no headache or rhinorrhea. PT recommended he be discharged home with with home PT on [**11-28**].

Medications on Admission:
Simvastatin 40 mg Tablet PO DAILY
Levetiracetam 500 mg 2 Tablets PO BID
Docusate Sodium 100 mg Tablet PO BID
Hydromorphone 2 mg Tablet PO Q4H PRN

Discharge Medications:
1. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2 times a day): Use while on pain medication hold for loose stools.
Disp:*40 Capsule(s)* Refills:*0*
2. Simvastatin 40 mg Tablet Sig: Two (2) Tablet PO DAILY (Daily).
3. Levetiracetam 500 mg Tablet Sig: Two (2) Tablet PO BID (2 times a day).
4. Hydromorphone 2 mg Tablet Sig: 1-2 Tablets PO Q4H (every 4 hours) as needed for pain.
Disp:*40 Tablet(s)* Refills:*0*
5. Vancomycin 250 mg Capsule Sig: One (1) Capsule PO Q6H (every 6 hours) for 3 days.
Disp:*12 Capsule(s)* Refills:*0*

6. Flagyl 500 mg Tablet Sig: One (1) Tablet PO three times a day for 3 days.
Disp:*9 Tablet(s)* Refills:*0*

7. Cefepime 2 gram Recon Soln Sig: One (1) Recon Soln Injection Q8H (every 8 hours) for 11 days.
Disp:*33 Recon Soln(s)* Refills:*0*

8. Heparin, Porcine (PF) 10 unit/mL Syringe Sig: One (1) ML Intravenous PRN (as needed) as needed for line flush for 11 days.
Disp:*33 ML(s)* Refills:*0*

9. PICC Line
PICC Line care per home infusion protocols

10. Vancomycin 750 mg Recon Soln Sig: Two (2) Intravenous twice a day for 11 days.
Disp:*44 * Refills:*0*

11. Outpatient Lab Work
Please draw CBC, BUN, Creatinine, vanco trough

Discharge Disposition:
Home With Service

Facility:
[**Location (un) **] Nursing Services

Discharge Diagnosis:
CSF Rhinorrhea
s/p right craniotomy for dural repair

Discharge Condition:

Neurologically stable

Discharge Instructions:

General Instructions

?????? Have a friend/family member check your incision daily for signs of infection.

?????? Take your pain medicine as prescribed.

?????? Exercise should be limited to walking; no lifting, straining, or excessive bending.

?????? You may wash your hair only after sutures and/or staples have been removed.

?????? You may shower before this time using a shower cap to cover your head.

?????? Increase your intake of fluids and fiber, as narcotic pain medicine can cause constipation. We generally recommend taking an over the counter stool softener, such as Docusate (Colace) while taking narcotic pain medication.

?????? Unless directed by your doctor, do not take any anti-inflammatory medicines such as Motrin, Aspirin, Advil, and Ibuprofen etc.

?????? If you have been prescribed an anti-seizure medicine, take it as prescribed and follow up with laboratory blood drawing in one week. Please have results faxed to [**Telephone/Fax (1) 87**].

?????? Clearance to drive and return to work will be addressed at your post-operative office visit.

CALL YOUR SURGEON IMMEDIATELY IF YOU EXPERIENCE ANY OF THE

FOLLOWING

?????? New onset of tremors or seizures.

?????? Any confusion or change in mental status.

?????? Any numbness, tingling, weakness in your extremities.

?????? Pain or headache that is continually increasing, or not

relieved by pain medication.

?????? Any signs of infection at the wound site: redness, swelling,

tenderness, or drainage.

?????? Fever greater than or equal to 101?????? F.

Followup Instructions:

Follow-Up Appointment Instructions

??????Please return to the office on Monday [**12-5**] @ 1100 for

removal of your staples or sutures.

??????Provider: [**Name10 (NameIs) 706**] MRI Phone:[**Telephone/Fax (1) 327**] Date/Time:[**2181-12-10**]

1:15

Provider: [**First Name11 (Name Pattern1) 640**] [**Last Name (NamePattern4) 4861**], MD Phone:[**Telephone/Fax (1) 1844**] Date/Time:[**2181-12-10**]

3:00

Completed by:[**2181-11-28**]"

"Admission Date: [**2181-10-3**] Discharge Date: [**2181-10-7**]

Date of Birth: [**2127-12-6**] Sex: M

Service: NEUROSURGERY

Allergies:

Penicillins

Attending:[**First Name3 (LF) 1854**]

Chief Complaint:

CC:[**CC Contact Info **]

Major Surgical or Invasive Procedure:

[**2181-10-5**]: Right Crani for Mass Resection

History of Present Illness:

HPI: 53 yo M with 2-3 week history of R Sided headaches, worsening in severity over the past several days. Yesterday awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan today. Pt. states friends have noticed that he has been confused lately and he reports generalized weakness, but denies nausea, blurred vision or diplopia, loss of balance. CT Scan demonstrates large R Temporal mass with mass effect creating midline shift. PT transferred via Med flight from OHS, received 10mg Decadron and IV Morphine.

Past Medical History:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Social History:

Married lives with wife. [**Name (NI) 1139**]: 50 pack-year. Quit 1 month ago

ETOH occasional. Toxic Exposure: none

Family History:

non-contributory

Physical Exam:

PE on Admission:

PHYSICAL EXAM:

O: BP: 122/80 HR: 61 R: 20 O2Sats: 94% RA

Gen: WD/WN, comfortable, NAD.

HEENT: Normocephalic, Atraumatic. Pupils: [**3-11**] Bilaterally. EOMs intact.

Extrem: Warm and well-perfused.

Neuro:

Mental status: Awake and alert, cooperative with exam, normal affect.

Orientation: Oriented to person, place, and date.

Language: Speech fluent with good comprehension and repetition.

Naming intact. No dysarthria or paraphasic errors.

Cranial Nerves:

I: Not tested

II: Pupils equally round and reactive to light, 2 to 1

mm bilaterally. Visual fields are full to confrontation.

III, IV, VI: Extraocular movements intact bilaterally without

nystagmus.

V, VII: Facial strength and sensation intact and symmetric.

VIII: Hearing intact to voice.

IX, X: Palatal elevation symmetrical.

[**Doctor First Name 81**]: Sternocleidomastoid and trapezius normal bilaterally.

XII: Tongue midline without fasciculations.

Motor: Normal bulk and tone bilaterally. No abnormal movements,

tremors. Strength full RUE, but [**5-13**] LUE, and [**5-13**] bilateral LE.

R-Sided pronator drift

Toes downgoing bilaterally

PE on d/c

O: BP: 122/80 HR: 61 R: 20 O2Sats: 94% RA

Gen: WD/WN, comfortable, NAD.

HEENT: Normocephalic, patient with crainiotomy scar, . Pupils:

[**4-9**] Bilaterally. EOMs

intact.

Extrem: Warm and well-perfused.

Neuro exam:

All CN intact,

motor full strength in all ext, no sensory deficits

ambulating

Pertinent Results:

MR head w/w/o ([**2181-10-6**]):

IMPRESSION: Postoperative changes with resection of right temporal mass. No residual enhancement seen. No acute infarct identified. Mass effect on the right lateral ventricle and mild midline shift are again seen with brain edema as before.

CT CHEST W/CONTRAST; CT ABD W&W/O C; CT PELVIS W/CONTRAST ([**2181-10-4**]):

IMPRESSION:

1. No evidence of metastatic disease.

2. No renal calculi or collecting system masses.

MR HEAD W & W/O CONTRAST ([**2181-10-3**])

IMPRESSION:

1. New large right anterior temporal intra-axial mass, 3 mm left parietal focus of enhancement and a questionable third focus areas of enhancement within the left parietal peripheral region strongly concerning for metastatic disease.

2. Marked midline shift of 1.3 cm to the contralateral left side and uncal

herniation. Small amount of subfalcine herniation.

Brief Hospital Course:

Patient was admitted with 2-3 weeks of R sided HA, was sent in with CT scan of head showing new R temporal mass with mass effect and midline shift. The patient was started on decadron and morphine. Patient was loaded with dilantin and admitted to ICU. f/u MRI revealed a new large right anterior temporal intra-axial mass, 3 mm left parietal focus of enhancement and a questionable third focus areas of enhancement within the left parietal peripheral region strongly concerning for metastatic disease. On [**10-5**] the patient had R sided crainiotomy for resection of the mass. The patient had a unremarkable post op course with the f/u MRI showing no residual tumor, with residual edema. The resected mass was sent for pathology and the patient will follow up in Brain [**Hospital 341**] Clinic.

Discharge Medications:

1. Acetaminophen 325 mg Tablet Sig: 1-2 Tablets PO Q6H (every 6 hours) as needed for Headache.
2. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2 times a day).
Disp:*60 Capsule(s)* Refills:*2*
3. Simvastatin 40 mg Tablet Sig: Two (2) Tablet PO DAILY (Daily).
4. Phenytoin Sodium Extended 100 mg Capsule Sig: Two (2) Capsule

PO BID (2 times a day).

Disp:*120 Capsule(s)* Refills:*2*

5. Hydromorphone 2 mg Tablet Sig: 1-2 Tablets PO Q4H (every 4 hours) as needed for headache.

Disp:*60 Tablet(s)* Refills:*0*

6. Dexamethasone 2 mg Tablet Sig: One (1) Tablet PO As Directed: Take 2 tablets every 8 hrs for day 1, then 2 tablets every 12 hours for day 2, then 1 tablet every 12 hours every day.

Disp:*60 Tablet(s)* Refills:*2*

7. Protonix 20 mg Tablet, Delayed Release (E.C.) Sig: One (1) Tablet, Delayed Release (E.C.) PO once a day.

Disp:*30 Tablet, Delayed Release (E.C.)(s)* Refills:*2*

Discharge Disposition:

Home

Discharge Diagnosis:

Right Temporal Mass

Discharge Condition:

Neurologically Stable

Discharge Instructions:

General Instructions/Information

?????? Have a friend/family member check your incision daily for signs of infection.

?????? Take your pain medicine as prescribed.

?????? Exercise should be limited to walking; no lifting, straining, or excessive bending.

?????? You may wash your hair only after sutures and/or staples have been removed. If your wound closure uses dissolvable sutures, you must keep that area dry for 10 days.

?????? You may shower before this time using a shower cap to cover your head.

?????? Increase your intake of fluids and fiber, as narcotic pain medicine can cause constipation. We generally recommend taking an over the counter stool softener, such as Docusate (Colace) while taking narcotic pain medication.

?????? Unless directed by your doctor, do not take any anti-inflammatory medicines such as Motrin, Aspirin, Advil, and Ibuprofen etc.

?????? You have been prescribed Dilantin (Phenytoin) for anti-seizure medicine, take it as prescribed and follow up with laboratory blood drawing in one week. This can be drawn at your PCP??????s office, but please have the results faxed to [**Telephone/Fax (1) 87**].

?????? You are being sent home on steroid medication, make sure you are taking a medication to protect your stomach (Prilosec, Protonix, or Pepcid), as these medications can cause stomach irritation. Make sure to take your steroid medication with meals, or a glass of milk.

?????? Clearance to drive and return to work will be addressed at your post-operative office visit.

?????? Make sure to continue to use your incentive spirometer while at home.

CALL YOUR SURGEON IMMEDIATELY IF YOU EXPERIENCE ANY OF THE FOLLOWING

?????? New onset of tremors or seizures.

?????? Any confusion or change in mental status.

?????? Any numbness, tingling, weakness in your extremities.

?????? Pain or headache that is continually increasing, or not relieved by pain medication.

?????? Any signs of infection at the wound site: increasing redness, increased swelling, increased tenderness, or drainage.

?????? Fever greater than or equal to 101?????? F.

Followup Instructions:

Follow-Up Appointment Instructions

?????? Please return to the office in [**8-17**] days (from your date of surgery) for removal of your staples/sutures and a wound check.

This appointment can be made with the Nurse Practitioner.

Please make this appointment by calling [**Telephone/Fax (1) 1669**]. If you live quite a distance from our office, please make arrangements for the same, with your PCP.

?????? You will be called with an appointment in the Brain [**Hospital 341**] Clinic. The Brain [**Hospital 341**] Clinic is located on the [**Hospital Ward Name 516**] of [**Hospital1 18**], in the [**Hospital Ward Name 23**] Building. Their phone number is [**Telephone/Fax (1) 1844**]. Please call if you need to change your appointment, or require additional directions.

?????? You will not need an MRI of the brain as this was done during your acute hospitalization

The following appointments have been included for your convenience:

Provider: [**Name10 (NameIs) **] SCAN Phone:[**Telephone/Fax (1) 327**] Date/Time:[**2181-10-23**] 11:30

Provider: [**First Name8 (NamePattern2) 251**] [**Name11 (NameIs) **], MD Phone:[**0-0-**]

Date/Time:[**2181-11-1**] 10:00

Provider: [**First Name11 (Name Pattern1) **] [**Last Name (NamePattern4) 12766**], MD Phone:[**Telephone/Fax (1) 22**]

Date/Time:[**2181-11-1**] 10:00

"

"Baseline artifact is present. Sinus rhythm. Normal tracing. Compared to the

previous tracing there is no significant change.

"

"Sinus rhythm. Borderline low limb lead voltage. Early R wave progression.

Since the previous tracing of [**2181-10-4**] the rate has increased.

"

"Sinus bradycardia. Compared to the previous tracing there is no diagnostic

change.

TRACING #2

"

"Sinus rhythm. Minor non-diagnostic repolarization abnormalities. Compared to

the previous tracing of [**2180-8-17**] some T wave flattening now present. Otherwise,

no major change.

TRACING #1

"

"Temporal lobe mass

Assessment:

CT scan showing right sided temporal lobe mass with midline shift. Pt alert & orientated x 3. Pt occasionally needs repeated direction for tasks. Strong to all extremities. Denies numbness or tingling. WBC elevated. Pt afebrile.

Action:

MRI scan completed. CT scan completed. Neuro vitals q 1 hour. Dilantin q 8 hours & decadron given IV. Pt NPO for possible OR tomorrow.

Response:

Pt continues to be alert & orientated. Dilantin level post load dose is <10. Creatinine elevated.

Plan:

? Pending OR for removal of mass. No date set at this time.

"

"TSICU

HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after midnight

Chief complaint:

severe headache

PMHx:

PMH: Adenocarcianoma; s/p VATS L lower lobectomy, Nephrolithiasis Hyperlipidemia

PSH: Left lwoer lobectomy

[**Last Name (un) **]: simvastatin

Current medications:

1000 mL NS 3. Acetaminophen 4. Bisacodyl 5. Dexamethasone 6. Docusate Sodium 7. Famotidine 8. Insulin 9. Morphine Sulfate 10. Ondansetron 11. Phenytoin 12. Senna 13. Simvastatin 14. Sodium Chloride 0.9% Flush

24 Hour Events:

MAGNETIC RESONANCE IMAGING - At [**2181-10-3**] 09:30 PM

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Dilantin - [**2181-10-4**] 02:15 AM

Morphine Sulfate - [**2181-10-4**] 04:15 AM

Other medications:

Flowsheet Data as of [**2181-10-4**] 05:33 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 36.4

C (97.6

T current: 36.4

C (97.6

HR: 61 (57 - 71) bpm

BP: 132/86(97) {106/54(67) - 134/86(103)} mmHg

RR: 15 (9 - 23) insp/min

SPO2: 91%

Heart rhythm: SR (Sinus Rhythm)

Total In:

119 mL

386 mL

PO:

Tube feeding:

IV Fluid:

119 mL

386 mL

Blood products:

Total out:

500 mL

300 mL

Urine:

500 mL

300 mL

NG:

Stool:

Drains:

Balance:

-381 mL

86 mL

Respiratory support

O2 Delivery Device: None

SPO2: 91%

ABG: ///24/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 3), (Responds to: Verbal stimuli, Tactile stimuli, Noxious stimuli), No(t) Moves all extremities, (LUE: Weakness)

Labs / Radiology

269 K/uL

14.7 g/dL

138 mg/dL

1.3 mg/dL

24 mEq/L

4.5 mEq/L

22 mg/dL

107 mEq/L

141 mEq/L

45.7 %

13.6 K/uL

[image002.jpg]

[**2181-10-4**] 02:01 AM

WBC

13.6

Hct

45.7

Plt

269

Creatinine

1.3

Glucose

138

Other labs: PT / PTT / INR:11.4/23.8/0.9, Albumin:4.0 g/dL, Ca:9.6 mg/dL, Mg:2.1 mg/dL, PO4:2.9 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: ASSESSMENT AND PLAN:

NEURO: Dilantin load - check am level, f/u MRI final read. Decadron 10 pre-hospital, now 4 q6. Neurosurg to take to OR today. LUE weakness, mild pronator drift

Neuro checks Q:1

Pain: morphine

CVS: HD stable, hct 45.7, no active issues

PULM: OSA/CPAP overnight, sats mid 90's

GI: NPO for OR

RENAL: Cr 1.3 (baseline 1-1.2); hydrate - s/p dye load

HEME: hct 45.7 ->stable

ENDO: RISS

ID: No active issues, WBC 13.6, afebrile

TLD: PIV

IVF: LR @75

CONSULTS: Neurosurg

BILLING DIAGNOSIS:

ICU CARE:

GLYCEMIC CONTROL:

PROPHYLAXIS:

DVT - boots

STRESS ULCER - pepcid

VAP BUNDLE -

COMMUNICATIONS: patient

ICU Consent: pending

CODE STATUS: full

DISPOSITION: ICU

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

16 Gauge - [**2181-10-3**] 08:00 PM

18 Gauge - [**2181-10-3**] 08:00 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting planning Comments:

Code status: Full code

Disposition: ICU

Total time spent:

"

"[**Last Name **] Problem

Temporal [**Name2 (NI) **] mass

Assessment:

CT scan showing right sided temporal [**Name2 (NI) **] mass with midline shift. Pt

alert & orientated x 3. Pt occasionally needs repeated direction for

tasks. Strong to all extremities. Denies numbness or tingling. WBC

elevated. Pt afebrile.

Action:

MRI scan completed. CT scan completed. Neuro vitals q 1 hour.

Dilantin q 8 hours & decadron given IV. Pt NPO for possible OR

tomorrow.

Response:

Pt continues to be alert & orientated. Dilantin level post load dose

is <10. Creatinine elevated.

Plan:

? Pending OR for removal of mass. No date set at this time.

"

"HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE

weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after

midnight

Chief complaint:

severe headache

PMHx:

PMH: Adenocarcianoma; s/p VATS L lower lobectomy, Nephrolithiasis

Hyperlipidemia

PSH: Left lwoer lobectomy

[**Last Name (un) **]: simvastatin

Temporal Lobe Mass

Assessment:

Pt alert and oriented x 3. Pleasant. MAE

s with equal strength.

Requires frequent reminding with directions. + cough, gag, corneals.

Action:

Neuro exam q 1 hour

Dilantin re-loaded and as ordered

Chest CT

Response:

Neuro exam remains the same

Plan:

NPO p mn for OR

Continue q 1 hour neuro exam

"

"[**Last Name **] Problem

Temporal [**Name2 (NI) **] mass

Assessment:

CT scan showing right sided temporal [**Name2 (NI) **] mass with midline shift. Pt alert & orientated x 3. Pt occasionally needs repeated direction for tasks. Strong to all extremities. Denies numbness or tingling.

Action:

MRI scan completed. Neuro vitals q 1 hour. Dilantin q 8 hours & decadron given IV.

Response:

Pt continues to be alert & orientated.

Plan:

? Pending OR for removal of mass. No date set at this time.

"

"TSICU

HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after midnight

Chief complaint:

severe headache

PMHx:

PMH: Adenocarcianoma; s/p VATS L lower lobectomy, Nephrolithiasis

Hyperlipidemia

PSH: Left lwoer lobectomy

[**Last Name (un) **]: simvastatin

Current medications:

1000 mL NS 3. Acetaminophen 4. Bisacodyl 5. Dexamethasone 6. Docusate

Sodium 7. Famotidine 8. Insulin 9. Morphine Sulfate 10. Ondansetron

11. Phenytoin 12. Senna 13. Simvastatin 14. Sodium Chloride 0.9% Flush

24 Hour Events:

MAGNETIC RESONANCE IMAGING - At [**2181-10-3**] 09:30 PM

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Dilantin - [**2181-10-4**] 02:15 AM

Morphine Sulfate - [**2181-10-4**] 04:15 AM

Other medications:

Flowsheet Data as of [**2181-10-4**] 05:33 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 36.4

C (97.6

T current: 36.4

C (97.6

HR: 61 (57 - 71) bpm

BP: 132/86(97) {106/54(67) - 134/86(103)} mmHg

RR: 15 (9 - 23) insp/min

SPO2: 91%

Heart rhythm: SR (Sinus Rhythm)

Total In:

119 mL

386 mL

PO:

Tube feeding:

IV Fluid:

119 mL

386 mL

Blood products:

Total out:

500 mL

300 mL

Urine:

500 mL

300 mL

NG:

Stool:

Drains:

Balance:

-381 mL

86 mL

Respiratory support

O2 Delivery Device: None

SPO2: 91%

ABG: ///24/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 3), (Responds to: Verbal stimuli, Tactile stimuli, Noxious stimuli), No(t) Moves all extremities, (LUE: Weakness)

Labs / Radiology

269 K/uL

14.7 g/dL

138 mg/dL

1.3 mg/dL

24 mEq/L

4.5 mEq/L

22 mg/dL

107 mEq/L

141 mEq/L

45.7 %

13.6 K/uL

[**2181-10-4**] 02:01 AM

WBC

13.6

Hct

45.7

Plt

269

Creatinine

1.3

Glucose

138

Other labs: PT / PTT / INR:11.4/23.8/0.9, Albumin:4.0 g/dL, Ca:9.6 mg/dL, Mg:2.1 mg/dL, PO4:2.9 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: ASSESSMENT AND PLAN:

NEURO: Dilantin load - check am level, f/u MRI final read. Decadron 10 pre-hospital, now 4 q6. Neurosurg to stage his disease. Possible OR tomorrow. LUE weakness, mild pronator drift but improving slight. Headache is improving but swelling is impressive on the CT with midline shift. Phenytoin level 7.1 and rebolused. We will check the levels.

Neuro checks Q:1

Pain: morphine

CVS: HD stable, hct 45.7, no active issues

PULM: OSA/CPAP overnight, sats mid 90's. Has OSA

GI: TF for today

RENAL: Cr 1.3 (baseline 1-1.2); hydrate - s/p dye load. We will followp up.

HEME: hct 45.7 ->stable

ENDO: RISS

ID: No active issues, WBC 13.6, afebrile

TLD: PIV

IVF: KVO

CONSULTS: Neurosurg

BILLING DIAGNOSIS:

ICU CARE:

GLYCEMIC CONTROL:

PROPHYLAXIS:

DVT - boots

STRESS ULCER - pepcid

VAP BUNDLE -

COMMUNICATIONS: patient

ICU Consent: pending

CODE STATUS: full

DISPOSITION: ICU

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

16 Gauge - [**2181-10-3**] 08:00 PM

18 Gauge - [**2181-10-3**] 08:00 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting planning Comments:

Code status: Full code

Disposition: ICU

Total time spent: 35

"

"Temporal mass

Assessment:

Pt alert and orientated x 3. appropriate. Pt requires reminders and guidance and supervision with care. Pt stated concerns regarding surgery tomorrow. Pt stated

maybe I

ll cancel the surgery

. Pt made

of possible complications regarding not going for surgery.

Action:

Neuro checks continue q 1 hour. Dilantin iv q 8 hours. Decondron IV q 6 hours. Tylenol & morphine for discomfort.

Response:

No changes in mental status.

Plan:

Continue with q 1 neuro vitals. Plan to OR in afternoon. NPO after midnight.

"

"Pt. is a 53y.o. with PMH of lung mass s/p resection last year. Pt. admitted with severe headache [**10-3**]. MRI/CT revealed right temporal mass with midline shift. Physical findings: left pronator drift and LUE weakness. Pt. placed on decadron and dilantin and underwent resection yesterday, OR uneventful.

PMHx:

PM/SH: Adenocarcianoma; s/p VATS, left lower lobectomy, Nephrolithiasis, Hyperlipidemia

Home meds: simvastatin

Temporal Lobe Mass

Assessment:

Pt alert and oriented x 3. Pleasant. MAE
s with some left upper
extremety weakness/
clumsiness
. Can lift and hold. OOB to chair
without difficulty. Slightly impulsive at times, needs limit setting
re: listening to directions. Pt. having moderate to severe headaches
[**2182-7-18**]. VSS.

Action:

Neuro exam q 1 hour, changed to Q4hr.

Dilantin and decadron as odered.

Post-op MRI done this morning without incident
results
pending.

Pain control with Dilaudid IV; switched to PO this
afternoon.

Response:

Neurologically stable. Fair pain control with IV Dilaudid, pending
effects of PO, given 1320.

Plan:

Transfer to floor, Q4hr neuro assessments, monitor and treat
as indicated.

Demographics

Attending MD:

[**Doctor Last Name **] [**Doctor Last Name **] C.

Admit diagnosis:

MASS,UNSPECIFIED LOCATION

Code status:

Full code

Height:

Admission weight:

113.3 kg

Daily weight:

112 kg

Allergies/Reactions:

Penicillins

Rash;

Precautions: No Additional Precautions

PMH:

CV-PMH:

Additional history: Lung CA s/p Left lower lung lobe resection 08

sleep apnea uses bipap @ home.

Surgery / Procedure and date: [**10-5**] right temp. tumor resection

Latest Vital Signs and I/O

Non-invasive BP:

S:123

D:78

Temperature:

96.9

Arterial BP:

S:106

D:81

Respiratory rate:

15 insp/min

Heart Rate:

72 bpm

Heart rhythm:

SR (Sinus Rhythm)

O2 delivery device:

None

O2 saturation:

92% %

O2 flow:

3 L/min

FiO2 set:

24h total in:

1,047 mL

24h total out:

1,080 mL

Pertinent Lab Results:

Sodium:

140 mEq/L

[**2181-10-6**] 03:11 AM

Potassium:

4.4 mEq/L

[**2181-10-6**] 03:11 AM

Chloride:

105 mEq/L

[**2181-10-6**] 03:11 AM

CO2:

22 mEq/L

[**2181-10-6**] 03:11 AM

BUN:

24 mg/dL

[**2181-10-6**] 03:11 AM

Creatinine:

1.3 mg/dL

[**2181-10-6**] 03:11 AM

Glucose:

123 mg/dL

[**2181-10-6**] 03:11 AM

Hematocrit:

40.5 %

[**2181-10-6**] 03:11 AM

Finger Stick Glucose:

114

[**2181-10-6**] 10:00 AM

Additional pertinent labs:

*** creat trending down to baseline

Lines / Tubes / Drains:

Valuables / Signature

Patient valuables: Glasses

Other valuables:

Clothes: Transferred with patient

Wallet / Money:

No money / wallet

Cash / Credit cards sent home with:

Jewelry: NONE

Transferred from: [**Hospital 230**]

Transferred to: 1108

Date & time of Transfer: [**2181-10-6**] 1440

"

"Pt. is a 53y.o. with PMH of lung mass s/p resection last year. Pt.

admitted with severe headache [**10-3**]. MRI/CT revealed right temporal

mass with midline shift. Physical findings: left pronator drift and LUE weakness. Pt. placed on decadron and dilantin and underwent resection yesterday, OR uneventful.

PMHx:

PM/SH: Adenocarcianoma; s/p VATS, left lower lobectomy, Nephrolithiasis, Hyperlipidemia

Home meds: simvastatin

Temporal Lobe Mass

Assessment:

Pt alert and oriented x 3. Pleasant. MAE
s with some left upper
extremety weakness/
clumsiness
. Can lift and hold. OOB to chair without difficulty. Slightly impulsive at times, needs limit setting re: listening to directions. Pt. having moderate to severe headaches [**2182-7-18**]. VSS.

Action:

Neuro exam q 1 hour, changed to Q4hr.

Dilantin and decadron as odered.

Post-op MRI done this morning without incident
results
pending.

Pain control with Dilaudid IV; switched to PO this afternoon.

Response:

Neurologically stable. Fair pain control with IV Dilaudid, pending effects of PO, given 1320.

Plan:

Transfer to floor, Q4hr neuro assessments, monitor and treat

as indicated.

"

"[**Last Name **] Problem - [**Name (NI) 10**] Description In Comments

Assessment:

Pt alert and oriented x3

Pupils equal and reactive to light

Right arm and right leg normal strength\

Left arm is weaker than right, pt does have a slight left

pronater drift

Left leg is slightly weaker this at 12 o

clock than this

morning [**First Name8 (NamePattern2) **] [**Last Name (NamePattern1) **](neurosurgical np) aware, dr. [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] aware

Dilantin level back as 7.6

Pt continues on decadron iv

Pt c/o headache, pt rated pain a scale 5 on a [**2-17**]

Action:

Pt to received an additional 300mg of iv dilanitin

Pt received morphine 2mg of iv morphine

Response:

Pain level down to a 2, which pt states is an acceptable

level of pain

Plan:

Continue to monitor

Pt to OR

Add: Dilantin 300mg iv started, pt c/o pain at the iv site, iv dilantin

stopped, pt to receive dilantin in OR when more iv access is obtain per

dr. [**First Name8 (NamePattern2) **] [**Last Name (NamePattern1) 8574**], [**First Name8 (NamePattern2) 553**] [**Last Name (NamePattern1) 581**] aware, and also or nurse [**Doctor First Name **] called and

aware

"

"HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE

weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after

midnight

Chief complaint:

severe headache

PMHx:

PMH: Adenocarcianoma; s/p VATS L lower lobectomy, Nephrolithiasis

Hyperlipidemia

PSH: Left lwoer lobectomy

[**Last Name (un) **]: simvastatin

Temporal Lobe Mass

Assessment:

Pt alert and oriented x 3. Pleasant. MAE

s with equal strength.

Requires frequent reminding with directions. + cough, gag, corneals.

Action:

Neuro exam q 1 hour

Dilantin re-loaded and as ordered

Chest CT

Response:

Neuro exam remains the same. Dilantin level WNL.

Plan:

NPO p mn for OR

Continue q 1 hour neuro exam

"

"SICU

HPI:

[**10-5**] HD3

Antibiotic:None

Anticoagulant:None

Antiseizure: Dilantin 100mg TID

Diagnosis: Rt Temporal Mass

Headache

HPI: 53 yo M with 2-3 week history of R Sided headaches,

worsening in severity over the past several days. Yesterday

awoke with a [**11-17**] headache and went to PCP's office, who ordered

a CT Scan today. Pt. states friends have noticed that he has been

confused lately and he reports generalized weakness, but denies

nausea, blurred vision or diplopia, loss of balance. CT Scan

demonstrates large R Temporal mass with mass effect creating

midline shift. PT transferred via Med flight from OHS, received

10mg Decadron and IV Morphine.

Chief complaint:

Headaches/confusion

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior to admission:

1. Simvastatin 80mg 1 PO Daily

2. Tricor - Dosage uncertain

Social Hx: Married, 4 living children. Currently employed as

Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased

from a traumatic fall.

ROS: Negative otherwise noted in HPI.

Current medications:

Active Medications [**Known lastname 8558**],[**Known firstname **]

1. 2. 1000 mL NS 3. Acetaminophen 4. Bisacodyl 5. Dexamethasone 6.

Docusate Sodium 7. Famotidine

8. Insulin 9. Morphine Sulfate 10. Morphine Sulfate 11. Ondansetron 12.

Phenytoin 13. Phenytoin

14. Senna 15. Simvastatin 16. Sodium Chloride 0.9% Flush

24 Hour Events:

MAGNETIC RESONANCE IMAGING - At [**2181-10-3**] 09:30 PM

NASAL SWAB - At [**2181-10-4**] 02:00 AM

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2181-10-4**] 08:00 AM

Dilantin - [**2181-10-4**] 05:30 PM

Morphine Sulfate - [**2181-10-4**] 08:50 PM

Other medications:

Flowsheet Data as of [**2181-10-5**] 02:38 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 37

C (98.6

T current: 36.7

C (98

HR: 59 (56 - 78) bpm

BP: 102/57(66) {90/52(43) - 159/90(102)} mmHg

RR: 13 (13 - 24) insp/min

SPO2: 95%

Heart rhythm: SB (Sinus Bradycardia)

Total In:

1,678 mL

PO:

200 mL

Tube feeding:

IV Fluid:

1,478 mL

Blood products:

Total out:

1,790 mL

0 mL

Urine:

1,790 mL

NG:

Stool:

Drains:

Balance:

-112 mL

0 mL

Respiratory support

O2 Delivery Device: None

SPO2: 95%

ABG: ////

Physical Examination

General Appearance: No acute distress

HEENT: PERRL, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Diminished)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Diminished)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

Moves all extremities, No(t) Sedated

Labs / Radiology

269 K/uL

14.7 g/dL

138 mg/dL

1.3 mg/dL

24 mEq/L

4.5 mEq/L

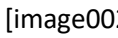
22 mg/dL

107 mEq/L

141 mEq/L

45.7 %

13.6 K/uL



[**2181-10-4**] 02:01 AM

WBC

13.6

Hct

45.7

Plt

269

Creatinine

1.3

Glucose

138

Other labs: PT / PTT / INR:11.4/23.8/0.9, Albumin:4.0 g/dL, Ca:9.6

mg/dL, Mg:2.1 mg/dL, PO4:2.9 mg/dL

Imaging: IMAGING:

CT:

Large R Temporal mass measuring approximately 3-4cm creating mass

effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal

cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: Assessment:

53M p/w [**11-17**] headache, left sided weakness. Seen by PCP who did [**Name9 (PRE) **]

CT and found to have large rt temporal mass

Plan:

To OR for Rt Crani for resection

Decadron 4mg q6h

Dilantin 100mg TID(level in AM)

SBP<160

Neuro: AOA x 3, Q1 Neuro checks Mso4/ Tylenol pain, decadron, Dilantin

CVS: SBP<160 HD stable.

Pulm: OSA Autoset CPAP O2: 3 L/Min to 10 L/Min to maintain saturation

> 92%

GI: NPO for Procedure except Meds

FEN: 1000 mL NS Continuous at 75 ml/hr

Renal: UO adequate

Heme: HCT 44.6 INR 0.9\

Endo: ISS

ID: -

TLD: PIV x1

Wounds: -

Prophylaxis: SCDs, h2b

Consults: Neurosurg

Code: full

Disposition: SICU

Billing Diagnosis: Intracranial mass

Lines:

18 Gauge - [**2181-10-3**] 08:00 PM

Total time spent: 31

"

"SICU

HPI:

53 yo M with 2-3 week history of R Sided headaches,

worsening in severity over the past several days. Yesterday

awoke with a [**11-17**] headache and went to PCP's office, who ordered

a CT Scan today. Pt. states friends have noticed that he has been

confused lately and he reports generalized weakness, but denies

nausea, blurred vision or diplopia, loss of balance. CT Scan

demonstrates large R Temporal mass with mass effect creating

midline shift. PT transferred via Med flight from OHS, received

10mg Decadron and IV Morphine.

Chief complaint:

left sided weakness

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

Bisacodyl, Dexamethasone 4mg IV q6, Docusate Sodium, Famotidine,

HYDROmorphone, HydrALAzine prn, RISS, Phenytoin, Senna, Simvastatin

24 Hour Events:

ARTERIAL LINE - START [**2181-10-5**] 07:31 PM

1. Right craniotomy for tumor resection.

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Morphine Sulfate - [**2181-10-5**] 08:00 PM

Dilantin - [**2181-10-6**] 02:00 AM

Hydromorphone (Dilaudid) - [**2181-10-6**] 04:00 AM

Other medications:

Flowsheet Data as of [**2181-10-6**] 05:35 AM

Vital signs

Hemodynamic monitoring

Fluid balance

Since [**84**] a.m.

Tmax: 36.7

C (98.1

T current: 35.7

C (96.2

HR: 61 (51 - 77) bpm

BP: 94/75(85) {90/59(71) - 150/84(104)} mmHg

RR: 13 (9 - 26) insp/min

SPO2: 94%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 112 kg (admission): 113.3 kg

Total In:

3,949 mL

515 mL

PO:

180 mL

100 mL

Tube feeding:

IV Fluid:

3,769 mL

415 mL

Blood products:

Total out:

5,270 mL

400 mL

Urine:

2,670 mL

400 mL

NG:

Stool:

Drains:

Balance:

-1,321 mL

115 mL

Respiratory support

O2 Delivery Device: None

SPO2: 94%

ABG: ///21/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Skin: (Incision: Clean / Dry / Intact)

Neurologic: (Awake / Alert / Oriented: x 3), Moves all extremities,

Left extremities slightly weaker than Right

Labs / Radiology

289 K/uL

12.9 g/dL

163 mg/dL

1.4 mg/dL

21 mEq/L

4.4 mEq/L

24 mg/dL

103 mEq/L

137 mEq/L

39.5 %

17.6 K/uL

[image002.jpg]

[**2181-10-4**] 02:01 AM

[**2181-10-5**] 04:42 AM

[**2181-10-5**] 06:19 PM

WBC

13.6

19.2

17.6

Hct

45.7

43.1

39.5

Plt

[**Telephone/Fax (3) 8589**]

Creatinine

1.3

1.2

1.4

Glucose

138

127

163

Other labs: PT / PTT / INR:11.7/24.0/1.0, Albumin:3.9 g/dL, Ca:8.4

mg/dL, Mg:2.1 mg/dL, PO4:4.0 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M p/w [**11-17**] headache, left sided weakness and pronator drift. Head CT showed large 3-4 cm right temporal mass. Now s/p crani for tumor resection.

PLAN:

Neuro: AOA x 3, Q1 Neuro checks, dilaudid prn pain, Decadron 4mg q6h, Dilantin 100 mg TID, repeat HCT post procedure slightly improved. For MRI head this AM

CVS: HD stable. Nicardipine/Hydralazine prn for goal SBP<160.

Pulm: OSA- Autoset CPAP.

GI: Regular diet. Famotidine. Zofran prn N/V.

FEN: KVO.

Renal: UOP adequate. Mildly increased creatinine, cont to follow for now.

Heme: Hct mildly decreased, cont to monitor daily. Coags wnl.

Endo: RISS.

ID: -

TLD: PIV x2, right radial a-line.

Wounds: head wound c/d/i

Prophylaxis: SCDs, H2B.

Consults: Neurosurgery

Code: Full

Disposition: Floor after MRI today.

Billing Diagnosis: Respiratory Insuff, post-op.

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

20 Gauge - [**2181-10-5**] 06:36 AM

Arterial Line - [**2181-10-5**] 07:31 PM

18 Gauge - [**2181-10-5**] 07:33 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: ICU consent signed

Code status: Full code

Disposition: Floor

Total time spent: 10

"

"SICU

HPI:

[**10-5**] HD3

Antibiotic:None

Anticoagulant:None

Antiseizure: Dilantin 100mg TID

Diagnosis: Rt Temporal Mass

Headache

HPI: 53 yo M with 2-3 week history of R Sided headaches,

worsening in severity over the past several days. Yesterday

awoke with a [**11-17**] headache and went to PCP's office, who ordered

a CT Scan today. Pt. states friends have noticed that he has been

confused lately and he reports generalized weakness, but denies

nausea, blurred vision or diplopia, loss of balance. CT Scan

demonstrates large R Temporal mass with mass effect creating

midline shift. PT transferred via Med flight from OHS, received

10mg Decadron and IV Morphine.

Chief complaint:

Headaches/confusion

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior to admission:

1. Simvastatin 80mg 1 PO Daily

2. Tricor - Dosage uncertain

Social Hx: Married, 4 living children. Currently employed as

Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased

from a traumatic fall.

ROS: Negative otherwise noted in HPI.

Current medications:

Active Medications [**Known lastname 8558**],[**Known firstname **]

1. 2. 1000 mL NS 3. Acetaminophen 4. Bisacodyl 5. Dexamethasone 6.

Docusate Sodium 7. Famotidine

8. Insulin 9. Morphine Sulfate 10. Morphine Sulfate 11. Ondansetron 12.

Phenytoin 13. Phenytoin

14. Senna 15. Simvastatin 16. Sodium Chloride 0.9% Flush

24 Hour Events:

MAGNETIC RESONANCE IMAGING - At [**2181-10-3**] 09:30 PM

NASAL SWAB - At [**2181-10-4**] 02:00 AM

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2181-10-4**] 08:00 AM

Dilantin - [**2181-10-4**] 05:30 PM

Morphine Sulfate - [**2181-10-4**] 08:50 PM

Other medications:

Flowsheet Data as of [**2181-10-5**] 02:38 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 37

C (98.6

T current: 36.7

C (98

HR: 59 (56 - 78) bpm

BP: 102/57(66) {90/52(43) - 159/90(102)} mmHg

RR: 13 (13 - 24) insp/min

SPO2: 95%

Heart rhythm: SB (Sinus Bradycardia)

Total In:

1,678 mL

PO:

200 mL

Tube feeding:

IV Fluid:

1,478 mL

Blood products:

Total out:

1,790 mL

0 mL

Urine:

1,790 mL

NG:

Stool:

Drains:

Balance:

-112 mL

0 mL

Respiratory support

O2 Delivery Device: None

SPO2: 95%

ABG: ////

Physical Examination

General Appearance: No acute distress

HEENT: PERRL, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse - Dorsalis pedis: Diminished)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse - Dorsalis pedis: Diminished)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands, Moves all extremities, No(t) Sedated

Labs / Radiology

269 K/uL

14.7 g/dL

138 mg/dL

1.3 mg/dL

24 mEq/L

4.5 mEq/L

22 mg/dL

107 mEq/L

141 mEq/L

45.7 %

13.6 K/uL

[image002.jpg]

[**2181-10-4**] 02:01 AM

WBC

13.6

Hct

45.7

Plt

269

Creatinine

1.3

Glucose

138

Other labs: PT / PTT / INR:11.4/23.8/0.9, Albumin:4.0 g/dL, Ca:9.6 mg/dL, Mg:2.1 mg/dL, PO4:2.9 mg/dL

Imaging: IMAGING:

CT:

Large R Temporal mass measuring approximately 3-4cm creating mass effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: Assessment:

53M p/w [**11-17**] headache, left sided weakness. Seen by PCP who did [**Name9 (PRE) **]

CT and found to have large rt temporal mass

Plan:

To OR for Rt Crani for resection

Decadron 4mg q6h

Dilantin 100mg TID(level in AM)

SBP<160

Neuro: AOA x 3, Q1 Neuro checks Mso4/ Tylenol pain, decadron, Dilantin

CVS: SBP<160 HD stable.

Pulm: OSA Autoset CPAP O2: 3 L/Min to 10 L/Min to maintain saturation

> 92%

GI: NPO for Procedure except Meds

FEN: 1000 mL NS Continuous at 75 ml/hr

Renal: UO adequate

Heme: HCT 44.6 INR 0.9\

Endo: ISS

ID: -

TLD: PIV x1

Wounds: -

Prophylaxis: SCDs, h2b

Consults: Neurosurg

Code: full

Disposition: SICU

Billing Diagnosis:

Lines:

18 Gauge - [**2181-10-3**] 08:00 PM

Total time spent:

"

"[**Last Name **] Problem - [**Name (NI) 10**] Description In Comments s/p craintotomy

Assessment:

Pt open his eyes to stimuli

Pupils equal and reactive to light

Pt does not follow commands.

Pt does left right arm of bed, pt moves left arm off bed, pt

will move both left and right leg

Pt oriented to name, month and year

Pt pulled out nasal trumpet

Pt c/o headache

Action:

Pt received 4mg of iv morphine

Response:

Await effect on morphine

Plan:

Continue to monitor

Q 1 hours neuro checks

Keep sbp less than 140

"

"s/p rt craniotomy for tumor resection

Assessment:

Pt alert and oriented x3. following commands. Lifts and hold all

4

s. lt side slightly weaker than rt.

No nausea-tolerating liquids.

Pt c/o headache #[**8-16**] on pain scale.

Action:

Pt medicated w/ morphine 4mg iv x2 with only 1 hr of relief. Pain med switch to dilaudid 1mg.

Radial aline dampened waveform-not able to draw am labs.

Response:

b/p <140 on own. Better pain control on dilaudid 1mg q3hrs

Plan:

Neuro checks q1hr.

Monitor and treat pain.

Dilantin 100mg iv tid-check w/ primary team about switching to po dose.

"

"HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after midnight

Chief complaint:

severe headache

[**Last Name **] Problem - [**Name (NI) 10**] Description In Comments

Assessment:

Patient transferred from Tsicu

Patient alert orientated x 3

Perrla, denies visual disturbances, numbness tingling

Mae, however patient continues to have left UE weakness with left pronator drift. With some neglect to left UE

Complained of headache before transfer from Tsicu, medicated with morphine, on arrival to Sicu patient pain free.

Lungs clear diminished o2 sat >95% on room.

[**Last Name (un) 110**] soft bs noted, tolerating po intake no nausea

Patient has history of osa (uses bipap at home)

Action:

Neuro check Q1

Monitor and treat pain

Patient npo after midnight for OR tomorrow.

Patient declined the use bipap overnight (wife will bring in patients

machine in am)

Iv fluids started after midnight as patient npo

Response:

Patient

s neuro check remains unchanged

Patients comfortable at time of report.

Plan:

Continue to monitor neuro checks Q1

Monitor and treat pain.

Patient for OR at noon tomorrow.

"

"HPI:

53y w/ lung mass; R temp mass midline shift 1.1, L pronator drift, LUE

weakness - 10 decadron; MRI pending, [**1-11**] q6, dilantin load, NPO after

midnight

Chief complaint:

severe headache

[**Last Name **] Problem - [**Name (NI) 10**] Description In Comments

Assessment:

Patient transferred from Tsicu

Patient alert orientated x 3

Perrla, denies visual disturbances, numbness tingling

Mae, however patient continues to have left UE weakness with left

pronator drift. With some neglect to left UE

Complained of headache before transfer from Tsicu, medicated with morphine, on arrival to Sicu patient pain free.

Lungs clear diminished o2 sat >95% on room.

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Monitor and treat pain

Patient npo after midnight for OR tomorrow.

Patient declined the use bipap overnight (wife will bring in patients machine in am)

Iv fluids started after midnight as patient npo

Response:

Patient

s neuro check remains unchanged

Patients comfortable at time of report.

Plan:

Continue to monitor neuro checks Q1

Monitor and treat pain.

Patient for OR at noon tomorrow.

"

"SICU

HPI:

53 yo M with 2-3 week history of R Sided headaches, worsening in severity over the past several days. Yesterday awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan today. Pt. states friends have noticed that he has been confused lately and he reports generalized weakness, but denies nausea, blurred vision or diplopia, loss of balance. CT Scan

demonstrates large R Temporal mass with mass effect creating

midline shift. PT transferred via Med flight from OHS, received

10mg Decadron and IV Morphine.

Chief complaint:

left sided weakness

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

Bisacodyl, Dexamethasone 4mg IV q6, Docusate Sodium, Famotidine,

HYDROmorphone, HydrALAzine prn, RISS, Phenytoin, Senna, Simvastatin

24 Hour Events:

ARTERIAL LINE - START [**2181-10-5**] 07:31 PM

1. Right craniotomy for tumor resection.

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Infusions:

Other ICU medications:

Morphine Sulfate - [**2181-10-5**] 08:00 PM

Dilantin - [**2181-10-6**] 02:00 AM

Hydromorphone (Dilaudid) - [**2181-10-6**] 04:00 AM

Other medications:

Flowsheet Data as of [**2181-10-6**] 05:35 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 36.7

C (98.1

T current: 35.7

C (96.2

HR: 61 (51 - 77) bpm

BP: 94/75(85) {90/59(71) - 150/84(104)} mmHg

RR: 13 (9 - 26) insp/min

SPO2: 94%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 112 kg (admission): 113.3 kg

Total In:

3,949 mL

515 mL

PO:

180 mL

100 mL

Tube feeding:

IV Fluid:

3,769 mL

415 mL

Blood products:

Total out:

5,270 mL

400 mL

Urine:

2,670 mL

400 mL

NG:

Stool:

Drains:

Balance:

-1,321 mL

115 mL

Respiratory support

O2 Delivery Device: None

SPO2: 94%

ABG: ///21/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Skin: (Incision: Clean / Dry / Intact)

Neurologic: (Awake / Alert / Oriented: x 3), Moves all extremities,

Left extremities slightly weaker than Right

Labs / Radiology

289 K/uL

12.9 g/dL

163 mg/dL

1.4 mg/dL

21 mEq/L

4.4 mEq/L

24 mg/dL

103 mEq/L

137 mEq/L

39.5 %

17.6 K/uL

[image002.jpg]

[**2181-10-4**] 02:01 AM

[**2181-10-5**] 04:42 AM

[**2181-10-5**] 06:19 PM

WBC

13.6

19.2

17.6

Hct

45.7

43.1

39.5

Plt

[**Telephone/Fax (3) 8589**]

Creatinine

1.3

1.2

1.4

Glucose

138

127

163

Other labs: PT / PTT / INR:11.7/24.0/1.0, Albumin:3.9 g/dL, Ca:8.4

mg/dL, Mg:2.1 mg/dL, PO4:4.0 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M p/w [**11-17**] headache, left sided weakness and pronator drift. Head CT showed large 3-4 cm right temporal mass. Now s/p crani for tumor resection.

PLAN:

Neuro: AOA x 3, Q1 Neuro checks, dilaudid prn pain, Decadron 4mg q6h, Dilantin 100 mg TID, repeat HCT post procedure slightly improved.

CVS: HD stable. Nicardipine/Hydralazine prn for goal SBP<160.

Pulm: OSA- Autoset CPAP.

GI: Regular diet. Famotidine. Zofran prn N/V.

FEN: KVO.

Renal: UOP adequate.

Heme: Hct mildly decreased, cont to monitor daily. Coags wnl.

Endo: RISS.

ID: -

TLD: PIV x2, right radial a-line.

Wounds: head wound c/d/i

Prophylaxis: SCDs, H2B.

Consults: Neurosurgery

Code: Full

Disposition: SICU

Billing Diagnosis:

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

20 Gauge - [**2181-10-5**] 06:36 AM

Arterial Line - [**2181-10-5**] 07:31 PM

18 Gauge - [**2181-10-5**] 07:33 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: ICU consent signed

Code status: Full code

Disposition: ICU

Total time spent:

"

"S/P Craniotomy

Assessment:

Action:

Response:

Plan:

"

"Had resection of met adenocarcinoma of R temporal lobe on [**10-5**] and now presented to hosp with recurrent CSF rhinorrhea (was d/c home on [**11-16**]) has been in house on floor with lumbar drain in place to OR today ([**11-21**]). Patient arrived from OR extubated/reversed/lethargic but arousable and hemodynamically stable.

S/P Craniotomy

Assessment:

Action:

Response:

Plan:

"

"Had resection of met adenocarcinoma of R temporal lobe on [**10-5**] and now presented to hosp with recurrent CSF rhinorrhea (was d/c home on [**11-16**]) has been in house on floor with lumbar drain in place to OR today

([**11-21**]). Patient arrived from OR extubated/reversed/lethargic but arousable and hemodynamically stable with lumbar drain in place.

S/P Craniotomy

Assessment:

Pt is A/Ox3, MAE with c/o mild HA

Per NSURG PA ^CSF output towards end of case so expected to have minimal output for first couple of hours via lumbar drain

Per NSURG this morning +Cdiff result reported to team

Urine output adequate

Action:

Lumbar drain leveled to shoulder and kept clamped except for on the hour when it

s opened to drain 15cc

Post-op head CT ordered

PO flagyl for cdiff

IVF infusing for hydration

Response:

Plan:

Neuro checks hourly

Lumbar drain clamped but open to drain 15cc CSF Qhr

"

"Had resection of met adenocarcinoma of R temporal lobe on [**10-5**] and now presented to hosp with recurrent CSF rhinorrhea (was d/c home on [**11-16**]) has been in house on floor with lumbar drain in place to OR today ([**11-21**]). Patient arrived from OR extubated/reversed/lethargic but arousable and hemodynamically stable with lumbar drain in place.

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Per NSURG this morning +Cdiff result reported to team

Urine output adequate

Arrived to unit with face mask on

No post-op labs ordered

Action:

Lumbar drain leveled to shoulder and kept clamped except for on the hour when it s opened to drain 15cc

Post-op head CT ordered

PO flagyl for cdiff

IVF infusing for hydration

PO dilaudid given for pain (back/head)

Inquired with NSURG re: oxygen delivery device

Response:

No output from lumbar drain

NSURG wants to keep face mask on for oxygen until post-op head CT complete to assess for pneumocephalus

Plan:

Neuro checks hourly

Lumbar drain clamped but open to drain 15cc CSF Qhr

Maintain flat bedrest but okay to position on side with pillow

"

"Had resection of met adenocarcinoma of R temporal lobe on [**10-5**] and now presented to hosp with recurrent CSF rhinorrhea (was d/c home on [**11-16**]) has been in house on floor with lumbar drain in place to OR today ([**11-21**]). Patient arrived from OR extubated/reversed/lethargic but

arousable and hemodynamically stable with lumbar drain in place.

S/P Craniotomy

Assessment:

Pt is A/Ox3, MAE with c/o mild HA

Per NSURG PA ^CSF output towards end of case so expected to have minimal output for first couple of hours via lumbar drain

Per NSURG this morning +Cdiff result reported to team (no stool)

Urine output adequate

Arrived to unit with face mask on

No post-op labs ordered

Action:

Lumbar drain leveled to shoulder and kept clamped except for on the hour when it

s opened to drain 15cc

Post-op head CT ordered

PO flagyl for cdiff

IVF infusing for hydration

PO dilaudid given for pain (back/head)

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Family in to visit (wife and 2 daughters-updated by RN)

Response:

No output from lumbar drain

NSURG wants to keep face mask on for oxygen until post-op head CT complete to assess for pneumocephalus

Plan:

Neuro checks hourly

Lumbar drain clamped but open to drain 15cc CSF Qhr

Maintain flat bedrest but okay to position on side with

pillow

"

"s/p Right sided crani for dural repair and lumbar drain

Assessment:

Pt lethargic but opens eyes to voice, Oriented x3, MAE c/o HA/pain to lower back [**2182-8-15**]

Pupils 2-3mm equal and briskly reactive. Denies numbness/tingling/post-nasal gtt

Lumbar drain leveled to shoulder and kept clamped except for on the hour when its opened to drain 15cc. Not to be transduced per report

NSURG again made aware on evening rounds no CSF has drained. Per NSURG minimal to no output expected first couple of hours d/t amount out at end of case

Right facial/periorbital swelling. Right crani dressing c/d/i. Lumbar drain benign w/ stitch and transparent dressing. LLQ w/ dermabond OTA w/o drainage

Flat bedrest/log roll only

Post op Head CT w/o Pneumocephalus. O2 sats 93% on 2L via NC

Action:

Neuro checks Q1hr

IV Dilaudid increased to 1mg Q3hrs PRN. Tylenol 1GM po

Pt NPO x meds/sips. Tolerated meds w/o N/V. NS w/20KCL @80cc/hr

PO Flagyl for hx of c.diff. Cefazolin IV Q8hrs for LD

Lumbar drain unclamped every hour and began draining clear CSF last eve at approx 2300

Turned and repositioned to side-lying positions. Maintained flat bedrest

Response:

Neuro checks unchanged

Pt reports increase in pain management w/ Dilaudid 1mg IV.

No N/V tolerating meds/sips

Lumbar drain continues to drain 15cc/hr of clear CSF

Right crani dressing continues to be c/d/i. Lumbar drain site remains benign

Plan:

Continue q1hr Neuro checks

Pain management

Flat bedrest

Unclamp Lumbar drain Q1 hr to drain 15cc of CSF

Monitor dressings/inc

"

"[**Last Name **] Problem - [**Name (NI) 10**] Description In Comments

Assessment:

Action:

Response:

Plan:

"

"s/p Right sided crani for dural repair and lumbar drain

Assessment:

Pt lethargic but opens eyes to voice, Oriented x3, MAE c/o HA/pain to lower back [**2182-8-15**]

Pupils 2-3mm equal and briskly reactive. Denies numbness/tingling/post-nasal gtt

Lumbar drain leveled to shoulder and kept clamped except for on the hour when its opened to drain 15cc. Not to be transduced per report

NSURG again made aware on evening rounds no CSF has drained. Per NSURG minimal to no output expected first couple of hours d/t amount out at end of case

Right facial/periorbital swelling. Right crani dressing c/d/i. Lumbar drain benign w/ stitch and transparent dressing

Flat bedrest/log roll only

Post op Head CT w/o Pneumocephalus. O2 sats 93% on 2L via NC

Action:

Neuro checks Q1hr

Pt NPO x meds/sips. Tolerated meds w/o N/V. NS w/20KCL @80cc/hr

Response:

Plan:

S/P Craniotomy

Assessment:

Pt is A/Ox3, MAE with c/o mild HA

Per NSURG PA ^CSF output towards end of case so expected to have minimal output for first couple of hours via lumbar drain

Per NSURG this morning +Cdiff result reported to team (no stool)

Urine output adequate

Arrived to unit with face mask on

No post-op labs ordered

Action:

Lumbar drain leveled to shoulder and kept clamped except for on the hour when it

s opened to drain 15cc

Post-op head CT ordered

PO flagyl for cdiff

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PO dilaudid given for pain (back/head)

Inquired with NSURG re: oxygen delivery device

Family in to visit (wife and 2 daughters-updated by RN)

Response:

No output from lumbar drain

NSURG wants to keep face mask on for oxygen until post-op

head CT complete to assess for pneumocephalus

Plan:

Neuro checks hourly

Lumbar drain clamped but open to drain 15cc CSF Qhr

* Maintain flat bedrest but okay to position on side with

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan today. Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement

Chief complaint:

Dural Leak

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

Acetaminophen 3. CefazoLIN 4. Docusate Sodium 5. Famotidine 6.

HYDROmorphone (Dilaudid)

7. HYDROmorphone (Dilaudid) 8. HYDROmorphone (Dilaudid) 9.

LeVETiracetam 10. MetRONIDAZOLE (FLagyl)

11. Ondansetron 12. Senna 13. Simvastatin

24 Hour Events:

OR RECEIVED - At [**2181-11-21**] 02:11 PM

ARTERIAL LINE - START [**2181-11-21**] 02:16 PM

ICP CATHETER - START [**2181-11-21**] 02:17 PM

ARTERIAL LINE - STOP [**2181-11-21**] 09:18 PM

Post operative day:

POD#1 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Metronidazole - [**2181-11-21**] 03:31 PM

Cefazolin - [**2181-11-22**] 12:10 AM

Infusions:

Other ICU medications:

Hydromorphone (Dilaudid) - [**2181-11-22**] 03:45 AM

Other medications:

Flowsheet Data as of [**2181-11-22**] 06:07 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 37.2

C (99

T current: 37.2

C (99

HR: 99 (73 - 100) bpm

BP: 127/66(78) {75/55(62) - 127/71(81)} mmHg

RR: 17 (13 - 30) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 102.1 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

2,483 mL

579 mL

PO:

45 mL

Tube feeding:

IV Fluid:

2,303 mL

534 mL

Blood products:

Total out:

745 mL

845 mL

Urine:

525 mL

755 mL

NG:

Stool:

Drains:

15 mL

90 mL

Balance:

1,738 mL

-266 mL

Respiratory support

O2 Delivery Device: Nasal cannula

SPO2: 96%

ABG: ///24/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

Moves all extremities

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement

Neurologic: s/p R crani for dural repair and lumbar drain placement, AOA x 3, Q1 Neuro checks, dilaudid prn pain, Decadron 4mg q6h, Dilantin 100 mg TID, LeVETiracetam 1000 mg PO bid, drain 15 ml CSF/hr via lumbar drain. Would recommend elevating HOB > 30 degrees.

Cardiovascular: HD stable. Hydralazine prn for goal SBP<160.

Pulmonary: OSA- Autoset CPAP if needed.

Gastrointestinal / Abdomen: Famotidine. Zofran prn N/V; Advance diet when able elevate HOB.

Nutrition: NPO

Renal: Foley, adeq UOP

Hematology: cont to monitor daily.

Endocrine: RISS

Infectious Disease: C-Diff, Ancef/Flagyl

Lines / Tubes / Drains: PIV right radial a-line d/c'd; Lumbar drain

Wounds: Clean and dry.

Imaging: None

Fluids: NS

Consults: Neuro surgery

Billing Diagnosis: Respiratory insuff, post-op.

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

ICP Catheter - [**2181-11-21**] 02:17 PM

20 Gauge - [**2181-11-21**] 02:18 PM

14 Gauge - [**2181-11-21**] 02:19 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Comments:

Code status: Full code

Disposition: ICU

Total time spent: 32 minutes

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on

[**10-5**] and now admitted on Sunday with recurrent CSF rhinorrhea (was d/c home on Fri [**11-16**] after a 9 day admission for rhinorrhea) was in house on floor with lumbar drain in place and brought to OR on wed [**11-21**]. OR course stable/uneventful admitted to SICU post-operatively for frequent neuro checks.

s/p Craniotomy for Dural Leak

Assessment:

Neurologically intact, no weakness in any extremeties, no rhinorrhea

This am no CSF draining when unclamped at 0800

Constantly c/o headache/backache rating at #8

Pt turning side to side independently on FLAT bedrest

Has superficial clot in LLE but okay to have venodyne on

On Flagyl PO for Cdiff (started yesterday) no stool post-op

Lumbar drain site C/D/I

Dermabond to small LLQ incision (fat flap site), Right crani incision with DSD

Sleeping unless interrupted and rating pain at 8 consistently

Complains of discomfort when blankets moved, O2 adjusted, foley moved very sensitive to touch

Afebrile, O2 sats high 90

s on 2L nc HR 90

s NSR, SBP 80-110

Action:

Lumbar drain kept clamped and opened hourly (overnight started draining 15cc/hr from 2300 on)

Discussed no CSF output with nsurg and per PA to be expected d/t lge CSF output intraop

Dilaudid IV/PO ordered (overnight using IV d/t not eating a regular diet yet)

IVF infusing for hydration

Response:

Tolerating PO meds does not want anything to eat at this time

Pt reports poor pain control

primary team notified

SBP drops to 80

s after IV dilaudid

Plan:

Called out to floor with Q4hr neuro/vitals

Lumbar drain to be clamped and opened hourly just to drain 15cc

Dilaudid for pain transition to PO from IV

Advance diet as tolerated

SICU resident spoke with NSURG and OK to raise HOB 25 degrees

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on [**10-5**] and now admitted on Sunday with recurrent CSF rhinorrhea (was d/c home on Fri [**11-16**] after a 9 day admission for rhinorrhea) was in house on floor with lumbar drain in place and brought to OR on wed [**11-21**]. OR course stable/uneventful admitted to SICU post-operatively for frequent neuro checks.

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Afebrile, O2 sats high 90

s on 2L nc HR 90

s NSR, SBP 80-110

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SBP drops to 80

s after IV dilaudid

Plan:

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Lumbar drain to be clamped and opened hourly just to drain

15cc

Dilaudid for pain transition to PO from IV

Advance diet as tolerated

SICU resident spoke with NSURG and OK to raise HOB 25

degrees

Demographics

Attending MD:

[**Doctor Last Name **] [**Doctor Last Name **] C.

Admit diagnosis:

CSF RHINORRHEA

Code status:

Full code

Height:

72 Inch

Admission weight:

109.1 kg

Daily weight:

102.1 kg

Allergies/Reactions:

Penicillins

Rash;

Precautions: Contact

PMH: ETOH

CV-PMH:

Additional history: Metastatic lung Ca. s/p VATS left lower lobectomy

[**2180**], Crani for tumor resection in [**9-16**], Obstructive sleep apnea, Has superficial clot in LLE (ok for venodynes and doesn't need anticoag)

Surgery / Procedure and date: [**11-21**]- Re-do right craniotomy for dural repair/lumbar drain

Latest Vital Signs and I/O

Non-invasive BP:

S:117

D:57

Temperature:

100.1

Arterial BP:

S:95

D:72

Respiratory rate:

17 insp/min

Heart Rate:

97 bpm

Heart rhythm:

SR (Sinus Rhythm)

O2 delivery device:

Nasal cannula

O2 saturation:

99% %

O2 flow:

2 L/min

FiO2 set:

24h total in:

1,131 mL

24h total out:

1,345 mL

Pertinent Lab Results:

Sodium:

139 mEq/L

[**2181-11-22**] 01:51 AM

Potassium:

4.3 mEq/L

[**2181-11-22**] 01:51 AM

Chloride:

110 mEq/L

[**2181-11-22**] 01:51 AM

CO2:

24 mEq/L

[**2181-11-22**] 01:51 AM

BUN:

10 mg/dL

[**2181-11-22**] 01:51 AM

Creatinine:

1.0 mg/dL

[**2181-11-22**] 01:51 AM

Glucose:

104 mg/dL

[**2181-11-22**] 01:51 AM

Hematocrit:

33.6 %

[**2181-11-22**] 01:51 AM

Finger Stick Glucose:

128

[**2181-11-22**] 10:00 AM

Valuables / Signature

Patient valuables:

Other valuables:

Clothes: Sent home with:

Wallet / Money:

No money / wallet

Cash / Credit cards sent home with:

Jewelry:

Transferred from: [**Hospital 3074**]

Transferred to: [**Wardname 8318**]

Date & time of Transfer: [**2181-11-22**] 1200

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches,
worsening in severity over the past several days and awoke with a [**11-17**]
headache and went to PCP's office, who ordered
a CT Scan Friends had noticed that he had been
confused lately and he reported generalized weakness. CT Scan
demonstrated large R Temporal mass with mass effect creating
midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for
metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented
with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for
dural repair and lumbar drain placement. Pt transferred to floor where
he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared
to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF
showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and
recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd

[**11-23**].

Chief complaint:

Mental status change

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

CefePIME

Vanco

Bisacodyl

tylenol

Heparin

Flagyl

Keppra

Simvastatin

Famotidine

Senna

Docusate

24 Hour Events:

[**11-23**]: Re admission to SICU [**3-12**] fever, increased WBC in CSF and mental

status change. s/p drain removal and empiric abx treatment

Post operative day:

POD#3 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Metronidazole - [**2181-11-21**] 03:31 PM

Cefazolin - [**2181-11-22**] 08:16 AM

Vancomycin - [**2181-11-24**] 02:13 AM

Infusions:

Other ICU medications:

Heparin Sodium (Prophylaxis) - [**2181-11-24**] 12:00 AM

Hydromorphone (Dilaudid) - [**2181-11-24**] 12:05 AM

Other medications:

Flowsheet Data as of [**2181-11-24**] 05:41 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 38.1

C (100.6

T current: 37.7

C (99.8

HR: 99 (85 - 103) bpm

BP: 119/74(85) {95/52(62) - 119/91(96)} mmHg

RR: 17 (8 - 25) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 103.2 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

726 mL

635 mL

PO:

30 mL

Tube feeding:

IV Fluid:

696 mL

635 mL

Blood products:

Total out:

255 mL

335 mL

Urine:

255 mL

335 mL

NG:

Stool:

Drains:

Balance:

471 mL

300 mL

Respiratory support

O2 Delivery Device: None

SPO2: 96%

ABG: ////

Physical Examination

General Appearance: Appear uncomfortable only when practitioner enters room

HEENT: Refused to open eyes

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: CTA bilateral :)

Abdominal: Soft

Left Extremities: (Temperature: Warm)

Right Extremities: (Temperature: Warm)

Neurologic: Pt refused to all questins except if he was in pain

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Imaging: CT:

Large R Temporal mass measuring approximately 3-4cm creating mass

effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal

cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

[**2181-11-21**] CT head Expected small pneumocephalus, subcutaneous gas and soft tissue swelling around the surgical site.Sliver of hyperdensity along the right frontoparietal convexity, compatible with tiny post-surgical subdural hematoma. No evidence of other intracranial hemorrhage.No shift of normally midline structure.No evidence of abnormal CSF collection to suggest leakage.

[**2181-11-22**] CT head No significant short-term changes.

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement, now with meningitis started in broad spectrum abx.

Neurologic: Neuro checks Q: 1 hr, s/p R crani for dural repair and lumbar drain placement,on Keppra. Now with meningitis. Lumbar drain removed per ID rec. Consider MRI or brain and spine if no clinical improvement by 24 hrs.

Cardiovascular: stable.

Pulmonary: Hx of OSA, but no issues currently

Gastrointestinal / Abdomen: no issues

Nutrition: Sips except for meds

Renal: Foley

Hematology: stable

Endocrine: no issues

Infectious Disease: Check cultures, Meningitis in setting of lumbar drain. On Flagyl, Vanco, Cefipime. Lumbar drain removed.

Lines / Tubes / Drains: Foley

Wounds: Drain removed.

Imaging: Consider MRI if no clinical improvement

Fluids: Other, KCL+NS 80/hr.

Consults: Neuro surgery

Billing Diagnosis: Other: meningitis

ICU Care

Nutrition:

Glycemic Control:

Lines:

20 Gauge - [**2181-11-23**] 05:57 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting planning Comments:

Code status: Full code

Disposition: ICU

Total time spent: 31 minutes

Patient is critically ill

"

"Attending Physician: [**Name10 (NameIs) 1964**]

Referral date: [**2181-11-26**]

Medical Diagnosis / ICD 9: / 191

Reason of referral: Eval and Treat

History of Present Illness / Subjective Complaint: Pt. is 53 y.o. male

with h/o metastatic adenocarcinoma s/p R temporal craniotomy for

resection of metastasis complicated by CSF rhinorrhea, re-admitted with

with recurrent CSF leak s/p craniotomy for dural tear repair with fat graft and placement lumbar drain developed fever and altered mental status post-op [**3-12**] meningitis.

Past Medical / Surgical History: Lung CA s/p RLL resection [**2180**], R crani for temporal mass resection [**9-16**]

Medications: Simvastatin, Dilaudid, LeVETiracetam, CefePIME, Midazolam, Acetaminophen, MetRONIDAZOLE, Vancomycin, Gabapentin

Radiology: Head CT: No significant short-term changes. Mild interval decrease of pneumocephalus and soft tissue air, but persistent mild soft tissue swelling around the surgical site. 2. Unchanged sliver of hyperdensity along the right frontoparietal convexity, compatible with tiny post-surgical subdural collection. 3. No evidence of new hemorrhagic site or developing hydrocephalus. 4. No shift of normally midline structures or evidence of abnormal CSF collection.

Labs:

35.2

11.8

367

11.5

[image002.jpg]

Other labs:

Activity Orders: OOB with assist

Social / Occupational History: 50pk yr tobacco hx, occas EtOH. Married, lives with wife. [**Name (NI) 6**] 4 children. Works in manufacturing

Living Environment: 1 level home

Prior Functional Status / Activity Level: [**Name (NI) 481**] PTA. Reports having difficulty ambulating.

Objective Test

Arousal / Attention / Cognition / Communication: Oriented to ""[**Hospital 1249**]"", ""[**2181-11-29**]"". Slightly HOH. Easily distractible. Needed

redirection to task

Hemodynamic Response

Aerobic Capacity

HR

BP

RR

O[2]sat

HR

BP

RR

O[2] sat

RPE

Supine

78

138/80

14

95 on RA

Rest

/

Sit

82

121/76

15

95 on RA

Activity

/

Stand

/

Recovery

78

112/68

25

95 on RA

Total distance walked:

Minutes:

Pulmonary Status: BS dimished at bases

Integumentary / Vascular: R craniotomy incision c/d/i, L UE PICC line,

Lumbar area stitches, c/d/i

Sensory Integrity: Sensation grossly intact to LT in UEs/[**Name Prefix (Prefixes) **]

[**Last Name (Prefixes) 222**] / Limiting Symptoms: Pt. c/o L LE: cramping pain

Posture: WNL

Range of Motion

Muscle Performance

Bilat. UEs/LEs: WFL throughout

Bilat. UEs/LEs: > [**5-13**] throuhgout

Motor Function: + 2 beat clonus in L LE. slightly dysmetric

finger-nose-finger on L

Functional Status:

Activity

Clarification

I

S

CG

Min

Mod

Max

Gait, Locomotion: Pt. amb 200 ft. pushing w/c with CGA min VCs for sequencing and technique.

Rolling:

T

Supine /
Sidelying to Sit:

T

Transfer:

T

Sit to Stand:

T

Ambulation:

pushing w/c

T

Stairs:

Balance: S for static standing, CGA for ambulating pushing w/c

Education / Communication: Pt. edu re: role of PT, [**Name (NI) 147**], d/c plan to home in a few visits. RN comm re: pt. status, needing assistance for mobility

Intervention: Vision: Tracks to all visual quadrants

Other:

Diagnosis:

1.

Arousal, Attention, and Cognition, Impaired

2.

Balance, Impaired

3.

Gait, Impaired

4.

Knowledge, Impaired

5.

Transfers, Impaired

Clinical impression / Prognosis: Pt. is 53 y.o. male s/p R craniotomy for repair of CSF leak and lumbar drain placement, c/b post-op infection that p/w above impairments associated with non-progressive d/o of the CNS. Pt. appears to be functioning below baseline and would benefit from continued PT. Anticipate that pt. will progress towards d/c home in [**2-9**] PT visits. Recommend OT consult for cognitive eval prior to d/c.

Goals

Time frame: [**2-9**] PT visits

1.

supine to sit [**Month/Day (2) **].

2.

sit to stand [**Month/Day (2) **].

3.

Amb. 300 ft [**Month/Day (2) **].

4.

Verbalize understanding of role of PT

5.

6.

Anticipated Discharge: Home without PT

Treatment [**Name (NI) 99**]:

Frequency / Duration: [**2-9**] PT visits

bed mobility, transfers, balance re-edu, gait-training

Face time: 11:10-11:52

Nsg recs: Ambulate with CGA

T Patient agrees with the above goals and is willing to participate in the rehabilitation program.

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on
[**10-5**]. Readmitted to SICU [**11-21**] with recurrent CSF rhinorrhea (was d/c
home on Fri [**11-16**] after a 9 day admission for rhinorrhea) after
undergoing lumbar drain placement in OR. Stable course and sent to [**Hospital Ward Name 383**]
11 where yesterday [**11-23**] became increasingly lethargic and brought back
to SICU for closer neuro monitoring.
s/p Craniotomy for Dural Leak
Assessment:
Alert and interactive with family. Oriented x3. No weakness
in any extremities. Sleeping unless interrupted where pt with c/o
generalized pain rating [**2182-7-16**] on [**11-17**] pain scale and also c/o
discomfort with many forms of intervention to pt: adjusting blankets,
washing skin and touching hand. Pt stated feeling catheter discomfort
as well. While asleep easy to arouse but difficult to get verbal
response however will follow commands. Dr [**Last Name (STitle) 9353**] notified and to
continue holding pain medicine until pt becoming more alert.
No rhinorrhea or noted CSF leaking.
Pt turning side to side independently on 25 degree bed rest.
Has superficial clot in LLE but okay to have venodyne on
Continues on PO Flagyl for CDIFF. Small liquid BM in
beginning of night.
Lumbar drain removed by MD. Suture and dressing placed.
Derma bond to small LLQ incision (fat flap site). Right
crani incision with DSD. Continues on IV antibiotics.
Low grade fever tmax 99.6. HR 80-90
s NSR. SBP 90-110.
Oxygen saturation >95% RA. Lungs CTAB.
Action:
Monitoring neuro status hourly.

Pt receiving Dilaudid IV/PO as ordered. Urojet applied to penis for catheter comfort.

Response:

Pt becoming more alert and verbal. Remains lift/holding all extremities moving independently in bed.

Remains NPO with sips for meds. Tolerating medications well.

Pt remains with c/o pain however less after initial intervention. No further catheter pain. Team notified.

No drainage from back suture. No CSF leak.

Plan:

Continue to monitor neuro exams hourly. Monitor for CSF leak.

Maintain HOB elevation to 25 degrees.

Monitor pain/comfort treating with Dilaudid (Fioricet also available for HA) as required.

Advance diet as tolerated

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan.Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per CPS recs. Tolerated diet advance.

[**11-25**] PICC line placed. IVAbx adjusted, WBCs still elevated.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized weakness, right slightly greater than left, no rhinorrhea

c/o HA [**8-17**]

Right crani incision CDI OTA

Poor IV access

Action:

Neuro checks as directed

Dilaudid IV and PO for HA

Intake improving, ADAT

PICC line inserted

Response:

HA improving with with Dilaudid PO and IV

Remains neurologically intact

Plan:

Transfer to floor when bed available

Dilaudid for pain

Advance diet as tolerated

Awaiting PT/OT consult

"

"SICU

HPI:

53 yo M with history of right sided headaches in beginning in [**Month (only) **] [**2181**]. CT Scan at that time demonstrated large R temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for right temporal craniotomy for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then re-presented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat in bed with no signs of CSF leakage. On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380, gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

rhinorrhea

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

1. IV access: Peripheral line, Date inserted: [**2181-11-18**] Order date:

[**11-23**] @ 1754

15. IV access request: PICC Evaluate, Place Indication: Antibiotics

Urgency: Urgent Order date: [**11-24**] @ 0705

2. IV access: Peripheral line Order date: [**11-23**] @ 1754

16. Insulin SC (per Insulin Flowsheet)

Sliding Scale Order date: [**11-24**] @ 0658

3. IV access: PICC, heparin dependent Location: Left, Date inserted:

[**2181-11-25**] Order date: [**11-25**] @ 0858

17. LeVETiracetam 1000 mg PO BID Order date: [**11-23**] @ 1754

4. Acetaminophen-Caff-Butalbital [**2-9**] TAB PO Q4H:PRN HA Order date:

[**11-23**] @ 1754

18. Lidocaine Jelly 2% (Urojet) 1 Appl TP PRN foley catheter pain

Order date: [**11-23**] @ 2232

5. Acetaminophen 325 mg PO Q4H:PRN fever

max apap 4g/24 hrs Order date: [**11-24**] @ 0756

19. MetRONIDAZOLE (FLagyl) 500 mg IV Q8H Order date: [**11-24**] @ 1050

6. Bisacodyl 10 mg PO/PR DAILY:PRN constipation Order date: [**11-23**] @

1754

20. Midazolam 1-2 mg IV Q4H:PRN procedure Order date: [**11-24**] @ 0705

7. CefePIME 2 g IV Q8H Order date: [**11-23**] @ [**2086**]

21. Ondansetron 4 mg IV Q8H:PRN nausea Order date: [**11-23**] @ 1754

8. Docusate Sodium 100 mg PO BID Order date: [**11-23**] @ 1754

22. Senna 1 TAB PO BID:PRN no Bm x2d Order date: [**11-23**] @ 1754

9. Famotidine 20 mg PO BID Order date: [**11-23**] @ 1754

23. Simvastatin 80 mg PO DAILY Order date: [**11-23**] @ 1754

10. Gabapentin 300 mg PO TID

Please give first dose - have HO evaluation prior to giving remainder

of dosing Order date: [**11-24**] @ 0853

24. Sodium Chloride 0.9% Flush 3 mL IV Q8H:PRN line flush

Peripheral line: Flush with 3 mL Normal Saline every 8 hours and PRN.

Order date: [**11-23**] @ 1754

11. HYDROmorphone (Dilaudid) 2-4 mg PO Q4H:PRN pain Order date: [**11-23**]

@ 1754

25. Sodium Chloride 0.9% Flush 3 mL IV Q8H:PRN line flush

Peripheral line: Flush with 3 mL Normal Saline every 8 hours and PRN.

Order date: [**11-23**] @ 1754

12. HYDROmorphone (Dilaudid) 0.5-1.0 mg IV Q3H:PRN severe pain Order

date: [**11-23**] @ 1754

26. Vancomycin Oral Liquid 250 mg PO Q6H Order date: [**11-24**] @ 1050

13. Heparin 5000 UNIT SC TID Order date: [**11-23**] @ 1754

27. Vancomycin 1000 mg IV ONCE Duration: 1 Doses Order date: [**11-25**] @

0654

14. Heparin Flush (10 units/ml) 2 mL IV PRN line flush

PICC, heparin dependent: Flush with 10mL Normal Saline followed by

Heparin as above daily and PRN per lumen. Order date: [**11-25**] @ 0858

28. Vancomycin 1000 mg IV Q 8H Order date: [**11-25**] @ 1157

24 Hour Events:

No events. Tolerating regular diet. PICC placed. Transferred to floor

however no bed available.

PICC LINE - START [**2181-11-25**] 09:00 AM

Post operative day:

POD#5 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Vancomycin - [**2181-11-25**] 10:21 PM

Metronidazole - [**2181-11-26**] 12:09 AM

Cefipime - [**2181-11-26**] 03:57 AM

Infusions:

Other ICU medications:

Heparin Sodium (Prophylaxis) - [**2181-11-26**] 12:09 AM

Other medications:

Flowsheet Data as of [**2181-11-26**] 07:01 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 36.9

C (98.5

T current: 36.1

C (97

HR: 76 (68 - 90) bpm

BP: 105/71(80) {96/59(70) - 119/82(88)} mmHg

RR: 16 (13 - 25) insp/min

SPO2: 95%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 103.2 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

2,600 mL

220 mL

PO:

600 mL

Tube feeding:

IV Fluid:

2,000 mL

220 mL

Blood products:

Total out:

2,820 mL

550 mL

Urine:

2,820 mL

550 mL

NG:

Stool:

Drains:

Balance:

-220 mL

-330 mL

Respiratory support

O2 Delivery Device: None

SPO2: 95%

ABG: ///24/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL, EOMI, neck with full ROM

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :)

Abdominal: Soft

Left Extremities: (Edema: Absent), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Right Extremities: (Edema: Absent), (Pulse - Dorsalis pedis: Present)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

(Responds to: Verbal stimuli), Moves all extremities

Labs / Radiology

367 K/uL

11.8 g/dL

108 mg/dL

0.9 mg/dL

24 mEq/L

4.1 mEq/L

14 mg/dL

101 mEq/L

134 mEq/L

35.2 %

11.5 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

[**2181-11-26**] 03:29 AM

WBC

17.2

11.5

Hct

33.6

35.2

Plt

289

367

Creatinine

1.0

0.9

Glucose

104

108

Other labs: Ca:8.5 mg/dL, Mg:1.8 mg/dL, PO4:3.3 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan:

Neurologic: s/p R crani for dural repair and lumbar drain placement,on keppra. Now with meningitis. Lumbar drain removed per ID rec. Consider MRI or brain and spine if clinical decline. Gabapentin per CPS recs.

Cardiovascular: Hemodynamically stable.

Pulmonary: H/o OSA. No other issues.

Gastrointestinal / Abdomen: Regular diet, famotidine, Zofran prn nausea.

Nutrition: Regular diet.

Renal: Foley; UOP appropriate.

Hematology: Stable, no issues.

Endocrine: RISS

Infectious Disease: Meningitis in setting of lumbar drain. On Flagyl, Vanco IV/PO, Cefipime. F/u cultures. Lumbar drain removed.

Lines / Tubes / Drains: PIV, PICC

Wounds: R crani incision clean / dry / intact

Imaging: none

Fluids: HLIV

Consults: neurosurgery

Billing Diagnosis: CSF leak

ICU Care

Nutrition: regular diet

Glycemic Control: RISS

Lines:

PICC Line - [**2181-11-25**] 09:00 AM

Prophylaxis:

DVT: SQH

Stress ulcer: H2B

VAP bundle: n/a

Comments:

Communication: Comments:

Code status: Full code

Disposition: floor

Total time spent: 31 min

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches,

worsening in severity over the past several days and awoke with a [**11-17**]

headache and went to PCP's office, who ordered

a CT Scan today. Friends had noticed that he had been

confused lately and he reported generalized weakness. CT Scan

demonstrated large R Temporal mass with mass effect creating

midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for

metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented

with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for

dural repair and lumbar drain placement

Chief complaint:

Dural Leak

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

Acetaminophen 3. CefazoLIN 4. Docusate Sodium 5. Famotidine 6.

HYDROmorphone (Dilaudid)

7. HYDROmorphone (Dilaudid) 8. HYDROmorphone (Dilaudid) 9.

LeVETiracetam 10. MetRONIDAZOLE (FLagyl)

11. Ondansetron 12. Senna 13. Simvastatin

24 Hour Events:

OR RECEIVED - At [**2181-11-21**] 02:11 PM

ARTERIAL LINE - START [**2181-11-21**] 02:16 PM

ICP CATHETER - START [**2181-11-21**] 02:17 PM

ARTERIAL LINE - STOP [**2181-11-21**] 09:18 PM

Post operative day:

POD#1 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Metronidazole - [**2181-11-21**] 03:31 PM

Cefazolin - [**2181-11-22**] 12:10 AM

Infusions:

Other ICU medications:

Hydromorphone (Dilaudid) - [**2181-11-22**] 03:45 AM

Other medications:

Flowsheet Data as of [**2181-11-22**] 06:07 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 37.2

C (99

T current: 37.2

C (99

HR: 99 (73 - 100) bpm

BP: 127/66(78) {75/55(62) - 127/71(81)} mmHg

RR: 17 (13 - 30) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 102.1 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

2,483 mL

579 mL

PO:

45 mL

Tube feeding:

IV Fluid:

2,303 mL

534 mL

Blood products:

Total out:

745 mL

845 mL

Urine:

525 mL

755 mL

NG:

Stool:

Drains:

15 mL

90 mL

Balance:

1,738 mL

-266 mL

Respiratory support

O2 Delivery Device: Nasal cannula

SPO2: 96%

ABG: ///24/

Physical Examination

General Appearance: No acute distress

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: Absent), (Temperature: Warm)

Right Extremities: (Edema: Absent), (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

Moves all extremities

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement

Neurologic: s/p R crani for dural repair and lumbar drain placement, AOA x 3, Q1 Neuro checks, dilaudid prn pain, Decadron 4mg q6h, Dilantin 100 mg TID, LeVETiracetam 1000 mg PO bid, drain 15 ml CSF/hr via lumbar drain

Cardiovascular: HD stable. Nicardipine/Hydralazine prn for goal

SBP<160.

Pulmonary: OSA- Autoset CPAP if needed. Stable

Gastrointestinal / Abdomen: Regular diet. Famotidine. Zofran prn N/V.

Nutrition: NPO

Renal: Follow UOP

Hematology: cont to monitor daily.

Endocrine: RISS

Infectious Disease: C-Diff, Ancef/Flagyl

Lines / Tubes / Drains: PIV right radial a-line d/c'd

Wounds:

Imaging:

Fluids: NS

Consults: Neuro surgery

Billing Diagnosis: Other: Dural leak

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

ICP Catheter - [**2181-11-21**] 02:17 PM

20 Gauge - [**2181-11-21**] 02:18 PM

14 Gauge - [**2181-11-21**] 02:19 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Comments:

Code status: Full code

Disposition: ICU

Total time spent: 31 minutes

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan.Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased

from a traumatic fall.

ROS: Negative otherwise noted in HPI.

Current medications:

. Acetaminophen-Caff-Butalbital 5. Acetaminophen

6. Bisacodyl 7. CefePIME 8. Docusate Sodium 9. Famotidine 10.

Gabapentin 11. HYDROmorphone (Dilaudid)

12. HYDROmorphone (Dilaudid) 13. Heparin 14. 15. Insulin 16.

LeVETiracetam 17. Lidocaine Jelly 2% (Urojet)

18. MetRONIDAZOLE (FLagyl) 19. Midazolam 20. Ondansetron 21. Senna 22.

Simvastatin 23. Sodium Chloride 0.9% Flush

24. Sodium Chloride 0.9% Flush 25. Vancomycin Oral Liquid

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per

CPS recs. Tolerated diet advance. PICC team consulted will place

line in coming days.

Post operative day:

POD#4 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Cefazolin - [**2181-11-22**] 08:16 AM

Vancomycin - [**2181-11-24**] 07:37 AM

Cefipime - [**2181-11-24**] 08:03 PM

Metronidazole - [**2181-11-25**] 12:06 AM

Infusions:

Other ICU medications:

Heparin Sodium (Prophylaxis) - [**2181-11-25**] 12:06 AM

Other medications:

Flowsheet Data as of [**2181-11-25**] 05:16 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 38.2

C (100.7

T current: 36.8

C (98.2

HR: 72 (69 - 94) bpm

BP: 101/67(75) {90/58(66) - 126/88(93)} mmHg

RR: 13 (13 - 21) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 103.2 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

2,553 mL

519 mL

PO:

30 mL

Tube feeding:

IV Fluid:

2,523 mL

519 mL

Blood products:

Total out:

1,935 mL

620 mL

Urine:

1,935 mL

620 mL

NG:

Stool:

Drains:

Balance:

618 mL

-101 mL

Respiratory support

O2 Delivery Device: None

SPO2: 96%

ABG: ////

Physical Examination

General Appearance: No acute distress

HEENT: PERRL, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :), (Sternum: Stable)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace)

Right Extremities: (Edema: Trace)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

Moves all extremities

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Imaging: Large R Temporal mass measuring approximately 3-4cm creating

mass

effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal

cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

[**2181-11-21**] CT head Expected small pneumocephalus, subcutaneous gas and

soft tissue swelling around the surgical site.Sliver of hyperdensity along the right frontoparietal convexity, compatible with tiny post-surgical subdural hematoma. No evidence of other intracranial hemorrhage.No shift of normally midline structure.No evidence of abnormal CSF collection to suggest leakage.

[**2181-11-22**] CT head No significant short-term changes.

Microbiology: NGTD

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement, now with meningitis started in broad spectrum abx.

PLAN:

Neuro: s/p R crani for dural repair and lumbar drain placement,on Keppra. Now with meningitis. Lumbar drain removed per ID rec. Consider MRI or brain and spine if no clinical improvement by 24 hrs. CPS consulting - recomending gabapentin

CVS: HD stable.

Pulm: Hx OSA. No other issues

GI: Full feeds. Famotidine. Zofran prn N/V.

FEN: KVO

Renal: Foley UOP adequate.

Heme: Stable.

Endo: Started RISS

ID: Meningitis in setting of lumbar drain. On Flagyl, Vanco, Cefipime. F/u cultures. Lumbar drain removed.

TLD: PIV

Wounds: head wound c/d/i

Prophylaxis: SCDs, H2B. SQH

Consults: Neurosurgery, ID

Code: Full

Disposition: Step-Down

Billing Diagnosis:

ICU Care

Nutrition:

Glycemic Control:

Lines:

20 Gauge - [**2181-11-23**] 05:57 PM

Prophylaxis:

DVT: SQH, SCD

Stress ulcer: H2B

VAP bundle:

Comments:

Communication: Comments:

Code status: Full code

Total time spent:

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on [**10-5**] and now admitted on Sunday with recurrent CSF rhinorrhea (was d/c home on Fri [**11-16**] after a 9 day admission for rhinorrhea) was in house on floor with lumbar drain in place and brought to OR on wed [**11-21**]. OR course stable/uneventful admitted to SICU post-operatively for frequent neuro checks.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized

weakness, no rhinorrhea

c/o HA [**9-17**]

Dermabond to small LLQ incision (fat flap site), Right crani

incision with DSD

Action:

Neuro checks q 2

Dilaudid IV for HA, also Fioricet and Neurontin

IVF infusing for hydration, poor po intake

Unable to obtain am labs-team aware

Response:

HA completely relieved with Dilaudid

Remains neurologically intact

Plan:

Transfer to neuro SDU when bed available

Cont q 2 neuro checks

Dilaudid for pain

Advance diet as tolerated

OOB as tolerated. Awaiting PT/OT consults.

?PICC placement for poor IV access

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches,

worsening in severity over the past several days and awoke with a [**11-17**]

headache and went to PCP's office, who ordered

a CT Scan.Friends had noticed that he had been

confused lately and he reported generalized weakness. CT Scan

demonstrated large R Temporal mass with mass effect creating

midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for

metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented

with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per CPS recs. Tolerated diet advance.

[**11-25**] PICC line placed. IVAbx adjusted, WBCs still elevated.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized weakness, right slightly greater than left, no rhinorrhea

c/o HA [**8-17**]

Right crani incision CDI OTA

Poor IV access

Action:

Neuro checks as directed

Dilaudid IV and PO for HA, also Fioricet and Neurontin

Intake improving, ADAT

PICC line inserted

Response:

HA improving with with Dilaudid PO and IV

Remains neurologically intact

Plan:

Transfer to floor when bed available

Dilaudid for pain

Advance diet as tolerated

Awaiting PT/OT consult

"

"SICU

HPI:

53 yo M with history of right sided headaches in beginning in [**Month (only) **] [**2181**]. CT Scan at that time demonstrated large R temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for right temporal craniotomy for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then re-presented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat in bed with no signs of CSF leakage. On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380, gram stain negative. Serum WBC=18. ID consulted and recommeded

adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

rhinorrhea

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Cognition, Impaired: Patient is A and O x 3. He was confused

initially when admitted to the SICU and has improved drastically.

Initially complaining of severe headache and sensitivity to touch.

Both have improved drastically since SICU admission.

C-Dif: Since changing antibiotics, diarrhea has improved. Out of bed

and toileting independently or with minimal assistance. D/C

ed foley

on previous shift and has been voiding appropriately.

Tolerating regular diet.

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches,

worsening in severity over the past several days and awoke with a [**11-17**]

headache and went to PCP's office, who ordered

a CT Scan.Friends had noticed that he had been

confused lately and he reported generalized weakness. CT Scan

demonstrated large R Temporal mass with mass effect creating

midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for

metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented

with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for

dural repair and lumbar drain placement. Pt transferred to floor where

he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared

to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF

showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per CPS recs. Tolerated diet advance. PICC team consulted will place line in coming days.

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan.Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented

with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per CPS recs. Tolerated diet advance.

[**11-25**] PICC line placed. IVAbx adjusted, WBCs still elevated.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized weakness, left greater than right, no rhinorrhea

c/o HA [**8-17**]

Right crani incision CDI OTA

Poor IV access

Action:

Neuro checks as directed

Dilaudid IV and PO for HA, also Fioricet and Neurontin

Intake improving, ADAT

PICC line inserted

Response:

HA improving with with Dilaudid PO and IV

Remains neurologically intact

Plan:

Transfer to floor when bed available

Dilaudid for pain

Advance diet as tolerated

Awaiting PT/OT consult

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan.Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per CPS recs. Tolerated diet advance.

[**11-25**] PICC line placed. IVAbx adjusted, WBCs still elevated.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized weakness, left greater than right, no rhinorrhea

c/o HA [**8-17**]

Right crani incision CDI OTA

Poor IV access

Action:

Neuro checks as directed

Dilaudid IV and PO for HA, also Fioricet and Neurontin

Intake improving, ADAT

PICC line inserted

Response:

HA improving with with Dilaudid PO and IV

Remains neurologically intact

Plan:

Transfer to floor when bed available

Dilaudid for pain

Advance diet as tolerated

Awaiting PT/OT consult

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on [**10-5**]. Readmitted to SICU [**11-21**] with recurrent CSF rhinorrhea (was d/c home on Fri [**11-16**] after a 9 day admission for rhinorrhea) after undergoing lumbar drain placement in OR. Stable course and sent to [**Hospital Ward Name 383**] 11 where yesterday [**11-23**] became increasingly lethargic and brought back to SICU for closer neuro monitoring.

s/p Craniotomy for Dural Leak

Assessment:

Neurologically intact. No weakness in any extremities.

Sleeping unless interrupted where pt with c/o generalized pain rating [**2182-7-16**] on [**11-17**] pain scale and also c/o discomfort with many forms of intervention to pt: adjusting blankets, washing skin and touching hand.

Pt stated feeling catheter discomfort as well.

No rhinorrhea or noted CSF leaking.

Pt turning side to side independently on 25 degree bed rest.

Has superficial clot in LLE but okay to have venodyne on

Continues on PO Flagyl for CDIFF. Small liquid BM in beginning of night.

Lumbar drain removed by MD. Suture and dressing placed.

Derma bond to small LLQ incision (fat flap site). Right crani incision with DSD. Continues on IV antibiotics.

Afebrile. HR 80-90

s NSR. SBP 90-110. Oxygen saturation >95%

RA. Lungs CTAB.

Action:

Monitoring neuro status hourly.

Pt receiving Dilaudid IV/PO as ordered. Urojet applied to penis for catheter comfort.

Response:

Neuro remains intact.

Remains NPO with sips for meds. Tolerating medications well.

Pt remains with c/o pain however less after initial intervention. No further catheter pain. Team notified.

No drainage from back suture. No CSF leak.

Plan:

Continue to monitor neuro exams hourly. Monitor for CSF leak.

Maintain HOB elevation to 25 degrees.

Monitor pain/comfort treating with Dilaudid (Fioricet also available for HA) as required.

Advance diet as tolerated

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

Mental status change

PMHx:

Lung CA - s/p L Lower Lung Lobe resection [**2180**]

Current medications:

CefePIME

Vanco

Bisacodyl

tylenol

Heparin

Flagyl

Keppra

Simvastatin

Famotidine

Senna

Docusate

24 Hour Events:

[**11-23**]: Re admission to SICU [**3-12**] fever, increased WBC in CSF and mental status change. s/p drain removal and empiric abx treatment

Post operative day:

POD#3 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Metronidazole - [**2181-11-21**] 03:31 PM

Cefazolin - [**2181-11-22**] 08:16 AM

Vancomycin - [**2181-11-24**] 02:13 AM

Infusions:

Other ICU medications:

Heparin Sodium (Prophylaxis) - [**2181-11-24**] 12:00 AM

Hydromorphone (Dilaudid) - [**2181-11-24**] 12:05 AM

Other medications:

Flowsheet Data as of [**2181-11-24**] 05:41 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 38.1

C (100.6

T current: 37.7

C (99.8

HR: 99 (85 - 103) bpm

BP: 119/74(85) {95/52(62) - 119/91(96)} mmHg

RR: 17 (8 - 25) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 103.2 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

726 mL

635 mL

PO:

30 mL

Tube feeding:

IV Fluid:

696 mL

635 mL

Blood products:

Total out:

255 mL

335 mL

Urine:

255 mL

335 mL

NG:

Stool:

Drains:

Balance:

471 mL

300 mL

Respiratory support

O2 Delivery Device: None

SPO2: 96%

ABG: ////

Physical Examination

General Appearance: Sleeping, somnolent, but arousable and complains of

HA

HEENT: Uncooperative with eye exam

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: CTA bilateral :)

Abdominal: Soft, benign

Left Extremities: (Temperature: Warm), No edema

Right Extremities: (Temperature: Warm), No edema

Neurologic: Pt refused to all questins except if he was in pain

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

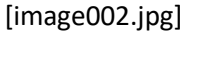
10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL



[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Imaging: CT:

Large R Temporal mass measuring approximately 3-4cm creating mass effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

[**2181-11-21**] CT head Expected small pneumocephalus, subcutaneous gas and soft tissue swelling around the surgical site.Sliver of hyperdensity along the right frontoparietal convexity, compatible with tiny post-surgical subdural hematoma. No evidence of other intracranial hemorrhage.No shift of normally midline structure.No evidence of abnormal CSF collection to suggest leakage.

[**2181-11-22**] CT head No significant short-term changes.

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement, now with meningitis started in broad spectrum

abx.

Neurologic: Neuro checks Q: 1 hr, s/p R crani for dural repair and lumbar drain placement,on Keppra. Now with meningitis. Lumbar drain removed per ID rec. Consider MRI or brain and spine if no clinical improvement by 24 hrs.

Cardiovascular: stable.

Pulmonary: Hx of OSA, but no issues currently

Gastrointestinal / Abdomen: Stress Ulcer prophylaxis

Nutrition: Sips except for meds

Renal: Foley, adeq UOP

Hematology: Labs pending this AM.

Endocrine: RISS

Infectious Disease: Recent C.Diff +; Check cultures, Meningitis in setting of lumbar drain. On Flagyl, Vanco, Cefipime. Lumbar drain removed.

Lines / Tubes / Drains: Foley

needs more reliable access for antibx

-

PICC eval today.

Wounds: Drain removed.

Imaging: Consider MRI if no clinical improvement

Fluids: Other, KCL+NS 80/hr.

Consults: Neuro surgery

Billing Diagnosis: Post-op Complication.

ICU Care

Nutrition:

Glycemic Control:

Lines:

20 Gauge - [**2181-11-23**] 05:57 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle:

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting planning Comments:

Code status: Full code

Disposition: ICU

Total time spent: 31 minutes

Patient is critically ill

"

"HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches,

worsening in severity over the past several days and awoke with a [**11-17**]

headache and went to PCP's office, who ordered

a CT Scan.Friends had noticed that he had been

confused lately and he reported generalized weakness. CT Scan

demonstrated large R Temporal mass with mass effect creating

midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for

metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented

with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for

dural repair and lumbar drain placement. Pt transferred to floor where

he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared

to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF

showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and

recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd

[**11-23**].

Chief complaint:

CSF Leak

PMHx:

PMHx: Lung CA - s/p L Lower Lung Lobe resection [**2180**]

All: PCN

Medications prior on admission:

simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as

Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased

from a traumatic fall.

ROS: Negative otherwise noted in HPI.

"

"Pain, Chronic

Assessment:

Continues to have

total body

pain today, mentioning that it hurts to

touch his legs, or move the blankets over his body. Reports being

very sensitive to cold.

Neurologically patient remains intact and

appropriate throughout the day.

Action:

Initiated gabapentin PO for presumed neuropathic pain.

Response:

Patient appears to be comfortable this afternoon.

Plan:

Transfer to the step down unit when a bed becomes available.

"

"SICU

HPI:

53 yo M with in [**9-16**] had a [**3-13**] week history of R Sided headaches, worsening in severity over the past several days and awoke with a [**11-17**] headache and went to PCP's office, who ordered a CT Scan.Friends had noticed that he had been confused lately and he reported generalized weakness. CT Scan demonstrated large R Temporal mass with mass effect creating midline shift. To OR in [**Month (only) **] for Right temporal craniotomy, for metastatic andeocarcinoma [**2181-10-5**]. Discharged [**2181-11-16**] then represented with gush of clear salty nasal fluid. [**2181-11-21**] to OR for R crani for dural repair and lumbar drain placement. Pt transferred to floor where he remained flat and no signs of CSF leakage.

On [**11-22**] was increasingly confused , a CT scan was stable compared to scan on [**11-21**]. On [**11-23**] pt noted to have a fever to 102 and CSF showed WBC=380,gram stain negative. Serum WBC=18. ID consulted and recommeded adding Vanco and Cefipime to Flagyl. Lumbar drain d/c'd [**11-23**].

Chief complaint:

CSF Leak

PMHx:

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simvastatin 40mg', keppra 1gm"", colace, dilaudid

Social Hx: Married, 4 living children. Currently employed as Manager at [**Company 8557**].

Family Hx: Mother is alive and well in her 80s, Father deceased from a traumatic fall.

ROS: Negative otherwise noted in HPI.

Current medications:

. Acetaminophen-Caff-Butalbital 5. Acetaminophen

6. Bisacodyl 7. CefePIME 8. Docusate Sodium 9. Famotidine 10.

Gabapentin 11. HYDROmorphone (Dilaudid)

12. HYDROmorphone (Dilaudid) 13. Heparin 14. 15. Insulin 16.

LeVETiracetam 17. Lidocaine Jelly 2% (Urojet)

18. MetRONIDAZOLE (FLagyl) 19. Midazolam 20. Ondansetron 21. Senna 22.

Simvastatin 23. Sodium Chloride 0.9% Flush

24. Sodium Chloride 0.9% Flush 25. Vancomycin Oral Liquid

24 Hour Events:

Well overnight. Minimal narcotic usage after begining gabapentin per

CPS recs. Tolerated diet advance. PICC team consulted will place

line in coming days.

Post operative day:

POD#4 - crani re-do for dural repair

Allergies:

Penicillins

Rash;

Last dose of Antibiotics:

Cefazolin - [**2181-11-22**] 08:16 AM

Vancomycin - [**2181-11-24**] 07:37 AM

Cefipime - [**2181-11-24**] 08:03 PM

Metronidazole - [**2181-11-25**] 12:06 AM

Infusions:

Other ICU medications:

Heparin Sodium (Prophylaxis) - [**2181-11-25**] 12:06 AM

Other medications:

Flowsheet Data as of [**2181-11-25**] 05:16 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**84**] a.m.

Tmax: 38.2

C (100.7

T current: 36.8

C (98.2

HR: 72 (69 - 94) bpm

BP: 101/67(75) {90/58(66) - 126/88(93)} mmHg

RR: 13 (13 - 21) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 103.2 kg (admission): 109.1 kg

Height: 72 Inch

Total In:

2,553 mL

519 mL

PO:

30 mL

Tube feeding:

IV Fluid:

2,523 mL

519 mL

Blood products:

Total out:

1,935 mL

620 mL

Urine:

1,935 mL

620 mL

NG:

Stool:

Drains:

Balance:

618 mL

-101 mL

Respiratory support

O2 Delivery Device: None

SPO2: 96%

ABG: ////

Physical Examination

General Appearance: No acute distress

HEENT: PERRL, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral :), (Sternum: Stable)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace)

Right Extremities: (Edema: Trace)

Neurologic: (Awake / Alert / Oriented: x 3), Follows simple commands,

Moves all extremities

Labs / Radiology

289 K/uL

11.2 g/dL

104 mg/dL

1.0 mg/dL

24 mEq/L

4.3 mEq/L

10 mg/dL

110 mEq/L

139 mEq/L

33.6 %

17.2 K/uL

[image002.jpg]

[**2181-11-22**] 01:51 AM

WBC

17.2

Hct

33.6

Plt

289

Creatinine

1.0

Glucose

104

Other labs: Ca:7.3 mg/dL, Mg:1.6 mg/dL, PO4:3.3 mg/dL

Imaging: Large R Temporal mass measuring approximately 3-4cm creating

mass

effect extending to the frontal and parietal lobes.

Approximately .5cm of midline shift. Mild effacement of basal

cisterns. No hydrocephalus.

[**2181-10-4**] MRI Head 2-3cm R Temporal mass with mass effect, 1.1cm shift

[**2181-11-21**] CT head Expected small pneumocephalus, subcutaneous gas and

soft tissue swelling around the surgical site.Sliver of hyperdensity

along the right frontoparietal convexity, compatible with tiny

post-surgical subdural hematoma. No evidence of other intracranial hemorrhage.No shift of normally midline structure.No evidence of abnormal CSF collection to suggest leakage.

[**2181-11-22**] CT head No significant short-term changes.

Microbiology: NGTD

Assessment and Plan

[**Last Name 9**] PROBLEM - ENTER DESCRIPTION IN COMMENTS

Assessment and Plan: 53M s/p crani for tumor resection with representation for CSF rhinorhea s/p R crani for dural repair and lumbar drain placement, now with meningitis started in broad spectrum abx.

PLAN:

Neuro: s/p R crani for dural repair and lumbar drain placement, on Keppra. Now with c/o meningitis. Lumbar drain removed per ID rec. CPS consulting - recommending gabapentin

CVS: HD stable.

Pulm: Hx OSA. No other issues. Advance activity to OOB today.

GI: Regular diet, encourage PO intake. Famotidine. Zofran prn N/V.

FEN: KVO

Renal: Foley UOP adequate.

Heme: no issues

Endo: Started RISS

ID: Meningitis in setting of lumbar drain. On Flagyl, Vanco, Cefipime. F/u cultures. Lumbar drain removed.

TLD: PIV

Wounds: head wound c/d/i

Prophylaxis: SCDs, H2B. SQH

Consults: Neurosurgery, ID

Code: Full

Disposition: Step-Down vs floor

Billing Diagnosis: Post-op complication

ICU Care

Nutrition:

Glycemic Control:

Lines:

20 Gauge - [**2181-11-23**] 05:57 PM

Prophylaxis:

DVT: SQH, SCD

Stress ulcer: H2B

VAP bundle:

Comments:

Communication: Comments:

Code status: Full code

Total time spent: 11

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on

[**10-5**] and now admitted with recurrent CSF leaks/rhinorrhea (was d/c

home on Fri [**11-16**] after a 9 day admission) was on [**Hospital Ward Name 383**] 11 with lumbar

drain in place and brought to OR on wed [**11-21**] for repair of dural tear.

OR course stable/uneventful admitted to SICU post-operatively for

frequent neuro checks.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized

weakness, no rhinorrhea

c/o HA [**2182-7-16**]

Dermabond to small LLQ incision (fat flap site), Right crani incision OTA, Lumbar drain site OTA

WBC down

Action:

Neuro checks q 4

Dilaudid po for HA and Neurontin for presumed neuropathic pain

Antibitotics as ordered

Response:

HA completely relieved with Dilaudid

Remains neurologically intact

Plan:

Transfer to floor when bed available

Cont q 4 neuro checks

Dilaudid for pain

OOB as tolerated. Awaiting PT/OT consults.

Cont antibiotics as ordered

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on [**10-5**] and now admitted on Sunday with recurrent CSF rhinorrhea (was d/c home on Fri [**11-16**] after a 9 day admission for rhinorrhea) was in house on floor with lumbar drain in place and brought to OR on wed [**11-21**]. OR course stable/uneventful admitted to SICU post-operatively for frequent neuro checks.

s/p Craniotomy for Dural Leak

Assessment:

Neurologically intact, no weakness in any extremeties, no rhinorrhea

This am no CSF draining when unclamped at 0800

Constantly c/o headache/backache rating at #8

Pt turning side to side independently on FLAT bedrest

Has superficial clot in LLE but okay to have venodyne on

On Flagyl PO for Cdiff (started yesterday) no stool post-op

Lumbar drain site C/D/I

Action:

Lumbar drain kept clamped and opened hourly (overnight started draining 15cc/hr from 2300 on)

Dilaudid IV/PO ordered (overnight using IV d/t not eating a regular diet yet)

IVF infusing for hydration

Response:

Tolerating PO meds

Pt reports poor pain control

primary team notified

Plan:

Called out to floor with Q4hr neuro/vitals

Lumbar drain to be clamped and opened hourly just to drain 15cc

Dilaudid for pain

Advance diet as tolerated

"

"Pain, Chronic

Assessment:

Continues to have total body pain today, mentioning that it hurts to touch his legs, or move the blankets over his body. Reports being very sensitive to cold.

Neurologically patient remains intact and

appropriate throughout the day.

Action:

Initiated gabapentin PO for presumed neuropathic pain.

Response:

Patient appears to be comfortable this afternoon.

Plan:

Transfer to the step down unit when a bed becomes available.

"

"53 yo male s/p met adenocarcinoma tumor resection of R temporal lobe on

[**10-5**] and now admitted with recurrent CSF leaks/rhinorrhea (was d/c

home on Fri [**11-16**] after a 9 day admission) was on [**Hospital Ward Name 383**] 11 with lumbar

drain in place and brought to OR on wed [**11-21**] for repair of dural tear.

OR course stable/uneventful admitted to SICU post-operatively for

frequent neuro checks.

s/p Craniotomy for Dural Leak

Assessment:

Afebrile, hemodynamically stable

Neurologically intact, follows commands with generalized

weakness, no rhinorrhea

c/o HA [**9-17**]

Dermabond to small LLQ incision (fat flap site), Right crani

incision with DSD

Action:

Neuro checks q 2

Dilaudid IV for HA, also Fioricet and Neurontin

IVF infusing for hydration, poor po intake

Unable to obtain am labs-team aware

Response:

HA completely relieved with Dilaudid

Remains neurologically intact

Plan:

Transfer to neuro SDU when bed available

Cont q 2 neuro checks

Dilaudid for pain

Advance diet as tolerated

OOB as tolerated. Awaiting PT/OT consults.

?PICC placement for poor IV access

"

"[**2181-11-15**] 7:21 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31031**]

Reason: evaluate for changes

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man hx right temporal crani for tumor rsxn, + CSF rhinorrhea

REASON FOR THIS EXAMINATION:

evaluate for changes

No contraindications for IV contrast

WET READ: [**First Name9 (NamePattern2) 4576**] [**Doctor First Name 141**] [**2181-11-15**] 4:39 PM

No acute hemorrhage.

stable post-surgical change s/p R craniotomy

No change at right temporal lobe resection site.

no significnt change of frontal sinus collection

Marked interval improvement of left maxillary sinus collection

WET READ VERSION #1 [**First Name9 (NamePattern2) 4576**] [**Doctor First Name 141**] [**2181-11-15**] 1:27 PM

No acute hemorrhage.

stable post-surgical change s/p R craniotomy

No change at right temporal lobe resection site.

Slight interval improvement of frontal sinus collection

Marked interval improvement of left maxillary sinus collection

---

FINAL REPORT

INDICATION: 53-year-old male with a history of right craniotomy for tumor resection, with history of CSF rhinorrhea. CT requested to evaluate for changes.

TECHNIQUE: CT of the head without IV contrast.

COMPARISON: CT of the head available from [**2181-11-12**], and [**2181-11-7**].

FINDINGS:

The patient is status post right craniotomy and resection of known right temporal mass. There is tissue loss and edema at the resection site, unchanged in appearance in comparison with the prior [**2181-11-12**] study. There is opacification and air seen within the right frontal sinus, which is enlarged. These findings are stable in comparison to the prior CT examination.

There is no evidence of a new hemorrhage, edema, masses, mass effect, or infarction. The [**Doctor Last Name 107**]-white matter differentiation is preserved and unchanged from prior exam. The ventricles are unchanged in size from prior exam. The

sulci are normal in configuration.

There has been marked interval improvement of the opacification in the left maxillary sinus. Included views of the mastoid cells demonstrate near complete opacification of the cells, unchanged from prior examination.

IMPRESSION: Stable post-surgical changes from the recent right temporal lobe

(Over)

[**2181-11-15**] 7:21 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31031**]

Reason: evaluate for changes

Admitting Diagnosis: CSF RHINORRHEA

FINAL REPORT

(Cont)

mass resection. There is little change in the amount of air and consolidation within the frontal sinus.

"

"[**2181-11-7**] 9:02 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31912**]

Reason: ? changed brain

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with s/p brain mets resection w ? CSF rhinorrhea

REASON FOR THIS EXAMINATION:

? changed brain

No contraindications for IV contrast

WET READ: [**First Name9 (NamePattern2) 1333**] [**Doctor First Name 141**] [**2181-11-8**] 12:33 AM

no intracranial hemorrhage

resolution of midline shift and of edema in comparison to [**2181-10-6**]

opacification of left maxillary sinus, left mastoid air cells and left middle ear

partial opacitification of rt posterior ethmoid air cells. the right middle ear is well aerated.

minimal thickening of bilateral anterior ethmoid air cells. ethmoid air cells otherwise clear.

lateral rt frontal sinus partially opacified. frontal, sphenoid sinuses otherwise clear

---

FINAL REPORT (REVISED)

HISTORY: A 53-year-old male after a brain metastasis resection with a question of CSF rhinorrhea. According to the medical record, the patient has increasing nasal discharge and postnasal drip for one week.

TECHNIQUE: Noncontrast head CT was performed. Sagittal and coronal reformatted images of the temporal bones were generated.

FINDINGS: The patient is post-right temporal mass resection. In comparison to the most recent prior studies, there is no longer shift of midline structures. The edema has essentially resolved. There is no hydrocephalus or intracranial hemorrhage.

The right posterior ethmoid air cells are partially opacified. The right external and middle ear canals are patent. There is focal opacification

laterally and dependently of the right frontal sinus in the area of the craniotomy. There is mucoscal thickening of bilateral anterior ethmoid air cells.

The left maxillary sinus is nearly completely opacified, there is new, near complete opacification of the left mastoid air cells. The left sphenoid, ethmoid, and frontal sinuses are well aerated. There is partial opacification of bilateral anterior ethmoid air cells. The left middle ear is opacified with soft tissue density. The left external ear canal is patent.

IMPRESSION:

1. Interval resolution of midline shift and edema in comparison to prior studies.

2. Partial opacification of right posterior mastoid air cells, new from prior studies. The right middle ear canal is patent.

(Over)

[**2181-11-7**] 9:02 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31912**]

Reason: ? changed brain

FINAL REPORT (REVISED)

(Cont)

3. Near complete opacification of the left maxillary sinus, similar to the prior studies, with near complete opacification of the left mastoid air cells and new opacification of the left middle ear.

NOTE ADDED AT ATTENDING REVIEW: The frontal craniotomy extended through the

right frontal sinus, involving the anterior and posterior walls. This portion

of the sinus is opacified, and there is a small air bubble in the surgical

defect in the anterior wall of the sinus. Overall, these findings suggest this

is the source of the CSF leak. These findings were discussed with [**First Name4 (NamePattern1) 3922**] [**Last Name (NamePattern1) 399**]

of Neurosurgery by Dr. [**First Name (STitle) 9422**].

"

"[**2181-11-23**] 9:18 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 32065**]

Reason: eval for obstruction

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with abdominal pain

REASON FOR THIS EXAMINATION:

eval for obstruction

PROVISIONAL FINDINGS IMPRESSION (PFI): YGd FRI [**2181-11-23**] 3:00 PM

Paucity of bowel gas renders definite rule out of obstruction difficult. No

dilated bowel loops are identified. Air is visualized in nondistended colon.

No evidence of free air.

FINAL REPORT

HISTORY: 53-year-old man with abdominal pain.

COMPARISON: CT torso from [**2181-10-4**].

ABDOMEN, TWO VIEWS: General paucity of bowel gas renders interpretation difficult. A few air-fluid levels are visualized on the decubitus view, which is nonspecific. Some air is visualized in nondistended colon. There is no evidence of pneumoperitoneum. No soft tissue calcification is identified. Underlying osseous structures show no concerning findings.

"

"[**Last Name (LF) **],[**First Name3 (LF) 760**] C. NSURG FA11 [**2181-11-23**] 9:18 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 32065**]

Reason: eval for obstruction

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with abdominal pain

REASON FOR THIS EXAMINATION:

eval for obstruction

PFI REPORT

Paucity of bowel gas renders definite rule out of obstruction difficult. No dilated bowel loops are identified. Air is visualized in nondistended colon. No evidence of free air.

"

"[**2181-11-19**] 5:39 PM

UNILAT LOWER EXT VEINS LEFT Clip # [**Clip Number (Radiology) 31783**]

Reason: PAIN SWELLING ? DVT

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with left leg swelling

REASON FOR THIS EXAMINATION:

DVT

WET READ: DLrc MON [**2181-11-19**] 6:10 PM

No evidence of left lower extremity DVT. Known superficial thrombophlebitis.

FINAL REPORT

INDICATION: Patient is a 53-year-old male with left lower extremity swelling.
Evaluate for deep venous thrombus.

EXAMINATION: Left lower extremity DVT study.

COMPARISONS: Comparison to left lower extremity DVT study from one day prior
from [**2181-11-18**].

FINDINGS: Grayscale and Doppler son[**Name (NI) 14**] demonstrate the left common
femoral, superficial femoral, and popliteal veins were performed. There is
normal compressibility, flow and augmentation. In addition, there is
symmetric respiratory variability seen in the right and left common femoral
veins. There is normal flow seen in the left peroneal and posterior tibial
veins. Note is made of thrombus in superficial calf veins.

IMPRESSION:

1. No evidence of left lower extremity DVT.

2. Thrombosis involving superficial calf veins.

SESHa

"

"[**2181-11-18**] 4:14 PM

UNILAT LOWER EXT VEINS LEFT Clip # [**Clip Number (Radiology) 31784**]

Reason: LLE PAIN R/O DVT

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with L LE pain, s/p recent hospitalization with 8 days of bed rest

REASON FOR THIS EXAMINATION:

r/o DVT

WET READ: SHfd SUN [**2181-11-18**] 5:23 PM

No dvt on left lower ext

WET READ VERSION #1 SHfd SUN [**2181-11-18**] 5:13 PM

no dvt on right lower ext

FINAL REPORT

REASON FOR EXAM: Left lower extremity pain.

TECHNIQUE: [**Doctor Last Name **]-scale and Doppler ultrasound images of the left lower extremity veins were obtained.

FINDINGS: The left common femoral, superficial femoral and popliteal veins demonstrate normal flow, compressibility and augmentation. The left peroneal and posterior tibial veins demonstrate wall-to-wall flow on color Doppler.

IMPRESSION: No DVT in the left lower extremity.

"

"[**2181-11-12**] 4:46 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31030**]

Reason: Evaluate for changes

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with CSF Rhinorrhea, now with new confusion

REASON FOR THIS EXAMINATION:

Evaluate for changes

No contraindications for IV contrast

WET READ: DLrc MON [**2181-11-12**] 7:56 PM

No significant interval change.

FINAL REPORT

INDICATION: Patient is a 53-year-old male with CSF rhinorrhea, now with new onset of confusion. Please evaluate for interval change.

EXAMINATION: CT OF THE HEAD WITHOUT INTRAVENOUS CONTRAST.

COMPARISONS: Comparison to head CT from [**2181-11-7**] and MR of the head from [**2181-10-6**].

TECHNIQUE: Contiguous axial images were obtained through the brain. No intravenous contrast was administered.

FINDINGS: The patient is status post right craniotomy and resection of known right temporal mass. Redemonstrated is the right frontal craniotomy site with extension through to the right frontal sinus, with associated opacification and air seen within the right frontal sinus, that likely serves as the site for cerebrospinal fluid leak. Overall, there is little interval change, with no evidence of new hemorrhage, edema, masses, mass effect, or acute infarction. The [**Doctor Last Name 107**]-white matter differentiation is preserved. There is mild persistent hypodensity within the right temporal region compatible with residual edema status post resection. There is no evidence of shift of midline structures. The ventricles and sulci are stable in size and configuration. There is complete opacification of the left maxillary sinus and mastoid air- cells and opacification involving the right frontal sinus and partial opacification of the right mastoid air- cells.

IMPRESSION:

1. No significant interval change. No acute hemorrhage, mass effect or hydrocephalus.
Right frontal craniotomy extends through the right frontal sinus with area of high attenuation-mixed with air compatible with site of CSF leak.

2. Stable appearance of complete opacification of the left maxillary sinus, and left mastoid air-cells, with near complete opacification of the right mastoid air-cells.

(Over)

[**2181-11-12**] 4:46 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31030**]

Reason: Evaluate for changes

Admitting Diagnosis: CSF RHINORRHEA

FINAL REPORT

(Cont)

"

"[**2181-11-21**] 5:23 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31036**]

Reason: Please evaluate for evidence of further CSF leak and for pos

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with CSF rhinorrhea, s/p crani for repair of dura and lumbar drain placement.

REASON FOR THIS EXAMINATION:

Please evaluate for evidence of further CSF leak and for post-op hemorrhage.

**Please do within 4 hours.

No contraindications for IV contrast

WET READ: ENYa WED [**2181-11-21**] 6:51 PM

1. Small expected pneumocephalus in the R frontal convexity.

2. Expected subcutaneous air and soft tissue at the R frontoparietal skull.

3. Sliver of hyperdensity in the R frontal convexity, likely trace of SDH from the procedure.

4. Minimal effacement of adjacent brain parenchyma, but no shift of normally midline structures.

FINAL REPORT

HISTORY: 53-year-old man with CSF rhinorrhea, now status post repair of dura and lumbar drain replacement. Assess for evidence of CSF leak and postop hemorrhage.

COMPARISON: CT head without contrast on [**2181-11-18**].

TECHNIQUE: Non-contrast MDCT images were acquired through the brain.

FINDINGS: In the right frontoparietal surgical site, there is a small amount of pneumocephalus along the right frontal convexity. A small amount of soft tissue subcutaneous air and soft tissue swelling is also noted. There is a sliver of hyperdensity tracking along the right frontoparietal convexity measuring less than 1 mm in thickness, likely represent post-surgical tiny subdural hematoma. There is minimal effacement of adjacent sulci. No other intracranial hemorrhage is noted. There is no fluid collection to suggest CSF leakage. The ventricles and sulci are otherwise normal in configuration and appearance. There is no shift of normally midline structures. The [**Doctor Last Name 107**]-white matter differentiation is well preserved. Other than the right frontal and frontoparietal region craniotomy sites, there is no bony deformity. Again noted is some fluid collection in the right lateral frontal sinus. There is mild mucosal thickening in the left maxillary sinus and scattered opacification of the ethmoid air cells.

IMPRESSION:

1. Expected small pneumocephalus, subcutaneous gas and soft tissue swelling around the surgical site.
2. Sliver of hyperdensity along the right frontoparietal convexity, compatible with tiny post-surgical subdural hematoma.

3. No evidence of other intracranial hemorrhage.

4. No shift of normally midline structure.

5. No evidence of abnormal CSF collection to suggest leakage.

(Over)

[**2181-11-21**] 5:23 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31036**]

Reason: Please evaluate for evidence of further CSF leak and for pos

Admitting Diagnosis: CSF RHINORRHEA

FINAL REPORT

(Cont)

"

"[**Last Name (LF) 31167**],[**First Name3 (LF) 2888**] T. MED FA6A [**2181-12-6**] 4:19 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 31168**]

Reason: ? progression of likely hemothorax

Admitting Diagnosis: PULMONARY EMBOLIS

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with lung [**Last Name (LF) **], [**First Name3 (LF) 464**] mets s/p resection, large PE on hep gtt,

HD stable.

REASON FOR THIS EXAMINATION:

? progression of likely hemothorax

PFI REPORT

Small but slightly decreased right and unchanged left pleural effusions, right

basilar atelectasis.

"

"[**2181-11-25**] 9:51 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 32066**]

Reason: 51 cm Picc placed in left brachial vein, need Picc tip place

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with new Picc

REASON FOR THIS EXAMINATION:

51 cm Picc placed in left brachial vein, need Picc tip placement

---

FINAL REPORT

SINGLE AP PORTABLE VIEW OF THE CHEST

REASON FOR EXAM: Assess PICC line.

Left PICC tip is in the mid SVC.

Cardiomediastinal silhouette is unchanged. Aside from right linear basal atelectasis the lungs are grossly clear. There is no pneumothorax. If any there is a small left pleural effusion.

"

"[**2181-11-13**] 8:07 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 31166**]

Reason: r/o pneumonia

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with CSF leak, increased temp

REASON FOR THIS EXAMINATION:

r/o pneumonia

FINAL REPORT

CHEST PORTABLE AP.

REASON FOR EXAM: Rule out pneumonia.

FINDINGS:There is a small volume of fluid in the lateral right horizontal fissure and small bilateral pleural effusions. No new consolidation or pneumothorax. Cardiomediastinal silhouette remains stable. Mild cardiomegaly.

IMPRESSION:

Mild cardiomegaly with small bilateral pleural effusions. No consolidation.

"

"[**2181-11-23**] 9:18 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 31786**]

Reason: eval for atelectasis

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with fever

REASON FOR THIS EXAMINATION:

eval for atelectasis

FINAL REPORT

HISTORY: Fever.

FINDINGS: In comparison with study of [**11-13**], the opacification in the region of the minor fissure is no longer seen. The right costophrenic angle is more sharply visualized. Relatively lower lung volumes, but no definite acute pneumonia. Mild cardiomegaly persists.

"

"[**2181-12-2**] 9:04 AM

IVC GRAM/FILTER Clip # [**Clip Number (Radiology) 31037**]

Reason: Place IVC filter

Admitting Diagnosis: PULMONARY EMBOLIS

Contrast: OPTIRAY Amt: 45

********** CPT Codes **********

* [**Numeric Identifier 3747**] INTERUP IVC [**Numeric Identifier 3748**] PERC PLCMT IVC FILTER *

* [**Numeric Identifier 87**] MOD SEDATION, FIRST 30 MIN. [**Numeric Identifier 88**] MOD SEDATION, EACH ADDL 15 MIN *

****

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with lung cancer with brain metastases now with large pulmonary embolism. Please place IVC filter.

REASON FOR THIS EXAMINATION:

Place IVC filter

PROVISIONAL FINDINGS IMPRESSION (PFI): MGRc SUN [**2181-12-2**] 9:01 PM

Successful infrarenal placement of Opt-Ease IVC filter.

FINAL REPORT

MEDICAL HISTORY: 52-year-old man with lung cancer and brain metastasis status post craniotomy, now with large pulmonary embolism. Request was made for an IVC filter placement.

CLINICIANS: Dr. [**First Name8 (NamePattern2) 9422**] [**Name (STitle) 90**] and Dr. [**First Name (STitle) 411**] [**Name (STitle) 412**]. Dr. [**Last Name (STitle) 412**] is the attending radiologist who was present and supervising throughout.

ANESTHESIA: Moderate sedation was provided by administering divided doses of 100 mcg of Fentanyl and 2 mg of Versed throughout the total intraservice time of 45 minutes during which the patient's hemodynamic parameters were continuously monitored. Local anesthesia obtained with 1% lidocaine.

PROCEDURE AND FINDINGS: Informed consent was obtained after explaining the procedure, risks and benefits of the procedure. The patient was brought to angiography suite and placed supine on the imaging table. The right groin was prepped and draped in the standard sterile fashion. A preprocedure huddle and time-out were performed as per [**Hospital1 184**] protocol. Using fluoroscopic and ultrasound guidance and after injection of 8 cc of 1% lidocaine, a 19-gauge needle was used to puncture the right common femoral vein. A 0.035 [**Last Name (un) 89**] wire was advanced through the needle into the inferior vena cava under fluoroscopic guidance. The needle was then exchanged for a 5-French Omni flush catheter which was advanced over the guidewire. The Omni flush catheter was redirected into the left common iliac vein over a 0.035 angled glidewire

and the wire removed. The catheter was connected to the power injector and a venogram obtained demonstrating a single patent inferior vena cava with no thrombus. The left renal vein was the lowest and its position was noted on the IVC gram with the help of a ruler. Based on the diagnostic findings, it was decided to place an inferior vena cava filter in the infrarenal position.

The [**Last Name (un) 89**] wire was replaced through the Omni flush catheter and the catheter removed. Over the wire, the 5-French sheath from the Opt-Ease filter set was placed and advanced up to a level of left renal vein which is the lower most. The inner dilator was removed and an Opt-Ease filter was advanced through the

(Over)

[**2181-12-2**] 9:04 AM

IVC GRAM/FILTER Clip # [**Clip Number (Radiology) 31037**]

Reason: Place IVC filter

Admitting Diagnosis: PULMONARY EMBOLIS

Contrast: OPTIRAY Amt: 45

FINAL REPORT

(Cont)

sheath. After positioning the catheter at the infrarenal position, the Opt-Ease filter was deployed under fluoroscopic guidance. Final fluoroscopic image was obtained and saved digitally demonstrating satisfactory position and placement of the filter. The sheath was then removed and manual compression was held for 10 minutes and hemostasis was achieved.

The patient tolerated the procedure well and there were no immediate complications.

IMPRESSION: Successful placement of an inferior vena cava Opt-Ease filter in the infrarenal position. The filter may be retrieved within 2 weeks of placement if clnically indicated.

"

"[**Last Name (LF) 15891**],[**First Name3 (LF) **] MED FA6A [**2181-12-2**] 9:04 AM

IVC GRAM/FILTER Clip # [**Clip Number (Radiology) 31037**]

Reason: Place IVC filter

Admitting Diagnosis: PULMONARY EMBOLIS

Contrast: OPTIRAY Amt: 45

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with lung cancer with brain metastases now with large pulmonary embolism. Please place IVC filter.

REASON FOR THIS EXAMINATION:

Place IVC filter

PFI REPORT

Successful infrarenal placement of Opt-Ease IVC filter.

"

"[**2181-12-6**] 4:19 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 31168**]

Reason: ? progression of likely hemothorax

Admitting Diagnosis: PULMONARY EMBOLIS

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with lung [**Last Name (LF) **], [**First Name3 (LF) 464**] mets s/p resection, large PE on hep gtt,

HD stable.

REASON FOR THIS EXAMINATION:

? progression of likely hemothorax

PROVISIONAL FINDINGS IMPRESSION (PFI): [**First Name9 (NamePattern2) 4212**] [**Doctor First Name 141**] [**2181-12-6**] 6:51 PM

Small but slightly decreased right and unchanged left pleural effusions, right

basilar atelectasis.

FINAL REPORT

PA AND LATERAL CHEST RADIOGRAPH

INDICATION: 54-year-old man with lung adenocarcinoma, brain metastasis, status post resection, with large PE on heparin drip. Query progression of likely hemothorax.

COMPARISON: [**2181-12-5**].

FINDINGS: The tip of the left PICC is not seen on the current study. The degree of cardiomegaly is unchanged. Left small pleural effusion is stable, the right pleural effusion has slightly decreased. Right basal opacity likely represents atelectasis. There is no new consolidation, pneumothorax, or pulmonary edema. Prominent mediastinal fat accounts for a linear anterior density on the lateral view.

IMPRESSION: Slight decrease in the right and persistent left small pleural effusions. Right basilar atelectasis.

"

"[**2181-11-18**] 2:53 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31032**]

Reason: evaluate for changes

[**Hospital 2**] MEDICAL CONDITION:

53 year old man hx right temporal craniotomy for tumor rsxn, + CSF rhinorrhea

REASON FOR THIS EXAMINATION:

evaluate for changes

No contraindications for IV contrast

WET READ: SHfd SUN [**2181-11-18**] 4:42 PM

No change since prior exam. No acute abnormality.

FINAL REPORT

REASON FOR EXAM: 53-year-old male with history of right temporal craniotomy for tumor resection. CSF rhinorrhea. Clinical concern for interval change.

COMPARISON: Head CT from [**2181-11-15**]. Brain MRI from [**2181-10-6**], [**2181-10-3**], [**2180-8-17**].

NON-CONTRAST CT OF THE HEAD: The patient is status post right craniotomy and resection of known right temporal mass. There are post-surgical changes and edema at the resection site, unchanged in appearance since prior exam from [**2181-11-15**]. There is no acute intracranial hemorrhage or mass effect. The ventricles and extra-axial spaces are otherwise unremarkable. The visualized paranasal sinuses demonstrate mild mucosal thickening in the right frontal

sinus. Bilateral mastoid air cells are opacified, unchanged since prior exam.

IMPRESSION:

1. Stable post-surgical changes in the right parietal region.

2. No acute intracranial hemorrhage.

Bilateral mastoid air cell opacification and right frontal opacification
stable since prior exam. Minimal left maxillary sinus mucosal thickening.
Stable since prior exam.

"

"[**2181-11-22**] 6:11 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31785**]

Reason: Evaluate for changes

Admitting Diagnosis: CSF RHINORRHEA

[**Hospital 2**] MEDICAL CONDITION:

53 year old man s/p right crani for dural repair

REASON FOR THIS EXAMINATION:

Evaluate for changes

No contraindications for IV contrast

WET READ: [**First Name9 (NamePattern2) 3077**] [**Doctor First Name 141**] [**2181-11-22**] 7:12 PM

Mild interval decrease of pneumocephalus. Otherwise, no significant short-interval changes.

FINAL REPORT

HISTORY: 53-year-old man, status post right craniotomy for dural repair.
Assess for interval change.

COMPARISON: [**2181-11-21**].

TECHNIQUE: Non-contrast MDCT images were acquired through the brain.

FINDINGS: There are no significant short-term changes. At the right frontoparietal surgical site, there is a persistent tiny curvilinear density along the right frontal convexity, compatible with a small subdural hematoma from the surgery. Minimal effacement is again noted in the adjacent sulci. Minimal interval decrease of pneumocephalus and soft tissue air is noted. There is persistent mild soft tissue swelling. No new foci of intracranial hemorrhage is identified. No fluid collection is noted to suggest CSF leakage. The ventricles and sulci are otherwise normal in configuration and appearance. There is no shift of normally midline structures. The [**Doctor Last Name 107**]-white matter differentiation is well preserved. There is persistent fluid in the right frontal sinus. Scattered opacification of the ethmoid air cell and mucosal thickening of the left maxillary sinus are again noted.

IMPRESSION:

1. No significant short-term changes. Mild interval decrease of pneumocephalus and soft tissue air, but persistent mild soft tissue swelling around the surgical site.
2. Unchanged sliver of hyperdensity along the right frontoparietal convexity,

compatible with tiny post-surgical subdural collection.

3. No evidence of new hemorrhagic site or developing hydrocephalus.

4. No shift of normally midline structures or evidence of abnormal CSF collection.

"

"[**2181-10-6**] 7:52 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31035**]

Reason: 53 year old man with R temporal mass s/p R crani, evaluate f

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with R temporal mass s/p R crani, evaluate for residual tumor

REASON FOR THIS EXAMINATION:

53 year old man with R temporal mass s/p R crani, evaluate for residual tumor

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): AFSN SAT [**2181-10-6**] 2:48 PM

PFI: Postoperative changes. No residual enhancement seen.

FINAL REPORT

EXAM: MR brain.

CLINICAL INFORMATION: Patient with right temporal mass status post resection.

TECHNIQUE: T1 sagittal and axial and FLAIR T2 susceptibility and diffusion axial images of the brain were obtained before gadolinium. T1 axial and MP-RAGE sagittal images acquired following gadolinium. Comparison was made with

the previous MRI of [**2181-10-3**].

FINDINGS: Since the previous study, the patient has undergone resection of enhancing right temporal mass. Blood products are seen in this region with craniotomy in the right temporal region. Extensive edema is again identified as before. There is mass effect on the right lateral ventricle with mild midline shift to the left. No hydrocephalus is seen. Edema also extends to the upper brainstem as before. Small amount of blood products are seen at the surgical site. Following gadolinium, no definite residual enhancement identified. Mild pachymeningeal enhancement is seen which is postoperative in nature. There is no acute infarct seen on diffusion images.

IMPRESSION: Postoperative changes with resection of right temporal mass. No residual enhancement seen. No acute infarct identified. Mass effect on the right lateral ventricle and mild midline shift are again seen with brain edema as before.

"

"[**Last Name (LF) **],[**First Name3 (LF) 760**] C. NSURG SICU-B [**2181-10-6**] 7:52 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31035**]

Reason: 53 year old man with R temporal mass s/p R crani, evaluate f

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with R temporal mass s/p R crani, evaluate for residual tumor

REASON FOR THIS EXAMINATION:

53 year old man with R temporal mass s/p R crani, evaluate for residual tumor

No contraindications for IV contrast

PFI REPORT

PFI: Postoperative changes. No residual enhancement seen.

"

"[**2181-10-4**] 9:09 AM

CT CHEST W/CONTRAST; CT ABD W&W/O C Clip # [**Clip Number (Radiology) 31164**]

CT PELVIS W/CONTRAST

Reason: Staging CT Scan

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with R Temporal Mass

REASON FOR THIS EXAMINATION:

Staging CT Scan

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): [**First Name9 (NamePattern2) 4913**] [**Doctor First Name 141**] [**2181-10-4**] 4:34 PM

1. No evidence of metastatic disease.
2. No renal calculi or collecting system masses.
3. Large axillary lymph nodes, fatty in nature, not characteristic of metastatic disease.

FINAL REPORT

HISTORY: 53-year-old man with right temporal mass concerning for metastatic disease given history of lung wedge resection positive for adenocarcinoma; also finding of hematuria; staging scan.

STUDY AND TECHNIQUE: CT of the torso with contrast. MDCT images were obtained through the torso after the administration of oral contrast and intravenous contrast. Three-minute delayed images were obtained through the abdomen. Coronal and sagittal reformatted images were also generated.

COMPARISON STUDY: [**2181-4-19**].

FINDINGS:

CT OF THE CHEST WITH CONTRAST: The thyroid is normal-appearing with no evidence of masses or nodules. Atelectasis is noted at the base of the right lower lung lobe. No masses or nodules are noted in the lung parenchyma. The trachea, bronchi and bronchioles appear patent. There is no evidence of pleural effusion or pneumothorax. The heart is normal-appearing with no evidence of pericardial effusion. The great vessels appear unremarkable. No mediastinal lymphadenopathy is appreciated. Large lymph nodes are noted in the axillary regions bilaterally measuring 16 x 32 mm on the left (3;18) and 11 x 23 mm on the right. Both lymph nodes appear to have prominent fatty hilum and do not appear to exhibit evidence of metastatic disease.

CT OF THE ABDOMEN WITH CONTRAST: The liver is normal size and appearance and exhibits no focal lesions or biliary dilatation. The gallbladder is fluid filled with no evidence of cholelithiasis or wall thickening. The spleen is homogenously enhancing and normal in size and shape. The pancreas exhibits no evidence of masses, cysts or calcifications. The adrenal glands are normal-

appearing bilaterally with no evidence of masses. The kidneys enhance and secrete contrast symmetrically. There is no evidence of stones. In the superior pole of the right kidney, there is a small well-circumscribed area of hyperdensity measuring 9 x 11 mm and likely reflects a simple cyst. The small and large bowel are normal-appearing with no signs of obstruction, masses or

(Over)

[**2181-10-4**] 9:09 AM

CT CHEST W/CONTRAST; CT ABD W&W/O C Clip # [**Clip Number (Radiology) 31164**]

CT PELVIS W/CONTRAST

Reason: Staging CT Scan

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

FINAL REPORT

(Cont)

wall thickening. The aorta, IVC, portal vein and their major branches appear patent. No lymphadenopathy is seen. No free air or fluid is noted within the abdomen.

CT OF THE PELVIS WITH CONTRAST. The bladder is normal appearing with no evidence of wall thickening or masses. The prostate is normal in size and shape. The rectum is normal-appearing with no evidence for masses. No lymphadenopathy is seen. No free air or fluid is seen in the pelvis.

BONE WINDOWS: Mild degenerative changes are noted in the thoracic and lumbar spine, but no sclerotic or lytic lesions are seen in the visualized portion of the skeleton.

IMPRESSION:

1. No evidence of metastatic disease.

2. No renal calculi or collecting system masses.

Preliminary renal findings were communicated to nurse practitioner of the

neurosurgery service by Dr. [**Last Name (STitle) 5773**] at approximately 10:30 a.m. on [**2181-10-4**].

"

"[**Last Name (LF) **],[**First Name3 (LF) 760**] C. NSURG TSICU [**2181-10-4**] 9:09 AM

CT CHEST W/CONTRAST; CT ABD W&W/O C Clip # [**Clip Number (Radiology) 31164**]

CT PELVIS W/CONTRAST

Reason: Staging CT Scan

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with R Temporal Mass

REASON FOR THIS EXAMINATION:

Staging CT Scan

No contraindications for IV contrast

PFI REPORT

1. No evidence of metastatic disease.

2. No renal calculi or collecting system masses.

3. Large axillary lymph nodes, fatty in nature, not characteristic of

metastatic disease.

"

"[**2181-10-3**] 9:23 PM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31163**]

Reason: Surgical Planning please do at time of MRI head w/w/o contra

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with large R temporal Mass

REASON FOR THIS EXAMINATION:

Surgical Planning please do at time of MRI head w/w/o contrast. Please place Feducials.

No contraindications for IV contrast

FINAL REPORT

HISTORY: 53-year-old male patient with a large right temporal mass.

TECHNIQUE: MRI of the head was performed with and without IV contrast as per departmental protocol.

COMPARISON: [**2180-8-17**].

FINDINGS:

There has been interval development of a right anterior temporal lobe intra-axial heterogenously enhancing mass which demonstrates restricted diffusion. There is a large amount of surrounding T2/FLAIR hyperintensity extending superiorly to involve the frontal lobe, posteriorly to involve the parietal and temporal lobe and inferiorly to involve the right cerebral peduncle. There is midline shift of approximately 1.3 cm to the contralateral side. Minimal subfalcine herniation is demonstrated. There is uncal herniation seen. There

is mass effect on the midbrain.

There is a questionable 3.8 and another 3.0-mm focus of enhancement within the left parietal [**Doctor Last Name 107**]-white matter junction seen best on the coronal views and to a lesser extent on the sagittal views which may represent other small areas of intraparenchymal enhancement versus a deep sulcal vessel.

No other foci of abnormal enhancement are identified. There is no acute infarction. There is no evidence of hydrocephalus. Mass effect is noted on the ipsilateral right lateral ventricle with no evidence for ventricular entrapment. The orbital structures are unremarkable. There is opacification in the left maxillary sinus. There is fluid within the left mastoid air cells.

IMPRESSION:

1. New large right anterior temporal intra-axial mass, 3 mm left parietal focus of enhancement and a questionable third focus areas of enhancement within the left parietal peripheral region strongly concerning for metastatic disease.

2. Marked midline shift of 1.3 cm to the contralateral left side and uncal herniation. Small amount of subfalcine herniation.

(Over)

[**2181-10-3**] 9:23 PM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31163**]

Reason: Surgical Planning please do at time of MRI head w/w/o contra

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: MAGNEVIST Amt: 20

FINAL REPORT

(Cont)

"

"[**2181-10-5**] 4:20 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 31911**]

Reason: 53 year old man s/p R crani, evaluate for interval changes.

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

[**Hospital 2**] MEDICAL CONDITION:

53 year old man s/p R crani, evaluate for interval changes. Please do w/n 4

hrs.

REASON FOR THIS EXAMINATION:

53 year old man s/p R crani, evaluate for interval changes. Please dp w/n 4

hrs.

No contraindications for IV contrast

FINAL REPORT

EXAM: CT of the head.

CLINICAL INFORMATION: Patient is status post craniotomy, for postoperative

evaluation.

TECHNIQUE: Axial images of the head were obtained without contrast.

Comparison was made with the CT of [**2181-10-3**].

FINDINGS: Postoperative changes are seen with right temporal craniotomy. There is pneumocephalus identified. There is edema in the right temporal lobe. Small amount of blood products are seen in the right temporal region, expected from previous surgery. There is opacification of the left maxillary sinus with high-density material as before.

IMPRESSION: Expected postoperative changes are seen with pneumocephalus and small amount of blood and craniotomy changes. No hydrocephalus seen. Mild mass effect on the right lateral ventricle which appears slightly decreased from before.

"

"[**2181-10-5**] 4:11 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 31034**]

Reason: infils

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with Lung CA - s/p L Lower Lung Lobe resection [**2180**]/ CT and found to have large rt temporal mass

REASON FOR THIS EXAMINATION:

infils

FINAL REPORT

HISTORY: Previous lower lobe resection with the large right temporal mass.

FINDINGS: In comparison with study of [**9-12**], the patient has taken a somewhat better inspiration. Hemidiaphragms are now sharply seen. Mild haziness at

the left base may reflect some residual pleural fluid.

No evidence of acute focal pneumonia. There is some increasing widening of the mediastinum, though this could merely reflect the AP semi-upright position. Slight impression on the right side of the lower cervical trachea could merely reflect position of the head of the patient.

"

"[**2181-10-3**] 6:22 PM

CT HEAD W/ & W/O CONTRAST Clip # [**Clip Number (Radiology) 31028**]

Reason: please assess extent of disease

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: OPTIRAY Amt: 90

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with 3cm mass on OSH ct scan

REASON FOR THIS EXAMINATION:

please assess extent of disease

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): MBue WED [**2181-10-3**] 7:32 PM

PFI: 2.6 cm peripherally hyperdense mass located within the inferior right temporal lobe with a large amount of surrounding edema and approximately 1.1 cm of right to left midline shift. Partial effacement of the right perimesencephalic cistern secondary to mass effect. No additional lesions identified. However, MRI is more sensitive for detection of intraparenchymal masses.

FINAL REPORT

HISTORY: 53-year-old man with 3 cm mass noted at outside hospital on CT scan.

COMPARISON: MRI of the brain dated [**2181-8-17**].

FINDINGS: A non-contrast CT of the head was obtained. There is a hyperdense mass located in the right inferior temporal lobe measuring approximately 2.6 cm and demonstrating central low density. There is a significant amount of surrounding hypodensity likely representing vasogenic edema within the right frontal and temporal lobes. There is mass effect with approximately 1.1 cm of right to left midline shift. There is mild effacement of the right perimesencephalic cistern secondary to mass effect. The suprasellar cistern is patent. Also noted is mass effect on the right lateral ventricle which is almost completely compressed. There is diffuse sulcal effacement noted throughout the right cerebral hemisphere. The calvarium is intact. There is near-complete opacification of the left maxillary sinus.

IMPRESSION:

2.6 cm peripherally hyperdense mass located within the inferior right temporal lobe with a large amount of surrounding vasogenic edema and approximately 1.1 cm of right to left midline shift. Partial effacement of the right perimesencephalic cistern secondary to mass effect. No additional lesions identified. However, MRI is more sensitive for detection of intraparenchymal masses.

"

"[**Last Name (LF) **],[**First Name3 (LF) 760**] C. NSURG TSICU [**2181-10-3**] 6:22 PM

CT HEAD W/ & W/O CONTRAST Clip # [**Clip Number (Radiology) 31028**]

Reason: please assess extent of disease

Admitting Diagnosis: MASS,UNSPECIFIED LOCATION

Contrast: OPTIRAY Amt: 90

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with 3cm mass on OSH ct scan

REASON FOR THIS EXAMINATION:

please assess extent of disease

No contraindications for IV contrast

PFI REPORT

PFI: 2.6 cm peripherally hyperdense mass located within the inferior right temporal lobe with a large amount of surrounding edema and approximately 1.1 cm of right to left midline shift. Partial effacement of the right perimesencephalic cistern secondary to mass effect. No additional lesions identified. However, MRI is more sensitive for detection of intraparenchymal masses.

"

"[**2182-4-15**] 12:32 PM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31170**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with metastatic nscl cancer to the brain

REASON FOR THIS EXAMINATION:

rule out progression or new lesions

No contraindications for IV contrast

FINAL REPORT

EXAMINATION: Brain MRI.

HISTORY: 54-year-old male presents with metastatic nonsmall cell lung cancer.

COMPARISON: Multiple prior brain MRIs [**2180-8-17**] through [**2182-3-4**].

TECHNIQUE: Sagittal T1, axial pre- and post-gadolinium T1, T2 FSE, T2 GRE, FLAIR, diffusion, sagittal post-gadolinium MP-RAGE with axial and coronal reformatted sequences of the brain were obtained.

FINDINGS: There are evolving post-surgical changes following prior right pterional craniotomy with resection of the large temporal mass. The appearance of the residual encephalomalacia is unchanged with asymmetric dilatation of the right temporal [**Doctor Last Name 503**]. There is residual dural thickening and slight nodular enhancement along the posterior and inferior aspect of the resection cavity, also unchanged from the prior study (10:35). Enhancement of the sphenoid triangle is stable.

There is a 15-mm nodular mass within the right CP angle cistern which has a broad attachment to the tentorium and involves or compresses the enhancing right trigeminal nerve. The mass appears to extend into the cavernous sinus, and/or Meckel's cave with equivocal extension into foramen ovale.

There is no acute infarct. There is a small residual fluid collection deep to

the craniotomy flap.

IMPRESSION:

1. Stable right temporal encephalomalacia, status post resection of the large mass with unchanged nodularity along the posterior and inferior aspect of the resection cavity.

2. More conspicuous on today's study is a right CP angle mass with a broad attachment to the tentorium. The mass extends into the cavernous sinus and, given its rapid short interval enlargement, is concerning for a dural-based metastasis. Meningioma is another possibility but would be unlikely to develop in this time frame.

The findings were posted to the critical results dashboard.

(Over)

[**2182-4-15**] 12:32 PM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31170**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 20

FINAL REPORT

(Cont)

"

"[**2182-1-17**] 10:26 AM

CT CHEST W/CONTRAST; CT ABDOMEN W/CONTRAST Clip # [**Clip Number (Radiology) 31038**]

CT PELVIS W/CONTRAST

Reason: evaluate for disease progression.

Contrast: OPTIRAY Amt:

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with non small cell lung cancer with brain metastases, s/p right temporal resection and XRT.

REASON FOR THIS EXAMINATION:

evaluate for disease progression.

No contraindications for IV contrast

FINAL REPORT

CLINICAL INDICATION: History of non-small cell lung cancer with brain metastases.

TECHNIQUE: MDCT of the chest, abdomen, and pelvis was performed following the uneventful administration of nonionic intravenous contrast and oral contrast. Delayed images were obtained through the abdomen.

Comparison exam is dated [**2181-10-4**].

FINDINGS:

CHEST: There is a new soft tissue mass adjacent to the esophagus, measuring 2.7 x 2.2 cm. No other pathologically enlarged thoracic lymph nodes are identified. There are coronary artery calcifications. Otherwise, the heart and great vessels are unremarkable. There is no pericardial or pleural effusion.

Lung windows demonstrate post-surgical changes in the left lung, without

nodule on the left. Minimal atelectasis is noted at the right lung base. There is a vague 4 mm ground-glass nodule in the right upper lobe near the fissure seen on image 40 of series 2, and a punctate nodule is seen on image 30 of series 2. These are indeterminate, but may be infectious or inflammatory. The central airways are patent, without endobronchial lesions.

ABDOMEN: There are no focal liver lesions, and there is no biliary dilatation. Again noted is a hypodensity within the upper pole of the right kidney, too small to characterize and parapelvic cysts in the left kidney. The kidneys are otherwise unremarkable. The adrenal glands, spleen, and gallbladder are normal. There is mild fatty replacement of the pancreas. There are no pathologically enlarged lymph nodes. There is mild diverticulosis, without evidence of acute inflammation. There is no free fluid or focal fluid collection. An IVC filter is noted.

PELVIS: There is mild diverticulosis, without acute inflammation. The bladder and prostate gland are unremarkable. There is no pelvic adenopathy or free fluid.

Bone windows demonstrate no focal suspicious lesions.

(Over)

[**2182-1-17**] 10:26 AM

CT CHEST W/CONTRAST; CT ABDOMEN W/CONTRAST Clip # [**Clip Number (Radiology) 31038**]

CT PELVIS W/CONTRAST

Reason: evaluate for disease progression.

Contrast: OPTIRAY Amt:

FINAL REPORT

(Cont)

IMPRESSION:

New pathologically enlarged lymph node adjacent to the left aspect of the esophagus, highly concerning for metastatic disease. Subcentimeter right upper lobe nodules are indeterminate, but may be infectious or inflammatory.

Findings were entered into the critical results dashboard at 9:06 a.m. on [**2182-1-18**].

"

"[**2182-1-7**] 9:39 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 32470**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with metastatic lung cancer to the brain. S/p resection and radiation

REASON FOR THIS EXAMINATION:

rule out progression or new lesions

No contraindications for IV contrast

FINAL REPORT

MRI OF THE BRAIN WITH AND WITHOUT CONTRAST DATED [**2182-1-7**]

CLINICAL HISTORY: 54-year-old man with metastatic lung cancer to the brain,

status post resection and radiation.

TECHNIQUE: MRI of the brain was performed both before and after the administration of intravenous contrast, as per the standard departmental protocol. Additionally, tumor volumetric was also performed.

COMPARISONS: MRI of the brain dated [**2181-10-6**].

FINDINGS: Post-surgical changes are noted status post right temporal craniotomy, with a small fluid collection overlying the craniotomy site, measuring 3.0 x 0.7 cm. Additionally, there is T1 hyperintensity within the right frontal sinus, consistent with the revision fat packing. Since the prior study, there has been significant interval decrease in the degree of edema in the right hemisphere. There is a small area of residual T2 and FLAIR hyperintensity in the right temporal lobe, measuring 6.5 cubic cm, which is significantly decreased since the prior examination. There is a small single focal area of nodular enhancement along the periphery of the resection cavity. There is mild leptomeningeal enhancement overlying the resection cavity which is smooth in appearance, likely post-surgical in nature.

Remainder of the brain parenchyma demonstrates stable appearance. There is no midline shift, mass effect or evidence of a space-occupying lesion. There is no new focus of abnormal enhancement. The ventricles, sulci and cisterns remain mildly prominent, but unchanged. There are scattered areas of T2 and FLAIR hyperintensity in the periventricular and subcortical white matter, stable since the prior study. There is no decreased diffusion to indicate an acute infarct. The flow voids of the major vessels are present.

There is extensive fluid within the mastoid air cells bilaterally. Mild

mucosal thickening is noted in the visualized paranasal sinuses in addition to the hyperintensity related to the fat packing in the right frontal sinus. The orbits and soft tissues are otherwise intact.

IMPRESSION: Post-surgical changes status post right temporal craniotomy and resection of a right temporal lobe mass as well as revision for a CSF leak with fat packing in the right frontal sinus. A small focus of residual nodular enhancement in the resection bed may represent post-treatment related

(Over)

[**2182-1-7**] 9:39 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 32470**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 20

FINAL REPORT

(Cont)

changes, but a small focus of residual neoplasm cannot be excluded. Continued close interval followup imaging as per the oncologic protocol is recommended.

"

"FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31169**]

Reason: NON SMALL CELL LUNG CA, RESTAGING

FINAL REPORT

RADIOPHARMACEUTICAL DATA:

21.3 mCi F-18 FDG ([**2182-2-13**]);

INDICATION: 54 year-old male with a history of non-small cell lung cancer, now

restaging.

METHODS: Approximately 1 hour after intravenous administration of F-18 fluorodeoxyglucose (FDG), noncontrast CT images were obtained for attenuation correction and for fusion with emission PET images. The noncontrast CT images are not used to diagnose disease independently of the PET images. A series of overlapping emission PET images was then obtained. The fasting blood glucose level, measured by glucometer before injection of FDG, was 96 mg/dL. The area imaged spanned the region from the top of the head to the thighs.

Computed tomography (CT) images were co-registered and fused with emission PET images to assist with the anatomic localization of tracer uptake. The determination of the site of tracer uptake seen on PET data can have important implications regarding the significance of that uptake.

INTERPRETATION:
Comparison is made to the CT Torso from [**2182-1-17**].

HEAD AND NECK: There is no FDG-avid disease or significant lymphadenopathy in the imaged portions of the head and the neck. There is evidence of a prior right-sided craniotomy with partial resection of the right temporal lobe.

CHEST: There is a large area of FDG-avidity (18.9 SUV) corresponding to a subcarinal lymph node described on the previous study measuring 42 x 39 mm (image 96), much increased from previous study and concerning for a metastatic lesion. There is no axillary or hilar lymphadenopathy. There is no pleural or pericardial effusion.

Additionally, the peri-fissural right upper lobe lung nodule described on

previous study is unchanged in size and exhibits no FDG-avidity. Additionally, in the right lower lung lobe, there is 12 x 5 mm subpleural nodule that appears unchanged from previous study and exhibits no FDG-avidity (image 107).

ABDOMEN/PELVIS: Below the diaphragm, tracer is distributed physiologically in the gastrointestinal and genitourinary tracts. There is no significant lymphadenopathy and no FDG-avid disease. An IVC filter is noted below the level of the renal vasculature.

MUSCULOSKELETAL: There is no FDG-avid or destructive bone lesion.

Physiologic uptake is seen in the brain, myocardium, salivary glands, GI and GU tracts, liver and spleen.

IMPRESSION: 1. 42 x 39 mm FDG-avid subcarinal lymph node, increased in size from

(Over)

FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31169**]

Reason: NON SMALL CELL LUNG CA, RESTAGING

FINAL REPORT

(Cont)

previous exam and consistent with metastatic disease. 2. Stable non-FDG-avid right pulmonary nodules.

[**First Name8 (NamePattern2) 510**] [**Last Name (NamePattern1) 5773**], M.D.

[**First Name8 (NamePattern2) 18**] [**Last Name (NamePattern1) 19**], M.D. Approved: [**First Name9 (NamePattern2) 162**] [**2182-2-15**] 4:24 PM

RADLINE [**Telephone/Fax (1) 20**]; A radiology consult service.

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Radiology Listen Line [**Telephone/Fax (1) 21**].

"

"[**2182-3-4**] 9:32 AM

MR HEAD W/CNTRST&TUMOR VOLUMETRIC; CT 3D RENDERING W/POST PROCESSING ON INDEPENDENT WSClip # [**Telephone/Fax (1) 31039**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 21

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with metastatic nscl cancer to the brain

REASON FOR THIS EXAMINATION:

rule out progression or new lesions

No contraindications for IV contrast

FINAL REPORT

CLINICAL HISTORY: 54-year-old male with metastatic non-small cell lung cancer to the brain, assess for progression.

TECHNIQUE: MRI of the brain was performed both before and after the administration of intravenous contrast, as per the standard departmental protocol. Tumor volumetrics was also obtained.

COMPARISONS: MRI of the brain dated [**2182-1-7**] and [**2181-10-6**].

FINDINGS: Post-surgical changes are again noted status post right frontal and temporal craniotomy and resection of the previously seen mass within the right temporal lobe. There is a stable appearance of the resection cavity, with a stable focus of nodular enhancement along the lateral aspect. No new focus of abnormal enhancement is identified. Additionally, there is mild pachymeningeal enhancement, most evident on the delayed FLAIR images which is smooth in appearance and overlies the right frontal and parietal lobe. T2 and FLAIR signal changes in the right temporal lobe are stable in appearance.

Post-surgical changes are also noted in the right frontal lobe, with the T1 hyperintensity decreased slightly since the prior study.

There is no midline shift. There is no acute hemorrhage or extra-axial collection. There is no decreased diffusion to indicate an acute infarct. The flow voids of the major vessels are present.

Tumor volumetrics: The area of residual FLAIR hyperintensity in the right temporal lobe measures 7.38 cm3 on the current study compared with 6.5 cm3 on the prior study, but given that the configuration is stable, this difference is felt to be related to increased motion on the current study rather than representing a true difference (with a FLAIR sequence that was even more motion compromised giving a volume of 10.07 cm3).

IMPRESSION: Stable appearance of the post-surgical changes status post right temporal craniotomy and resection of the mass within the right temporal lobe as well as revision of a CSF leak the right frontal sinus. The small focus of residual nodular enhancement previously noted along the resection margin is stable in appearance. No new focus of abnormal enhancement is identified.

(Over)

[**2182-3-4**] 9:32 AM

MR HEAD W/CNTRST&TUMOR VOLUMETRIC; CT 3D RENDERING W/POST PROCESSING ON INDEPENDENT WSClip # [**Telephone/Fax (1) 31039**]

Reason: rule out progression or new lesions

Contrast: MAGNEVIST Amt: 21

FINAL REPORT

(Cont)

"

"[**2181-12-4**] 11:36 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 32468**]

Reason: ? pulmonary effusion/hemorrhage?

Admitting Diagnosis: PULMONARY EMBOLIS

[**Hospital 2**] MEDICAL CONDITION:

53 year old man with metastatic lung ca and recent neurosurg now with large PE and HCt drop on anticoag with desats on anticoag and decreased right basilar lung sounds.

REASON FOR THIS EXAMINATION:

? pulmonary effusion/hemorrhage?

FINAL REPORT

TYPE OF EXAMINATION: Chest AP portable single view.

INDICATION: Metastatic lung cancer and recent neurosurgery, now with large

pulmonary embolism and hematocrit drop on anticoagulation. Decreased right basilar lung sounds, evaluate for pneumonia or effusion or hemorrhage.

FINDINGS: AP single view of the chest has been obtained with patient in sitting upright position. Available for comparison is a next preceding similar study of [**2181-11-25**]. Comparison demonstrates the appearance of a new right-sided basal density obliterating the lateral pleural sinus. In addition, there is a parenchymal density consisting with an infiltrative process in the right lower lobe lateral segment. No other new infiltrates are seen. No pulmonary vascular congestion is identified and no pneumothorax exists.

IMPRESSION: Right lower lobe infiltrate and evidence of pleural effusion. These findings match the described clinical findings and in the patient setting are consistent with pulmonary embolism and infarction with hemorrhagic effusion.

"

"[**2181-12-5**] 4:08 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 32469**]

Reason: further eval effusion, ? progression

Admitting Diagnosis: PULMONARY EMBOLIS

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with adenoca of lung and brain s/p neurosurg w large pe and slowly decreasing hct w ? hemorrhagic effusion yesterday on CXR.

REASON FOR THIS EXAMINATION:

further eval effusion, ? progression

FINAL REPORT

REASON FOR EXAMINATION: Evaluation of patient with adenocarcinoma of the lung after neurosurgery and large pulmonary embolism.

Portable PA radiograph was reviewed.

Current study demonstrates bilateral pleural effusions, cardiomegaly, that is unchanged, as well as no evidence of pulmonary edema. Questionable left upper lobe nodule is noted, approximately 1.5 cm in diameter, not seen on the prior CT torso from [**2181-10-4**] and might represent either true pulmonary nodule or summation of shadows. There is no pneumothorax. The left PICC line tip is at the level of mid SVC. Further evaluation with chest CT might be considered for precise characterization of the pulmonary nodules. No acute abnormalities are demonstrated on the current study.

"

"[**2182-6-14**] 10:45 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31171**]

Reason: rule out progression or new lesions, please do with fine cut

Contrast: MAGNEVIST Amt: 18

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with metastatic nscl cancer to the brain

REASON FOR THIS EXAMINATION:

rule out progression or new lesions, please do with fine cuts of base of skull.

No contraindications for IV contrast

FINAL REPORT

MRI OF THE BRAIN WITHOUT AND WITH GAD

HISTORY: Metastatic NSCL.

COMPARISON: [**2182-4-15**].

FINDINGS:

There is interval enlargement of the mass in the right Meckel's cave, lateral margin of the cavernous sinus and along the back of the clivus. The enhancing component of the mass along the tentorial reflection also appears slightly larger.Enhancement along the right cisternal portion of the fifth nerve and in the region of the right Dorello's canal is noted concerning for leptomeningeal neoplasm.

No additional lesions are seen. There are post-surgical changes in the right temporal lobe.

There is left mastoid opacification. No definite enhancement is noted in the right temporal operative bed.

Intracranial flow voids are maintained.

IMPRESSION:
Progression of neoplasm in the right cavernous sinus and petroclival region.
Findings are concerning for metastatic involvement.

"

"FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31172**]

Reason: LUNG CA; SPN

FINAL REPORT

RADIOPHARMACEUTICAL DATA:

20.7 mCi F-18 FDG ([**2182-6-25**]);

INDICATION: 54 year-old-male with metastatic non-small cell lung cancer.

METHODS: Approximately 1 hour after intravenous administration of F-18 fluorodeoxyglucose (FDG), noncontrast CT images were obtained for attenuation correction and for fusion with emission PET images. [The noncontrast CT images are not used to diagnose disease independently of the PET images.] A series of overlapping emission PET images was then obtained. The fasting blood glucose level, measured by glucometer before injection of FDG, was 107 mg/dL. The area imaged spanned the region from the skull to the pubic symphysis.

Computed tomography (CT) images were co-registered and fused with emission PET images to assist with the anatomic localization of tracer uptake. The determination of the site of tracer uptake seen on PET data can have important implications regarding the significance of that uptake.

INTERPRETATION:

Comparison is made to PET-CT on [**2182-2-13**] and MR [**Name13 (STitle) 1699**] on [**6-14**] and [**4-15**], [**2182**].

HEAD/NECK: Again noted are hyper-pneumatized frontal sinuses. The patient is status post right frontotemporal craniotomy with similar right temporal encephalomalacia. The previously described nodular soft tissue lesion at the right pretemporal area adjacent to the carotid canal now measures approximately

16 x 12 mm (Image 2:27) and demonstrates abnormal FDG-avidity at SUVmax 4.7, most compatible with a dural-based metastasis.

CHEST: A new left lower paratracheal node measures 20 x 12 mm (Image 2:87), with abnormal FDG-avidity at SUVmax 9.1. A previously small and non-FDG-avid right lower paratracheal node now measures 26 x 21 mm (Image 2:80) with FDG-avidity at SUVmax 10.6. A right upper paratracheal node measures 14 x 10 mm (Image 2:77) with FDG-avidity at SUVmax 3.5.

There is also moderate interval progression of FDG-avid (SUVmax 15.2) large conglomerate subcarinal lymphadenopathy, now measures 67 x 44 mm (Image 2:97) compared to 42 x39 mm previously.

There is no FDG-avid pulmonary nodule. Bibasilar atelectasis is minimal. No pneumothorax, pleural effusion or focal air-space consolidation is noted.

ABDOMEN/PELVIS: No FDG-avid disease is noted in the liver, spleen, adrenal, pancreas. An infra-renal IVC filter is again noted.

MUSCULOSKELETAL: No FDG-avid or destructive bone lesion is noted.

Physiologic uptake is seen in the brain, myocardium, salivary glands, GI and GU

(Over)

FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31172**]

Reason: LUNG CA; SPN

FINAL REPORT

(Cont)

tracts, liver and spleen.

IMPRESSION: 1. Moderate interval progression of the FDG-avid subcarinal

lymphadenopathy. Multiple new or increased size of FDG-avid paratracheal nodes.

2. FDG-avid right pre-temporal lesion, consistent with metastasis.

[**First Name8 (NamePattern2) 16**] [**Last Name (NamePattern1) 17**], M.D.

[**First Name8 (NamePattern2) 18**] [**Last Name (NamePattern1) 19**], M.D. Approved: [**Last Name (NamePattern1) 162**] [**2182-6-28**] 4:31 PM

RADLINE [**Telephone/Fax (1) 20**]; A radiology consult service.

To hear preliminary results, prior to transcription, call the

Radiology Listen Line [**Telephone/Fax (1) 21**].

"

"[**2182-8-5**] 11:46 AM

MR HEAD W & W/O CONTRAST Clip # [**Clip Number (Radiology) 31173**]

Reason: rule out progression or new lesions,please do with fine cuts

Contrast: MAGNEVIST Amt: 20

_____

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with metastatic nscl cancer to the brain

REASON FOR THIS EXAMINATION:

rule out progression or new lesions,please do with fine cuts of base of skull.

No contraindications for IV contrast

FINAL REPORT

MR HEAD WITHOUT AND WITH CONTRAST, [**2182-8-5**]

HISTORY: Right cavernous sinus mass, is evidence of progression of metastatic disease?

Sagittal and axial short TR short TE spin echo imaging were performed through the brain. After administration of 20 cc of Magnevist intravenous contrast, axial imaging was performed with [**Last Name (LF) 1168**], [**First Name3 (LF) 1169**] TR long TE fast spin echo, gradient echo, diffusion, and short TR short TE spin echo technique. Sagittal MP-RAGE imaging was performed and reformatted into axial and coronal orientations. Comparison to brain MR examinations of [**2182-6-14**], [**2182-4-15**] and [**2182-3-4**].

FINDINGS: There is continued enlargement of the right cavernous sinus mass that fills Meckel's cave and extends posteriorly along the free edge of the tentorium. This has enlarged significantly since the study of [**6-14**], however its irregular contours precludes meaningful measurement. There have been no other significant changes. No other masses or regions of abnormal enhancement are detected. Again seen are postoperative changes with tissue loss in the right temporal lobe. Although an MRA examination was not performed, the findings suggest encasement of the supraclinoid right internal carotid artery by the mass.

The mastoid air cells remain densely opacified.

CONCLUSION: Continued enlargement of a right cavernous sinus mass, compatible with the history of metastatic disease. No other masses are detected and there are no other findings suggestive of metastases elsewhere.

"

"FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31174**]

Reason: NON SMALL CELL LUNG CA RESTAGING

FINAL REPORT

RADIOPHARMACEUTICAL DATA:

22.0 mCi F-18 FDG ([**2182-8-23**]);

INDICATION: 54 y/o man with metastatic lung cancer on Tarceva to the brain and mediastinal lymph nodes for restaging.

METHODS: Approximately 1 hour after intravenous administration of F-18 fluorodeoxyglucose (FDG), noncontrast CT images were obtained for attenuation correction and for fusion with emission PET images. The noncontrast CT images are not used to diagnose disease independently of the PET images. A series of overlapping emission PET images was then obtained. The fasting blood glucose level, measured by glucometer before injection of FDG, was 106 mg/dL. The area imaged spanned the region from the mid-skull to the thighs.

Computed tomography (CT) images were co-registered and fused with emission PET images to assist with the anatomic localization of tracer uptake. The determination of the site of tracer uptake seen on PET data can have important implications regarding the significance of that uptake.

COMPARISON: [**2182-6-25**]

CORRELATION: MR brain [**2182-8-5**]

HEAD/NECK: There is a focus of moderate FDG avidity in the medial aspect of the right inferior temporal lobe with [**Year (4 digits) 31175**] 10.1, previously 11.4, although the extent of abnormal avidity has increased since the prior study. See the correlating MR study of the brain for more precise anatomical information. There has been prior right temporal-parietal craniotomy with underlying encephalomalacia consistent with prior resected brain metastasis from this location.

There is mild uptake with the parotid gland with some muscular atrophy in the right temporal region. Prominent uptake in mucosa of the hard palate is unchanged. There is opacification of the mastoid air cells and a large frontal sinus.

CHEST: There is scarring of the left lung base and volume loss of the left hemithorax consistent with prior LLL wedge resection. There is no suspicious lung nodules. There is a small pericardial effusion and no significant pleural effusion.

There is a new 1.0 cm FDG left supraclavicular lymph node with [**Year (4 digits) 31175**] 4.5. There has been interval growth and avidity of several mediastinal lymph nodes. For example, a high right paratracheal lymph node measuring 2.4 x 2.3 cm seen on image 60 has [**Year (4 digits) 31175**] 11.9, previously 7.1. A smaller lymph node at the same level just to the right has increased in size and now has [**Year (4 digits) 31175**] 11.6, previously 4.9. A high right paratracheal lymph node seen on image 65 has increased slightly in size and now has [**Year (4 digits) 31175**] 24.9, previously 10.6. A large subcarinal

(Over)

FDG TUMOR IMAGING (PET-CT) Clip # [**Clip Number (Radiology) 31174**]

Reason: NON SMALL CELL LUNG CA RESTAGING

FINAL REPORT

(Cont)

lymph node is relatively stable in size and now has [**Name (NI) 31175**] 26.3, previously 13.7. Two paraesophageal lymph nodes, seen on images 83 and 88, have [**Name (NI) 31175**] 7.0 and 8.4, respectively. There is no significant axillary or hilar lymphadenopathy.

ABDOMEN/PELVIS: There is no significant lymphadenopathy or FDG avid disease in the abdomen or pelvis. There is an infrarenal IVC filter in place.

MUSCULOSKELETAL: A focus of uptake adjacent to the C6 spinous process has no clear CT correlate and is probably the sequelae of minor trauma. There is diffuse tracer uptake in the muscles of the shoulder girdles and in the lateral hips, likely exertional.

Physiologic uptake is seen in the brain, myocardium, salivary glands, GI, and GU tracts, liver and spleen.

IMPRESSION:

Increasing FDG avidity within the medial aspect of the right temporal lobe, new FDG avid left supraclavicular lymph node, and interval increase in size and uptake within enlarged, FDG avid mediastinal lymphadenopathy consistent with disease progression.

[**First Name4 (NamePattern1) **] [**Last Name (NamePattern1) 31176**], M.D.

[**First Name11 (Name Pattern1) 436**] [**Last Name (NamePattern1) 814**], M.D.
Approved: MON [**2182-8-26**] 3:25 PM

RADLINE [**Telephone/Fax (1) 20**]; A radiology consult service.

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"

"[**2182-8-16**] 9:41 AM

MR [**Name13 (STitle) 279**] W& W/O CONTRAST Clip # [**Clip Number (Radiology) 31177**]

Reason: ? cervical lesion

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

54 year old man with NSC lung cancer and brain mets, new left hand weakness

REASON FOR THIS EXAMINATION:

? cervical lesion

CONTRAINDICATIONS for IV CONTRAST:

nausea with gado

FINAL REPORT

HISTORY: Male with history of intermittent vertigo, for further evaluation.

TECHNIQUE: Multiplanar T1- and T2-weighted images were acquired through the cervical spine without administration of intravenous contrast. There is no relevant prior imaging for comparison.

FINDINGS:

The C2-3 level is unremarkable with preserved alignment and disc anatomy.

At C3-C4 level, there is bilateral uncovertebral joint hypertrophy with mild effacement of the thecal sac and mild bilateral foraminal narrowing.

At C4-5 level, there is severe left-sided foraminal narrowing due to uncovertebral hypotrophy and mild right foraminal narrowing. At C5-C6 level, there is mild right foraminal narrowing due to uncovertebral hypertrophy.

At C6-7 level, there is moderate bilateral foraminal narrowing due to uncovertebral hypertrophy. C7-T1 level, there is no significant disc disease or joint abnormality. There is no abnormal cord signal or abnormal enhancement to suggest metastatic disease. There is no abnormal marrow signal.

The C7-T1 level demonstrates a posterior central disc protrusion with minor bilateral foraminal narrowing.

The visualized brainstem and cerebellum appear unremarkable.

IMPRESSION:

Multilevel degenerative changes with uncovertebral joint hypertrophy as described above. No evidence of metastatic disease to the cervical spine or the cord.

"