"Admission Date: [**2187-3-2**] Discharge Date: [**2187-3-8**]

Date of Birth: [**2114-8-20**] Sex: M

Service: CARDIOTHORACIC

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 922**]

Chief Complaint:

Epigastric Pain

Major Surgical or Invasive Procedure:

[**2187-3-5**] - Thoracic aorta stent graft coverage of penetrating

descending thoracic aortic ulcer witha [**Doctor Last Name **] TAG endoprosthesis

History of Present Illness:

Patient is a 72-year-old gentleman who is admitted with

symptomatic penetrating

descending thoracic aortic ulcer. The patient remained

symptomatic from pain standpoint despite adequate medical

management with some radiographic evidence of progression of the

internal hematoma. The patient was therefore felt to be a

good candidate for stent graft placement to cover the

penetrating ulcer. The penetrating ulcer appeared to be at the

T9-T10 level by CT scan. The patient understood the risks and

benefits of the procedure and wished to proceed.

Past Medical History:

Endovascular stent graft placement [**2187-3-5**]

BPH

HTN

Back surgery

Social History:

No tobacco or alcohol use. From [**Country **].

Family History:

Noncontributory

Physical Exam:

BP 148/80 67 Reg 97% RA

GEN: NAD, WDWN

HEENT: MMM, EOMI, anicteric sclera

NECK: No bruit, no lymphadenopathy

HEART: RRR, No murmur

LUNGS: Clear

ABD: Soft, NT, ND, NABS

EXT: No edema, warm. 2+ DP and PT bilaterally

NEURO: Grossly intact

Pertinent Results:

[**2187-3-2**] 04:50AM PT-13.1 PTT-28.7 INR(PT)-1.1

[**2187-3-2**] 04:50AM WBC-7.7 RBC-6.51* HGB-15.0 HCT-43.8 MCV-67*

MCH-23.0* MCHC-34.2 RDW-15.5

[**2187-3-2**] 04:50AM GLUCOSE-111* UREA N-14 CREAT-0.9 SODIUM-134 POTASSIUM-3.8 CHLORIDE-99 TOTAL CO2-26 ANION GAP-13

[**2187-3-2**] 06:45AM URINE BLOOD-NEG NITRITE-NEG PROTEIN-NEG GLUCOSE-NEG KETONE-NEG BILIRUBIN-NEG UROBILNGN-NEG PH-7.0 LEUK-NEG

[**2187-3-2**] 08:56PM ALT(SGPT)-13 AST(SGOT)-16 LD(LDH)-142 CK(CPK)-70 ALK PHOS-81 AMYLASE-85 TOT BILI-1.1

[**2187-3-2**] CTA

1. Tiny penetrating ulcer-like projection in the distal descending thoracic aorta, with adjacent crescentic hematoma, which currently appears contained within the aoric wall. No evidence of active extravasation.
2. Left renal simple cysts. Multiple low-attenuation lesions within the left kidney, too small to characterize.
3. Very small left pleural effusion.

[**2187-3-5**] ECHO

1. No atrial septal defect is seen by 2D or color Doppler.
2. Left ventricular wall thicknesses are normal. The left ventricular cavity size is normal. Overall left ventricular systolic function is normal (LVEF>55%).
3. Right ventricular chamber size and free wall motion are normal.
4. The ascending aorta is mildly dilated. The descending thoracic aorta is mildly dilated. There are complex (>4mm) atheroma in the descending thoracic aorta. An area of hemotoma and ulceration is visualized in the descending thoracic aorta.
5. There are three aortic valve leaflets. There is no aortic

valve stenosis. Trace aortic regurgitation is seen.

6. The mitral valve leaflets are mildly thickened. Mild (1+)

mitral

regurgitation is seen. An endostent is visualized in the

descending thoracic aorta at the end of the procedure

Brief Hospital Course:

Mr. [**Known lastname 66702**] was admitted to the [**Hospital1 18**] on [**2187-3-2**] for further

work-up of his epigastric pain. A CT Angiogram was performed

which revealed a tiny penetrating ulcer-like projection in the

distal descending thoracic aorta, with adjacent crescentic

hematoma, which appeared contained within the aortic wall

without evidence of active extravasation. Given these findings,

the vascular and cardiac surgical services were consulted for

surgical management. Mr. [**Known lastname 66702**] was worked-up in the usual

preoperative manner. He remained on nitroglycerin for blood

pressure control. On [**2187-3-5**], Mr. [**Known lastname 66702**] was taken to the

operating room where he underwent an endovascular stent

placement. Postoperatively he was taken to the cardiac surgical

intensive care unit for monitoring. By postoperative day one,

Mr. [**Known lastname 66702**] [**Last Name (Titles) 5058**] neurologically intact and was extubated. His

lumbar drain was removed on postoperative day two and he was

then transferred to the step down unit for further recovery. The

physical therapy service was consulted for assistance with his

postoperative strength and mobility. He continued to make steady

progress and was discharged home on postoperative day three. Mr.

[**Known lastname 66702**] will follow-up with Dr. [**Last Name (STitle) 914**], Dr. [**Last Name (STitle) **] and

his primary care provider as an outpatient.

Medications on Admission:

Proscar

Discharge Medications:

1. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2

times a day).

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

2. Ranitidine HCl 150 mg Tablet Sig: One (1) Tablet PO BID (2

times a day).

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

3. Aspirin 81 mg Tablet, Delayed Release (E.C.) Sig: One (1)

Tablet, Delayed Release (E.C.) PO DAILY (Daily).

Disp:*30 Tablet, Delayed Release (E.C.)(s)* Refills:*0*

4. Atenolol 50 mg Tablet Sig: One (1) Tablet PO DAILY (Daily).

Disp:*30 Tablet(s)* Refills:*0*

5. Tamsulosin 0.4 mg Capsule, Sust. Release 24HR Sig: One (1)

Capsule, Sust. Release 24HR PO HS (at bedtime).

Disp:*30 Capsule, Sust. Release 24HR(s)* Refills:*2*

6. Oxycodone-Acetaminophen 5-325 mg Tablet Sig: 1-2 Tablets PO

every 4-6 hours as needed for pain.

Disp:*40 Tablet(s)* Refills:*0*

Discharge Disposition:

Home With Service

Facility:

[**Last Name (un) 2646**]

Discharge Diagnosis:

Dscending aorta penetrating ulcer

BPH

HTN

back surgery

Discharge Condition:

Good.

Discharge Instructions:

Call with fever, redness or drainage from incision or weight

gain more than 2 pounds in one day or five in one week.

[**Last Name (NamePattern4) 2138**]p Instructions:

RTC 1 week for staple removal

Dr. [**Last Name (STitle) 914**] & Dr. [**Last Name (STitle) **] on same day in approximately 4

weeks.

CT Scan before 1 month appointment, Dr. [**Last Name (STitle) **] [**Last Name (Prefixes) 2546**] office

will call to schedule it.

Primary Care doctor 2 weeks

Completed by:[**2187-4-12**]"

"Admission Date: [**2189-7-4**] Discharge Date: [**2189-7-27**]

Date of Birth: [**2114-8-20**] Sex: M

Service: CARDIOTHORACIC

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 922**]

Chief Complaint:

fever and hemoptysis

Major Surgical or Invasive Procedure:

[**2189-7-6**] Flexible bronchoscopy and EGD with biopsy of

esophageal nodules.

-s/p Left thoracoabdominal removal of infected ao. stent,

placement of Dacron ao. graft, primary repair of iatrogenic

esophageal injury, Omental wrap, G and J tubes

History of Present Illness:

Patient is a 74 year-old gentleman with a history of an aortic

stented graft in [**2186**] with subsequent brucellosis aortitis. The

patient has been complaining of hemoptysis which required the

placement of another stent in [**Country **] around [**2189-2-17**]. The

patient had recurrent symptoms of fever and hemoptysis and was

admitted to [**Hospital1 18**] to rule out a fistulous process.

Past Medical History:

Endovascular stent graft placement [**2187-3-5**] for descending

thoracic aortic ulcer c/b brucellosis aortitis on long term abx

then stopped

BPH

HTN

hx back surgery

hx opiate use

Social History:

Farsi speaking only. Lives with wife. Had recent travel to [**Country **]

~2months ago and wife is experiencing similar symptoms.

Family History:

N/C

Physical Exam:

Upon discharge:

Pt is alert, oriented in NAD

Vital signs: 98.6, 156/77, 80-paced, 18, 100%RA

Lungs- CTAB

CV- RRR, no murmur

abd- NABS, soft, nontender

thoracoabdominal incision- clean, dry, intact, no erythema or

drainage

ext- no edema

Pertinent Results:

[**Known lastname **],[**Known firstname **] [**Medical Record Number 66712**] M 74 [**2114-8-20**]

Radiology Report CTA CHEST W&W/O C&RECONS, NON-CORONARY Study

Date of [**2189-7-3**] 10:27 PM

[**Last Name (LF) 30346**],[**First Name4 (NamePattern1) 30347**] [**Last Name (NamePattern1) 30348**] EU [**2189-7-3**] SCHED

CTA CHEST W&W/O C&RECONS, NON-; CTA ABD W&W/O C & RECONS; CTA

PELVIS W&W/O C & RECONS Clip # [**Clip Number (Radiology) 66713**]

Reason: please eval for endovasc bleed, rp bleed

Contrast: OPTIRAY

[**Hospital 93**] MEDICAL CONDITION:

72yo M s/p recent endovascular stent placement [**3-5**] to

descending thoracic

aorta for ulcerating plaque. seen in [**Country **]. transported here

from [**Country **] for ?

leak. describes pain in LUQ/LLQ, l flank

REASON FOR THIS EXAMINATION:

please eval for endovasc bleed, rp bleed

CONTRAINDICATIONS FOR IV CONTRAST:

None.

Wet Read: DXAe FRI [**2189-7-3**] 11:04 PM
Thick (19 mm) rind of soft tissue around the descending aorta
graft with
locules of air is very worrisome for graft infection. No
evidence of contrast
extravisation.

Final Report
INDICATION: 72-year-old man with endovascular stent placement 2
months ago
inside old vascular stent placed on [**4-24**], presenting with left
upper quadrant
pain, with possible endovascular leak.

COMPARISON: [**2187-4-3**].

TECHNIQUE: MDCT acquired images were obtained through the torso
before and
then immediately after the uneventful administration of 80 cc of
IV Optiray
contrast. Multiplanar reformats were reviewed.

CTA CHEST: The patient is post endograft stent in the descending

thoracic aorta with marked soft tissue thickening around the
graft measuring
17 mm (previously 8 mm). Focal areas of air within the soft
tissue, are
highly concerning for infection. There is no evidence of
contrast
extravasation or ruptured atherosclerotic plaque. The lung
parenchyma is
grossly unremarkable. The airways are patent to the subsegmental
level. There
are no pathologically enlarged central or axillary lymph nodes.

CT ABDOMEN: The liver, spleen, pancreas, gallbladder, and
adrenals are
grossly unremarkable. The kidneys demonstrate several
subcentimeter cysts
bilaterally which are stable since [**2187-4-3**]. The intra-abdominal
loops of
large and small bowel are unremarkable. There is no free fluid
or free air.

CT PELVIS: The bladder is mildly enlarged. The prostate is
markedly enlarged
measuring 5.6 x 6.5 cm, unchanged. Seroma in the right inguinal
region has
resolved.

Bone windows demonstrate stable degenerative changes in the
lower lumbar spine

without evidence of suspicious lytic or blastic lesion.

IMPRESSION:

1. 8 weeks post-op from repeat thoracic aortic stent graft with

increase in

the peri- aortic soft tissue rind and perigraft pockets of air

suggestive of

infection. Close follow-up is recomended.

2. Markedly enlarged prostate, unchanged.

The study and the report were reviewed by the staff radiologist.

DR. [**First Name4 (NamePattern1) **] [**Last Name (NamePattern1) 94**]

DR. [**First Name (STitle) 28783**] [**Name (STitle) 28784**]

DR. [**First Name8 (NamePattern2) **] [**Name (STitle) **]

Approved: SAT [**2189-7-4**] 2:07 PM

Imaging Lab

[**Hospital1 18**] ECHOCARDIOGRAPHY REPORT

[**Known lastname **], [**Known firstname **] [**Hospital1 18**] [**Numeric Identifier 66714**]TTE (Complete)

Done [**2189-7-6**] at 9:42:05 AM FINAL

Referring Physician [**Name9 (PRE) **] Information

[**Name9 (PRE) **], [**First Name11 (Name Pattern1) **] [**Initial (NamePattern1) **]

[**Hospital1 **] C

[**Hospital Unit Name 22682**]

[**Location (un) 86**], [**Numeric Identifier 718**] Status: Inpatient DOB: [**2114-8-20**]

Age (years): 74 M Hgt (in): 70

BP (mm Hg): 123/57 Wgt (lb): 185

HR (bpm): 70 BSA (m2): 2.02 m2

Indication: Aortic valve disease.

ICD-9 Codes: 424.1, 424.0

Test Information

Date/Time: [**2189-7-6**] at 09:42 Interpret MD: [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **]

[**Last Name (NamePattern1) **], MD

Test Type: TTE (Complete) Son[**Name (NI) 930**]: [**First Name8 (NamePattern2) **] [**Last Name (NamePattern1) **]

Doppler: Full Doppler and color Doppler Test Location: West Echo

Lab

Contrast: None Tech Quality: Adequate

Tape #: 2008W000-0:00 Machine: Vivid i-3

Echocardiographic Measurements

Results Measurements Normal Range

Left Atrium - Long Axis Dimension: 2.7 cm <= 4.0 cm

Left Atrium - Four Chamber Length: 4.0 cm <= 5.2 cm

Right Atrium - Four Chamber Length: 4.7 cm <= 5.0 cm

Left Ventricle - Septal Wall Thickness: 1.1 cm 0.6 - 1.1 cm

Left Ventricle - Inferolateral Thickness: 1.1 cm 0.6 - 1.1 cm

Left Ventricle - Diastolic Dimension: 4.2 cm <= 5.6 cm

Left Ventricle - Systolic Dimension: 2.9 cm

Left Ventricle - Fractional Shortening: 0.31 >= 0.29

Left Ventricle - Ejection Fraction: >= 60% >= 55%

Left Ventricle - Lateral Peak E': *0.07 m/s > 0.08 m/s

Left Ventricle - Septal Peak E': *0.08 m/s > 0.08 m/s

Left Ventricle - Ratio E/E': 12 < 15

Aorta - Sinus Level: 3.3 cm <= 3.6 cm

Aorta - Ascending: *3.7 cm <= 3.4 cm

Aortic Valve - Peak Velocity: 1.4 m/sec <= 2.0 m/sec

Mitral Valve - E Wave: 0.9 m/sec

Mitral Valve - A Wave: 0.7 m/sec

Mitral Valve - E/A ratio: 1.29

Mitral Valve - E Wave deceleration time: 207 ms 140-250 ms

TR Gradient (+ RA = PASP): *25 to 27 mm Hg <= 25 mm Hg

Findings

This study was compared to the prior study of [**2187-4-11**].

LEFT ATRIUM: Normal LA size.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size.

LEFT VENTRICLE: Normal LV wall thickness, cavity size and regional/global systolic function (LVEF >55%). No resting LVOT gradient. No VSD.

RIGHT VENTRICLE: Normal RV chamber size and free wall motion.

AORTA: Normal aortic diameter at the sinus level. Mildly dilated ascending aorta.

AORTIC VALVE: Mildly thickened aortic valve leaflets (3). No AS.

No masses or vegetations on aortic valve, but cannot be fully excluded due to suboptimal image quality. Trace AR.

MITRAL VALVE: Mildly thickened mitral valve leaflets. No MVP. Mild mitral annular calcification. Calcified tips of papillary muscles. Mild (1+) MR. Normal LV inflow pattern for age.

TRICUSPID VALVE: Normal tricuspid valve leaflets with trivial TR. Borderline PA systolic hypertension.

PULMONIC VALVE/PULMONARY ARTERY: Pulmonic valve not visualized. No PS. Physiologic PR.

PERICARDIUM: No pericardial effusion.

Conclusions

The left atrium is normal in size. Left ventricular wall thickness, cavity size and regional/global systolic function are normal (LVEF >55%). There is no ventricular septal defect. Right ventricular chamber size and free wall motion are normal. The ascending aorta is mildly dilated. The aortic valve leaflets (3) are mildly thickened but aortic stenosis is not present. No masses or vegetations are seen on the aortic valve, but cannot be fully excluded due to suboptimal image quality. Trace aortic regurgitation is seen. The mitral valve leaflets are mildly thickened. There is no mitral valve prolapse. Mild (1+) mitral regurgitation is seen. There is borderline pulmonary artery systolic hypertension. There is no pericardial effusion.

IMPRESSION: Mildly thickened aortic valve leaflets without

obvious vegetation. Trace aortic regurgitation. Mild mitral
regurgitation. Preserved regional and global LV systolic
function.

If clinically suggested, the absence of a vegetation by 2D
echocardiography does not exclude endocarditis.

Compared with the prior study (images reviewed) of [**2187-4-11**],
the findings are similar. The prior echo measured the ascending
aorta as 4.5cm but this was likely an OVERestimation.

Electronically signed by [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] [**Last Name (NamePattern1) **], MD, Interpreting
physician [**Last Name (NamePattern4) **] [**2189-7-6**] 10:59

Brief Hospital Course:
[**2189-7-2**] Patient was admitted initally to medicine then to CT
surgery for question of aortic /thoracic stent graft leak versus
infection. CTA showed 19 mm rind of soft tissue around
descending aorta graft with locules of air that were worrisome
for infection.

[**2189-7-3**] Vascular surgery consult-recs EGD, bronchoscopy,
continue antibiotics per ID, CT surgery consult-recs BP control,
bronch, and ID consults-recs vanc/gent/doxy.
CTA: 8 weeks post-op from repeat thoracic aortic stent graft

with increase in the peri- aortic soft tissue rind and perigraft
pockets of air suggestive of infection

[**2189-7-4**] CT surgery-arranged for bronchoscopy and EGD to be done
on [**2189-7-6**]
[**7-5**] No acute events, NPO for bronchoscopy in am.
[**7-6**] EGD/Bronch to evaluate for fistula - no fistula, polyp in
esophagus
[**7-6**] Echo nl LV Fnx EFx >55%, thickened Ao leaflets, trace AR,
mild MR, mildly dilated Asc Ao, borderline pulm art htn.

[**2189-7-6**] STRESS study- No anginal symptoms or ischemic ST
changes.

[**7-6**] MIBI Normal mycocardial perfusion study; LVEF 69%.
[**7-6**] EGD/Bronch: poylp in esophagus, no fistula, mild LLL infl

[**7-7**]: MRI T-L spine: Degenerative changes in the lumbar region
with mild-to-moderate spinal stenosis at L2-33 and mild spinal
stenosis at L3-4 and L4-5 levels due to disc degenerative
changes. No evidence of discitis or osteomyelitis. Other
changes as described above.

[**7-9**]: OR for Replacement of the descending thoracic aortic
stent
with a 24-mm Vascutek Dacron tube graft using deep hypothermic
circulatory arrest; repair of aortoesophageal fistula as well as
aortolung fistula replacement stent, placement intraoperative
pacers, went to ICU with 3 CT, J tube, intbuated, started on

epicardial pacing (intraop) for complete heart block; started on caspofungin, doxy, gent, vanco, zosyn

[**2104-7-8**]: In CV ICU, on epi, neo, intubated, started on nitro for ST depression

[**7-12**]: In CVICU extubated, off pressors, started on tube feeds

[**7-14**]: remains in heart block, EP consult -> for temp pacer

Next several days observed for rhythm recovery, possible PPM.

EP,ID, and thoracic continues to follow. Tube feeds at goal.

[**7-15**]: CT placed to Water seal, NTG drip weaned to off with ACE-I initiated. Some confusion persists; narcotics minimized with Methadone adjustments.

[**7-16**]: PICC inserted, EP recommends temporary pacer- family refused

[**7-17**]: transferred to floor, salt tabs for hyponatremia, which would eventually resolve.

The pt was found to have a chylothorax, and tube feeds were adjusted accordingly.

Temporary pacer was implanted on [**7-21**] with the plan to convert to permanent pacer in [**12-21**] weeks. Remaining chest tubes were discontinued without complication.

The patient made progress with physical therapy and was ambulating with minimal assistance before discharge. The patient was discharged to rehab on POD 18 with plans to follow up with cardiology for an internal pacer, and with thoracics for a barium swallow study, and infectious disease for further anti-microbial management.

Medications on Admission:

Flomax

Atenolol

methadone, dose?

opium hx.

Discharge Medications:

1. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2 times a day).

2. Lisinopril 20 mg Tablet Sig: One (1) Tablet PO DAILY (Daily).

3. Methadone 5 mg Tablet Sig: One (1) Tablet PO BID (2 times a day).

4. Aspirin 325 mg Tablet Sig: One (1) Tablet PO DAILY (Daily).

5. Heparin (Porcine) 5,000 unit/mL Solution Sig: One (1) Injection TID (3 times a day).

6. Acetaminophen 160 mg/5 mL Solution Sig: [**11-19**] PO Q4H (every 4 hours) as needed.

7. Tamsulosin 0.4 mg Capsule, Sust. Release 24 hr Sig: One (1) Capsule, Sust. Release 24 hr PO HS (at bedtime).

8. Bisacodyl 10 mg Suppository Sig: One (1) Suppository Rectal DAILY (Daily) as needed for constipation.

9. Potassium Chloride 20 mEq Packet Sig: One (1) Packet PO Q12H (every 12 hours).

10. Magnesium Hydroxide 400 mg/5 mL Suspension Sig: Thirty (30) ML PO QHS (once a day (at bedtime)) as needed.

11. Oxycodone-Acetaminophen 5-325 mg/5 mL Solution Sig: 5-10 MLs PO Q6H (every 6 hours) as needed for pain.

12. Doxycycline Hyclate 100 mg Capsule Sig: One (1) Capsule PO Q12H (every 12 hours).
13. Furosemide 20 mg Tablet Sig: One (1) Tablet PO DAILY (Daily).
14. Pantoprazole 40 mg IV Q24H
15. Piperacillin-Tazobactam-Dextrs 4.5 gram/100 mL Piggyback Sig: One (1) Intravenous Q8H (every 8 hours) for 4 days: through [**7-30**].
16. Gentamicin 40 mg/mL Solution Sig: Five (5) mL Injection Q24H (every 24 hours) for 4 days: through [**7-30**].
17. Octreotide Acetate 100 mcg/mL Solution Sig: One (1) Injection Q8H (every 8 hours).
18. Sodium Chloride 0.9% Flush 10 mL IV PRN line flush PICC, non-heparin dependent: Flush with 10 mL Normal Saline daily and PRN per lumen.
19. Ondansetron 4 mg IV Q8H:PRN
20. Vancomycin in Dextrose 1 gram/200 mL Piggyback Sig: One (1) Intravenous Q 12H (Every 12 Hours) for 4 days: through [**7-30**].
21. Rifampin 300 mg Capsule Sig: Two (2) Capsule PO once a day: BEGIN ON [**2189-7-31**].
22. Caspofungin 50 mg Recon Soln Sig: One (1) Intravenous once a day for 4 days: through [**7-30**].

Discharge Disposition:
Extended Care

Facility:
[**Hospital3 7**] & Rehab Center - [**Hospital1 8**]

Discharge Diagnosis:

-s/p Left thoracoabdominal removal of infected aortic stent, placement of Dacron aortic graft, primary repair of iatrogenic esophageal injury, Omental wrap, G and J tubes -[**7-9**]

-desc. thoracic ao. ulcer, HTN,BPH, Brucellosis aortitis

Discharge Condition:

good

Discharge Instructions:

Please shower daily including washing incisions, no baths or swimming

Monitor wounds for infection - redness, drainage, or increased pain

Report any fever greater than 101

Report any weight gain of greater than 2 pounds in 24 hours or 5 pounds in a week

No creams, lotions, powders, or ointments to incisions

No driving for approximately one month

No lifting more than 10 pounds for 10 weeks

Please call with any questions or concerns [**Telephone/Fax (1) 170**]

Followup Instructions:

Dr. [**Last Name (STitle) 914**] ([**Telephone/Fax (1) 1504**], and Dr. [**Last Name (STitle) **] ([**Telephone/Fax (1) 44777**]

in 4 weeks ([**Telephone/Fax (1) 170**]) please call for appointments on the

same day.

Dr. [**Last Name (STitle) 111**] ([**Telephone/Fax (1) 457**]) in the infectious disease clinic,

[**2189-8-21**], 9:00am, [**Hospital Unit Name **], [**Last Name (NamePattern1) 439**], basement,

[**Location (un) 86**], [**Numeric Identifier 718**]

Barium Swallow Study- you will be called for appointment

Dr. [**Last Name (STitle) 11482**] [**Name (STitle) 1533**] ([**Telephone/Fax (1) 11763**] call for appt. on the same

day as Barium Swallow Study.

**if you will require an interpreter for any of the

appointments, please request at the time you make the

appointment**

Wound check appointment [**Hospital Ward Name 121**] 6 as instructed by nurse

([**Telephone/Fax (1) 3071**])

Completed by:[**2189-7-27**]"

"PATIENT/TEST INFORMATION:

Indication: Shortness of breath.

Status: Inpatient

Date/Time: [**2189-7-9**] at 09:15

Test: Portable TEE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

There are two aortic stents visible. One in the descending thoracic aorta at the left of mid-esophagus. The second is at the arch/descending thoracic aortic junction.

There was a perforation of esophagus during surgical dissection of esophagus and the TEE probe wa removed from the esophagus after the Pre.CPB examination.

The TEE probe was re-inserted prior to separation from CPB and repair of the esophageal perforatrion for de-airing maneuvers and assessment of LV function upon surgeon's request. Probe inserted without any difficulty and its easy/atraumatic insertion was confirmed by the surgical team with direct inspection of the mediastinum.

LEFT ATRIUM: Mild LA enlargement. No mass/thrombus in the [**Name Prefix (Prefixes) 4**] [**Last Name (Prefixes) 5**] LAA. All four pulmonary veins identified and enter the left atrium.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size. No mass or thrombus in the RA or RAA.

LEFT VENTRICLE: Normal LV wall thickness and cavity size. Normal LV wall

thickness. No LV aneurysm. Normal regional LV systolic function. No LV mass/thrombus. Mildly depressed LVEF.

LV WALL MOTION: basal anterior - normal; mid anterior - normal; basal anteroseptal - normal; mid anteroseptal - normal; basal inferoseptal - normal; mid inferoseptal - normal; basal inferior - normal; mid inferior - normal; basal inferolateral - normal; mid inferolateral - normal; basal anterolateral - normal; mid anterolateral - normal; anterior apex - normal; septal apex - normal; inferior apex - normal; lateral apex - normal; apex - normal;

RIGHT VENTRICLE: Normal RV wall thickness. Mildly dilated RV cavity. Normal RV systolic function. Nl interventricular septal motion. No RV mass/thrombus.

AORTA: Normal aortic diameter at the sinus level. Normal ascending aorta diameter. Moderately dilated aortic arch. Mildly dilated descending aorta. Simple atheroma in descending aorta.

AORTIC VALVE: Normal aortic valve leaflets (3). No masses or vegetations on aortic valve. No AS. Mild to moderate ([**11-19**]+) AR.

MITRAL VALVE: Normal mitral valve leaflets. No mass or vegetation on mitral valve. Normal mitral valve supporting structures. No MS. Mild (1+) MR.

TRICUSPID VALVE: Normal tricuspid valve leaflets with trivial TR. Normal tricuspid valve supporting structures.

PULMONIC VALVE/PULMONARY ARTERY: Normal pulmonic valve leaflet. No PS. Physiologic PR.

PERICARDIUM: No pericardial effusion.

GENERAL COMMENTS: A TEE was performed in the location listed above. I certify I was present in compliance with HCFA regulations. The patient was under general anesthesia throughout the procedure. The TEE probe was passed with assistance from the anesthesioology staff using a laryngoscope.

Conclusions:

PRE-BYPASS:

The left atrium is mildly dilated. No mass/thrombus is seen in the left atrium or left atrial appendage. No mass or thrombus is seen in the right atrium or right atrial appendage. Left ventricular wall thicknesses and cavity size are normal. Left ventricular wall thicknesses are normal. No left ventricular aneurysm is seen. Regional left ventricular wall motion is normal. No masses or thrombi are seen in the left ventricle. Overall left ventricular systolic function is mildly depressed (LVEF= 50 %). The right ventricular cavity is mildly dilated with normal free wall contractility. Interventricular septal motion is normal. There is no mass/thrombus in the right ventricle. The aortic arch is moderately dilated. The descending thoracic aorta is mildly dilated. There are simple atheroma in the descending thoracic aorta. The aortic valve leaflets (3) appear structurally normal with good leaflet excursion. No masses or vegetations are seen on the aortic valve. There is no aortic valve stenosis. Mild to moderate ([**11-19**]+) aortic regurgitation is seen. The mitral valve leaflets are structurally normal. No mass or vegetation is seen on the mitral valve. Mild (1+) mitral regurgitation is seen. There is no pericardial effusion.

POST CPB:

Preserved biventricular systolic function.

Mild MR and Mild AI.

Prosthetic graft visualized in descending aortic position.

"

"PATIENT/TEST INFORMATION:

Indication: Aortic valve disease.

Height: (in) 70

Weight (lb): 185

BSA (m2): 2.02 m2

BP (mm Hg): 123/57

HR (bpm): 70

Status: Inpatient

Date/Time: [**2189-7-6**] at 09:42

Test: TTE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

This study was compared to the prior study of [**2187-4-11**].

LEFT ATRIUM: Normal LA size.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size.

LEFT VENTRICLE: Normal LV wall thickness, cavity size and regional/global systolic function (LVEF >55%). No resting LVOT gradient. No VSD.

RIGHT VENTRICLE: Normal RV chamber size and free wall motion.

AORTA: Normal aortic diameter at the sinus level. Mildly dilated ascending aorta.

AORTIC VALVE: Mildly thickened aortic valve leaflets (3). No AS. No masses or vegetations on aortic valve, but cannot be fully excluded due to suboptimal image quality. Trace AR.

MITRAL VALVE: Mildly thickened mitral valve leaflets. No MVP. Mild mitral annular calcification. Calcified tips of papillary muscles. Mild (1+) MR.
Normal LV inflow pattern for age.

TRICUSPID VALVE: Normal tricuspid valve leaflets with trivial TR. Borderline PA systolic hypertension.

PULMONIC VALVE/PULMONARY ARTERY: Pulmonic valve not visualized. No PS. Physiologic PR.

PERICARDIUM: No pericardial effusion.

Conclusions:
The left atrium is normal in size. Left ventricular wall thickness, cavity

size and regional/global systolic function are normal (LVEF >55%). There is no ventricular septal defect. Right ventricular chamber size and free wall motion are normal. The ascending aorta is mildly dilated. The aortic valve leaflets (3) are mildly thickened but aortic stenosis is not present. No masses or vegetations are seen on the aortic valve, but cannot be fully excluded due to suboptimal image quality. Trace aortic regurgitation is seen. The mitral valve leaflets are mildly thickened. There is no mitral valve prolapse. Mild (1+) mitral regurgitation is seen. There is borderline pulmonary artery systolic hypertension. There is no pericardial effusion.

IMPRESSION: Mildly thickened aortic valve leaflets without obvious vegetation. Trace aortic regurgitation. Mild mitral regurgitation. Preserved regional and global LV systolic function.

If clinically suggested, the absence of a vegetation by 2D echocardiography does not exclude endocarditis.

Compared with the prior study (images reviewed) of [**2187-4-11**], the findings are similar. The prior echo measured the ascending aorta as 4.5cm but this was likely an OVERestimation.

"

"PATIENT/TEST INFORMATION:

Indication: Endocarditis.

Height: (in) 66

Weight (lb): 165

BSA (m2): 1.84 m2

BP (mm Hg): 124/59

HR (bpm): 60

Status: Inpatient

Date/Time: [**2187-4-12**] at 17:01

Test: TEE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

LEFT ATRIUM: No spontaneous echo contrast or thrombus in the body of the [**Name Prefix (Prefixes) 4**] [**Last Name (Prefixes) 5**]

LAA.

RIGHT ATRIUM/INTERATRIAL SEPTUM: No spontaneous echo contrast in the body of

the RA. Normal interatrial septum. No ASD by 2D or color Doppler.

LEFT VENTRICLE: Overall normal LVEF (>55%).

RIGHT VENTRICLE: Normal RV systolic function.

AORTA: No atheroma in ascending aorta. No atheroma in aortic arch.

AORTIC VALVE: Mildly thickened aortic valve leaflets (3). No masses or

vegetations on aortic valve. No aortic valve abscess. Trace AR.

MITRAL VALVE: Normal mitral valve leaflets with trivial MR. [**Name13 (STitle) 6**] mass or vegetation on mitral valve.

TRICUSPID VALVE: Mildly thickened tricuspid valve leaflets. No mass or vegetation on tricuspid valve. No abscess of tricuspid valve. Mild [1+] TR.

PULMONIC VALVE/PULMONARY ARTERY: Normal pulmonic valve leaflets. No vegetation/mass on pulmonic valve. No PR.

PERICARDIUM: No pericardial effusion.

GENERAL COMMENTS: A TEE was performed in the location listed above. I certify I was present in compliance with HCFA regulations. The patient was monitored by a nurse [**First Name (Titles) 1**] [**Last Name (Titles) 2**] throughout the procedure. The patient was sedated for the TEE. Medications and dosages are listed above (see Test Information section). Local anesthesia was provided by benzocaine topical spray. The posterior pharynx was anesthetized with 2% viscous lidocaine. No TEE related complications. 0.2 mg of IV glycopyrrolate was given as an antisialogogue prior to TEE probe insertion. The patient appears to be in sinus rhythm. Echocardiographic results were reviewed by telephone with the houseofficer caring for the patient.

Conclusions:
No spontaneous echo contrast or thrombus is seen in the body of the left atrium or left atrial appendage. No spontaneous echo contrast is seen in the body of the right atrium. No atrial septal defect is seen by 2D or color Doppler. Overall left ventricular systolic function is normal (LVEF>55%). Right ventricular systolic function is normal. The aortic valve leaflets (3)

are mildly thickened. No masses or vegetations are seen on the aortic valve. No aortic valve abscess is seen. Trace aortic regurgitation is seen. The mitral valve appears structurally normal with trivial mitral regurgitation. No mass or vegetation is seen on the mitral valve. The tricuspid valve leaflets are mildly thickened. There is no abscess of the tricuspid valve. No vegetation/mass is seen on the pulmonic valve. There is no pericardial effusion. A graft was visualized in the descending thoracic aorta between 25 and 35 cm beyond the patient's incisors.

Impression: no vegetation or abscess seen.

"

"PATIENT/TEST INFORMATION:

Indication: Endocarditis.

Height: (in) 66

Weight (lb): 165

BSA (m2): 1.84 m2

BP (mm Hg): 125/61

HR (bpm): 76

Status: Inpatient

Date/Time: [**2187-4-11**] at 09:44

Test: TTE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

LEFT ATRIUM: Mild LA enlargement.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Moderately dilated RA. Normal interatrial septum. No ASD by 2D or color Doppler.

LEFT VENTRICLE: Mild symmetric LVH with normal cavity size and systolic function (LVEF>55%). Normal regional LV systolic function. No resting LVOT gradient.

AORTA: Normal aortic root diameter. Moderately dilated ascending aorta. Mildly dilated aortic arch.

AORTIC VALVE: Mildly thickened aortic valve leaflets (3). No AS. No masses or vegetations on aortic valve. Trace AR.

MITRAL VALVE: Mildly thickened mitral valve leaflets. No MVP. No mass or vegetation on mitral valve. Trivial MR. Prolonged (>250ms) transmitral E-wave decel time.

TRICUSPID VALVE: Normal tricuspid valve leaflets. No mass or vegetation on tricuspid valve. Mild [1+] TR. Borderline PA systolic hypertension.

PULMONIC VALVE/PULMONARY ARTERY: Normal pulmonic valve leaflets with physiologic PR. No PS.

PERICARDIUM: No pericardial effusion.

Conclusions:

The left atrium is mildly dilated. The right atrium is moderately dilated. No atrial septal defect is seen by 2D or color Doppler. There is mild symmetric left ventricular hypertrophy with normal cavity size and systolic function (LVEF>55%). Regional left ventricular wall motion is normal. The ascending aorta is moderately dilated. The aortic arch is mildly dilated. The aortic valve leaflets (3) are mildly thickened but aortic stenosis is not present. No masses or vegetations are seen on the aortic valve. Trace aortic regurgitation is seen. The mitral valve leaflets are mildly thickened. There is no mitral valve prolapse. No mass or vegetation is seen on the mitral valve. Trivial mitral regurgitation is seen. There is borderline pulmonary artery systolic hypertension. There is no pericardial effusion.

IMPORESSION: No valvular vegetations seen.

"

"PATIENT/TEST INFORMATION:

Indication: Intra-op TEE for Endovascular aortic stenting of Desc aortic ulcer.

Status: Inpatient

Date/Time: [**2187-3-5**] at 15:48

Test: TEE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

RIGHT ATRIUM/INTERATRIAL SEPTUM: No ASD by 2D or color Doppler.

LEFT VENTRICLE: Normal LV wall thickness. Normal LV cavity size. Overall normal LVEF (>55%).

RIGHT VENTRICLE: Normal RV chamber size and free wall motion.

AORTA: Normal aortic root diameter. Mildly dilated ascending aorta. Mildly dilated descending aorta. There are complex (>4mm) atheroma in the descending thoracic aorta.

AORTIC VALVE: Three aortic valve leaflets. No AS. Trace AR.

MITRAL VALVE: Mildly thickened mitral valve leaflets. Mild (1+) MR.

TRICUSPID VALVE: Mild [1+] TR.

PULMONIC VALVE/PULMONARY ARTERY: Physiologic (normal) PR.

GENERAL COMMENTS: A TEE was performed in the location listed above. I certify I was present in compliance with HCFA regulations. No TEE related complications. The patient was under general anesthesia throughout the procedure. The patient appears to be in sinus rhythm. Results were personally reviewed with the MD caring for the patient.

Conclusions:

1. No atrial septal defect is seen by 2D or color Doppler.
2. Left ventricular wall thicknesses are normal. The left ventricular cavity size is normal. Overall left ventricular systolic function is normal (LVEF>55%).
3. Right ventricular chamber size and free wall motion are normal.
4. The ascending aorta is mildly dilated. The descending thoracic aorta is mildly dilated. There are complex (>4mm) atheroma in the descending thoracic aorta. An area of hemotoma and ulceration is visualized in the descending thoracic aorta.
5. There are three aortic valve leaflets. There is no aortic valve stenosis. Trace aortic regurgitation is seen.
6. The mitral valve leaflets are mildly thickened. Mild (1+) mitral regurgitation is seen.

An endostent is visualized in the descending thoracic aorta at the end of the procedure

"

"Sinus bradycardia. Left atrial enlargement. Right bundle-branch block.
Borderline low limb lead voltage. Compared to the previous tracing of [**2187-4-15**]
lead V6 is now recorded. No apparent diagnostic interim change.

"

"Sinus rhythm
Right bundle branch block
Lead V6 absent
Since previous tracing of [**2187-3-20**], no significant change

"

"Sinus rhythm. Left atrial abnormality. Right bundle-branch block. Leftward precordial R wave transition point. Cannot exclude prior anterior myocardial infarction. Compared to the previous tracing of [**2189-7-24**] heart rate is increased. Otherwise, no major change.

"

"Sinus rhythm. Left atrial abnormality. Right bundle-branch block. Possible lateral myocardial infarction. Compared to the previous tracing of [**2189-7-22**] cardiac rhythm is no longer ventricular paced.

"

"Sinus rhythm, rate 95. Ventricular paced rhythm with capture. Compared to the previous tracing of [**2189-7-20**] no diagnostic interim change. Intrinsic A-V conduction is no longer recorded.

"

"Sinus rhythm with intrinsic A-V conduction and intermiittent ventricular paced rhythm, new as compared with tracing of [**2189-7-17**]. Atrial flutter is no longer recorded.
TRACING #2

"

"Atrial flutter with slow ventricular response Right bundle-branch block with left anterior fascicular block. Compared to the previous tracing of [**2189-7-15**] no diagnostic interim change.
TRACING #1

"

"Atrial flutter

Slow ventricular response with pattern of right bundle branch block and left

anterior fascicular block - possibly independent from the flutter

Since previous tracing of [**2188-7-12**], findings as outlined now present

"

"Sinus rhythm with third degree A-V block. Ventricular rhythm has pattern

of left bundle-branch block with left axis deviation. Since the previous

tracing of [**2189-7-11**] there is no significant change.

"

"There is complete heart block with an escape rhythm likely arising from below

the His bundle. Compared to the previous tracing ventricular pacing is no

longer present. Complete heart block is evident and the escape rhythm is in a

left bundle-branch block configuration.

TRACING #2

"

"Regular ventricular pacing at 75 beats per minute in a right bundle-branch

configuration - confirm lead position. Likely underlying complete heart block.

Compared to the previous tracing of [**2189-7-3**] ventricular pacing is now present

and intrinsic conduction to the A-V node is no longer present.

TRACING #1

"

"Sinus rhythm

Right bundle branch block

Since previous tracing of [**2187-3-5**], no significant change

"

"Sinus rhythm

Right bundle branch block

Since previous tracing of same date, no significant change

"

"Sinus rhythm

Right bundle branch block

Since previous tracing of [**2187-3-5**], sinus tachycardia absent

"

"Sinus tachycardia

Right bundle branch block

Since previous tracing of [**2187-3-2**], sinus tachycardia present

"

"Sinus rhythm.

Right bundle branch block

Since previous tracing of same date, no significant change

"

"Sinus rhythm. Left atrial abnormality. Right bundle-branch block. No previous

tracing available for comparison.

"

"[**2187-3-21**] 11:58 AM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79681**]

CTA PELVIS W&W/O C & RECONS; CT 150CC NONIONIC CONTRAST

Reason: readmitted with fever

Admitting Diagnosis: POST OP FEVER

Field of view: 36 Contrast: OPTIRAY Amt: 120

[**Hospital 2**] MEDICAL CONDITION:

72 year old man s/p thoracic aortic stent

REASON FOR THIS EXAMINATION:

readmitted with fever

No contraindications for IV contrast

FINAL REPORT

INDICATION: Status post thoracic aortic stent placement, readmitted with fever.

COMPARISONS: CTA chest of [**2187-3-2**].

TECHNIQUE: Axial MDCT images of the chest, abdomen, and pelvis with 150 cc of non-ionic Optiray contrast per CTA protocol with coronal and sagittal reformations.

CTA CHEST WITH IV CONTRAST: Patient is status post metallic stent placement in the descending thoracic aorta adjacent to the region of small aortic ulceration and intramural hematoma. The stent appears intact and in good position. Posterior wall of the native aorta remains thickened; however, is unchanged from the prior CT. There is no evidence of air or other specific CT evidence to suggest abscess or peristent infection. The remainder of the thoracic aorta is unremarkable. Pulmonary arteries enhance normally. The

heart, pericardium, and great vessels are normal in appearance. The lungs are clear. Motion artifact limits assessment of the lung bases.

CT ABDOMEN WITH IV CONTRAST: The abdominal aorta enhances normally without evidence of dissection, ulceration, or aneurysmal dilatation. Severe motion artifact limits assessment of the abdomen and pelvis. Allowing for this limitation, the liver, spleen, gallbladder, kidneys, adrenal glands, pancreas, and intra-abdominal bowel appear grossly normal with the exception of a simple-appearing left renal cyst.

CT PELVIS WITH IV CONTRAST: The intrapelvic aorta and iliac branches opacify normally without evidence of dissection, ulceration, or aneurysmal dilatation. In the most inferior images, there is thickening of the lateral wall, with a markedly enlarged prostate impressing on the base of the bladder. Given the single phase, it is difficult to exclude filling defect at the base of the bladder and ultrasound is recommended if clinically warranted.

BONE WINDOWS: Mild degenerative changes throughout the axial spine without suspicious lytic or blastic lesions. There are severe degenerative and osteophytic changes involving the vertebral bodies of the lower thoracic level, adjacent to the lower portion of the stent; however, compared to the prior study, there is no evidence of interval bone destruction to suggest

(Over)

Admitting Diagnosis: POST OP FEVER

Field of view: 36 Contrast: OPTIRAY Amt: 120

FINAL REPORT

(Cont)

osteomyelitis or another infectious process.

IMPRESSION:

1) S/p stent placement within the descending thoracic aorta.

2) Stable thickening of the posterior aortic wall at the previous site of ulceration; unchanged from the CT of [**2187-3-2**]. No evidence of air or other specific CT features to suggest superimposed infection.

3) Motion artifact limits assessment of the abdomen and pelvis; however, allowing for this, no source of the patient's fever is identified.

4) Likely simple left renal cyst, too small to characterize.

5) Enlarged prostate impressing upon the base of the bladder, incompletely evaluated on this study. Correlation with PSA, and/or ultrasound is recommended.

"

"[**2187-3-5**] 6:30 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79843**]

Reason: r/o effusion

Admitting Diagnosis: CHEST PAIN

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with cp

REASON FOR THIS EXAMINATION:

r/o effusion

FINAL REPORT

INDICATION: 72-year-old man with chest pain, rule out effusion.

FINDINGS: ET tube is now present located just below the clavicle, 5.3 cm above the carina. Swan-Ganz catheter tip overlies the main/right main pulmonary artery. A new aortic stent is present. NG tube is located in the stomach. Left lower lobe atelectasis is present, otherwise the lungs are clear. No pleural effusions or pneumothoraces are identified. The cardiac silhouette is enlarged, and the mediastinal contours are within normal limits.

"

"[**2187-3-2**] 8:41 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79680**]

CTA PELVIS W&W/O C & RECONS; CT 150CC NONIONIC CONTRAST

Reason: Please evaluate the descending thoracic aorta for an atheros

Admitting Diagnosis: CHEST PAIN

Field of view: 36 Contrast: OPTIRAY Amt: 130

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with known atherosclerotic ulcer and possible peri-aortic hematoma now with recurrent substernal/back pain

REASON FOR THIS EXAMINATION:

Please evaluate the descending thoracic aorta for an atherosclerotic

ulcer/hematoma

No contraindications for IV contrast

WET READ: JVg FRI [**2187-3-2**] 11:43 PM

WET READ VERSION #1

FINAL REPORT

INDICATION: 72-year-old male with known atherosclerotic ulcer and possible periaortic hematoma, now with recurrence of substernal back pain. Evaluate descending thoracic aorta for an atherosclerotic ulcer/hematoma.

No comparison studies.

TECHNIQUE: MDCT acquired axial images of the chest were obtained without IV contrast. Chest, abdomen and pelvis images were then performed with IV contrast. Multiplanar and thin-slice reformations were obtained according to the Aorta CTA protocol.

CT CHEST WITHOUT AND WITH IV CONTRAST: Lung windows demonstrate dependent atelectatic changes. Soft tissue windows demonstrate a few nonpathologically enlarged mediastinal lymph nodes. No pathological enlarged lymph nodes within the axilla and hila. The proximal pulmonary arterial vasculature demonstrates no filling defects. Examination not optimal for pulmonary emboli evaluation. No evidence of pericardial effusions. Small left pleural effusion.

CT ABDOMEN WITH IV CONTRAST: The liver, pancreas, spleen, adrenal glands are within normal limits. The gallbladder is difficult to visualize. There are multiple low-attenuation lesions within the left kidney, one within the middle pole, likely representing simple renal cyst, the others are too small to

characterize. Small bowel and large bowel are unremarkable. No pathologically enlarged nodes within the retroperitoneum or mesentery.

CTA AORTA: As was previously described on outside CT report, there is focal soft tissue thickening immediately adjacent to and/or within the posterolateral wall of the distal descending thoracic aorta. The overall outer axial diameters at this level are 3.5 cm x 3.4 cm. The aortic lumen measures 2.5 cm, with the thickness of this soft tissue crescentic area measuring 10 mm. It extends over about a 4 cm sagittal length. Protruding from the lumen into this soft tissue, there is a tiny approximately 3 mm penetrating ulcer / beak- like projection of contrast that has been described on outside reports. There is no definite evidence of active extravasation.

(Over)

[**2187-3-2**] 8:41 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79680**]

CTA PELVIS W&W/O C & RECONS; CT 150CC NONIONIC CONTRAST

Reason: Please evaluate the descending thoracic aorta for an atheros

Admitting Diagnosis: CHEST PAIN

Field of view: 36 Contrast: OPTIRAY Amt: 130

FINAL REPORT

(Cont)

However the density appears to be in the range of hematoma. Atherosclerotic plaques along with calcium are seen throughout the aortic arch and throughout the descending aorta. The celiac axis, SMA, and renal arteries are patent.

IMPRESSION:

1. Tiny penetrating ulcer-like projection in the distal descending thoracic aorta, with adjacent crescentic hematoma, which currently appears contained within the aoric wall. No evidence of active extravasation.

2. Left renal simple cysts. Multiple low-attenuation lesions within the left kidney, too small to characterize.

3. Very small left pleural effusion.

"

"[**2187-4-3**] 10:03 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79682**]

CTA PELVIS W&W/O C & RECONS; CT 100CC NON IONIC CONTRAST

Reason: assess for graft infetion

Field of view: 36 Contrast: OPTIRAY Amt: 100

[**Hospital 2**] MEDICAL CONDITION:

fever, s/p aortic graft

REASON FOR THIS EXAMINATION:

assess for graft infetion

No contraindications for IV contrast

FINAL REPORT

INDICATION: Fevers status post aortic graft. Evaluate.

COMPARISON: [**2187-3-21**].

TECHNIQUE: MDCT axial images of the chest, abdomen and pelvis were obtained

after the administration of IV Optiray contrast. Delayed scans as well as multiplanar reformatted images were performed. Prior to administration of IV Optiray contrast, a non-contrast chest CT scan was performed.

CT CHEST WITHOUT AND WITH IV CONTRAST: Patient is status post metallic stent in the descending thoracic aorta. The posterior wall of the native aorta remains thickened, compatible with the excluded ulceration sac/wall components, and has not changed in size compared to the prior CT examination. There is no evidence of air to suggest abscess. The remainder of the thoracic aorta is unremarkable. There is bibasilar atelectasis. No pathologically enlarged mediastinal or hilar lymph nodes.

CT ABDOMEN WITH IV CONTRAST: The liver, gallbladder, right kidney, spleen, pancreas, and adrenal glands are within normal limits. Left kidney hypodensities likely represent cysts but cannot be further characterized. There are no pathologically enlarged mesenteric or inguinal lymph nodes. No free fluid or free air in the abdomen.

The intra-abdominal portions of the aorta as well as major branches are unremarkable.

CT PELVIS WITH IV CONTRAST: The rectum, sigmoid colon, and bladder are unremarkable. The prostate is markedly enlarged. There is a 3.8 x 2.5 cm fluid collection in the right inguinal region possibly representing a seroma.

BONE WINDOWS: There are severe degenerative changes of the lower lumbar spine.

IMPRESSION:

1. Status post stent placement within the descending thoracic aorta. Stable

appearance of thickened posterior wall at the previous site of ulceration.

There is no definitive CT evidence to suggest infection.

2. Left kidney hypodensities likely representing cysts but unable to be

further characterized.

3. Enlarged prostate. Correlation with PSA and/or ultrasound is recommended.

(Over)

[**2187-4-3**] 10:03 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79682**]

CTA PELVIS W&W/O C & RECONS; CT 100CC NON IONIC CONTRAST

Reason: assess for graft infetion

Field of view: 36 Contrast: OPTIRAY Amt: 100

FINAL REPORT

(Cont)

"

"[**2187-4-13**] 6:55 PM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 79958**]

Reason: Please read for right PICC. Thanks! [**Doctor First Name 147**]

Admitting Diagnosis: FEVER

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with infection req. abx

REASON FOR THIS EXAMINATION:

Please read for right PICC. Thanks! [**Doctor First Name 147**]

FINAL REPORT

INDICATION: Infection right PICC.

COMPARISON: [**2187-4-3**].

FINDINGS: New right PICC catheter tip overlies the mid SVC. There is no significant change otherwise from [**2187-4-3**]. The heart size and mediastinal contours are within normal limits. Again seen is an aortic stent graft. Pulmonary vasculature is normal. Increased opacity at the right lower lobe may represent a small amount of atelectasis.

IMPRESSION: Status post right PICC.

"

"[**2187-4-3**] 9:14 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 79908**]

Reason: assess for pneumonia

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with fever

REASON FOR THIS EXAMINATION:

assess for pneumonia

FINAL REPORT

INDICATION. 72-year-old with fever. Assess for pneumonia.

COMPARISON: [**2187-3-20**].

PA AND LATERAL CHEST RADIOGRAPH: Heart size and mediastinal contours are within normal limits. Again seen is an aortic stent graft in unchanged position. Pulmonary vasculature is normal. Again seen is left lower lobe linear atelectasis and blunting of the left costophrenic angle. The osseous structures are unremarkable.

IMPRESSION:

1. No interval change compared to [**2187-3-20**].

"

"[**2187-4-13**] 2:17 PM

MR [**Name13 (STitle) 203**] W &W/O CONTRAST; MR CONTRAST GADOLIN Clip # [**Clip Number (Radiology) 79685**]

Reason: R/O brucellosis of spine, need to use GADALINIUM. Please als

Admitting Diagnosis: FEVER

Contrast: MAGNEVIST Amt: 13

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with

REASON FOR THIS EXAMINATION:

R/O brucellosis of spine, need to use GADALINIUM. Please also do axial cuts.

FINAL REPORT

INDICATION: 72-year-old man, rule out brucellosis of spine.

COMPARISON: MR thoracic spine [**2187-4-8**].

TECHNIQUE: T1- and T2-weighted axial and sagittal scans were performed of the thoracic spine. Axial images were obtained from the T5-T6 interspaces through the T9-T10 interspaces. Post-gadolinium images imaging was performed.

FINDINGS:

As described on prior study at the level of T4-T5. There is ligamentous hypertrophy pushing against the thecal sac with no evidence of compression. As previously described at the level of T9-T10, there is increase signal seen on T2-weighted and STIR imaging. There is no evidence of disc enhancement in this region or elsewhere in the thoracic spine upon gadolinium administration. There is a very mild enhancement of the anterior portion of the T10 vertebral body and anterior osteophyte is again noted at the level of T9-T10. No evidence of enhancing discs seen at this level or elsewhere within the thoracic vertebrae. No evidence of leptomeningeal enhancement. No evidence of paraspinal masses or paraspinal soft tissue enhancement. No significant neural foramen narrowing throughout the thoracic vertebrae.

IMPRESSION:

1. No evidence of leptomeningeal enhancement.

2. No evidence of paraspinal masses or paraspinal enhancement.

3. Very mild enhancement of T10 vertebral body with no adjacent disc enhancement. Baseline increased signal is seen at this level and the level of T9 on T2-weighted and STIR images. These findings are nonspecific and could represent degenerative change, infection, or even trauma.

"

"[**2187-4-8**] 11:07 AM

MR [**Name13 (STitle) 202**] W& W/O CONTRAST; MR [**Name13 (STitle) 203**] W &W/O CONTRAST Clip # [**Clip Number (Radiology) 79683**]

MR CONTRAST GADOLIN

Reason: r/o abscess

Admitting Diagnosis: FEVER

Contrast: MAGNEVIST Amt: 15

[**Hospital 2**] MEDICAL CONDITION:

72 year old man s/p aortic stent, fever, back pain

REASON FOR THIS EXAMINATION:

r/o abscess

No contraindications for IV contrast

FINAL REPORT

INDICATION: 72-year-old man status post aortic stent with fever and back pain. Rule out abscess.

TECHNIQUE: Axial and sagittal T1- and T2-weighted imaging was performed of the cervical and thoracic spine. Gadolinium-enhanced images were obtained.

FINDINGS: Sagittal images of the cervical spine demonstrate a small disc bulge with extrusion superiorly at the level of C4-C5 that is abutting upon the thecal sac and spinal cord. An additional disc bulge is seen at the level of C5-C6 with a lesser degree of thecal sac and spinal cord abutment. Axial views of the cervical spine were not performed.

Within the thoracic spine at the level of T4, extensive left ligamentous hypertrophy is pushing upon the thecal sac and spinal cord with no evidence of compression. At the level of T6, there is a hyperdense focus within the T6 vertebral body on T1-weighted images, likely representing benign degenerative change. At the level of T9-T10, there is moderate anterior osteophyte formation with mild hyperintensity seen on noncontrast-enhanced T2-weighted images and STIR images. There is very mild enhancement post-gadolinium administration within the T10 vertebral body. Within this region, there is no evidence of disc enhancement. There is no evidence of cord or thecal sac enhancement.

No significant neural foramen narrowing or cord compression is identified throughout the visualized cervical and thoracic spine.

IMPRESSION:

1. Mild disc bulge with extrusion superiorly at the level of C4-C5 and to a lesser degree at C5-C6, abutting the thecal sac with no evidence of compression.
2. High signal within T9 and T10 vertebral bodies on T2 and STIR images with very slight enhancement of T9 vertebral body. No enhancing discs or thecal sac. These findings are fairly nonspecific as they could be from degenerative changes, infection or trauma.
3. No evidence of leptomeningeal enhancement.

4. No evidence of enhancing paraspinal soft tissues/masses.

(Over)

[**2187-4-8**] 11:07 AM

MR [**Name13 (STitle) 202**] W& W/O CONTRAST; MR [**Name13 (STitle) 203**] W &W/O CONTRAST Clip # [**Clip Number (Radiology) 79683**]

MR CONTRAST GADOLIN

Reason: r/o abscess

Admitting Diagnosis: FEVER

Contrast: MAGNEVIST Amt: 15

FINAL REPORT

(Cont)

"

"[**2187-4-8**] 11:07 AM

MR [**Name13 (STitle) 622**] W & W/O CONTRAST Clip # [**Clip Number (Radiology) 79684**]

Reason: r/o abscess

Admitting Diagnosis: FEVER

Contrast: MAGNEVIST Amt: 15

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with fever

REASON FOR THIS EXAMINATION:

r/o abscess

FINAL REPORT (REVISED)

INDICATION: Rule out abscess.

No comparison studies.

TECHNIQUE: Sagittal T1 and T2-weighted lumbar spine images were obtained with axial T1 and T2-weighted scan of the L2-3 through L5-S1 interspaces.

FINDINGS: There is a small, focal central disc protrusion seen at the level of L2/3 with mild superior extrusion. There is mild-to-moderate compression of the thecal sac.

Multilevel degenerative changes are present, the most prominent are seen at the endplates of the L3/4 interspace and L4/5 interspaces. Mild disc bulges are seen at the L2/3-L4/5 levels. These bulging discs cause mild bilateral L2/3 and moderate bilateral L3/4 and L4/5 neural foraminal narrowing. At L5/S1, facet joint degeneration causes moderate bilateral foraminal narrowing. All lumbar discs are moderately desiccated.

No evidence of abnormal enhancement is seen and there is no evidence for abscess.

IMPRESSION:

1. No evidence of abscess.
2. Focal disc protrusion at the level of L2/3 with superior extrusion and mild thecal sac compression.
3. Multilevel degenerative change, predominantly at L3/4 and L4/5 interspaces.

See above report for additional findings.

"

"[**2187-3-20**] 9:31 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 79889**]

Reason: r/o infiltrate, effusion

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with fever

REASON FOR THIS EXAMINATION:

r/o infiltrate, effusion

FINAL REPORT

INDICATION: 72-year-old man with fever, rule out infiltrate, effusion.

PA and lateral chest radiograph were compared to [**2187-3-5**]. The lungs are hyperinflated, but clear. The cardiac and mediastinal contours are normal. The pulmonary vasculature is normal. There is atelectasis or pleural thickening of the left lung base, and a likely small left pleural effusion. Aortic stent graft is unchanged in position.

IMPRESSION: No active pulmonary disease.

"

"[**2187-5-15**] 2:22 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79686**]

CTA PELVIS W&W/O C & RECONS; CT 150CC NONIONIC CONTRAST

Reason: CTA WITH MMS PROTOCOL

Field of view: 36 Contrast: OPTIRAY Amt: 150

FINAL REPORT

CT ANGIOGRAM OF THORAX, ABDOMEN AND PELVIS (CT ANGIOGRAM PROTOCOL)

TECHNIQUE: Arterial and delayed post-contrast CT of the abdomen and pelvis.

RECONSTRUCTIONS: Multiplanar reformations in the sagittal and coronal plane, volume rendered and MIP images are also included.

CLINICAL DETAILS: Followup post-endostent repair of intramural thoracic aortic hematoma.

Comparison made to previous imaging.

FINDINGS:

Ascending arch and descending thoracic aorta are normal in caliber. Interval placement of a 10cm descending thoracic aortic arch endoluminal stent extending from just inferior to the arch to the distal descending thoracic aorta. A thin crescentic area of thickening along the posterior and posterolateral descending thoracic aorta measuring up to 1 cm is located at the most inferior extent of the endoluminal thoracic aortic graft (series 3, image 70). This is at the site of small prior intramural ulceration, no evidence of residual ulceration at that point.
Just below the inferior most extent of the stent graft, there is a small (7 mm x 4 mm) area of ulceration into the posterior descending thoracic aortic wall (series 3, image 80) without associated mural thickening. The descending

thoracic aorta at that level is normal in caliber at 2.5 cm.

The abdominal aorta is normal in caliber measuring 2 cm just below the origin of the renal arteries. The celiac, superior mesenteric, inferior mesenteric, and renal arteries are widely patent and normal in caliber. There are two left renal arteries which share a common ostial origin. Mild atheromatous calcification in the abdominal aorta, both common, internal, and external iliac arteries are widely patent and normal in caliber.

CT SCAN OF THORAX:

Lungs clear. No mass lesion or mediastinal lymphadenopathy. Tiny 3-mm granuloma in the right middle lobe anteriorly (series 3, image 47). Normal heart size and normal-caliber central pulmonary arterial vasculature.

CT SCAN OF ABDOMEN WITH INTRAVENOUS CONTRAST:

The liver, spleen, pancreas, gallbladder, both adrenal glands are normal in size. No concerning lesions. Several subcentimeter cysts noted bilaterally.

(Over)

[**2187-5-15**] 2:22 PM

CTA CHEST W&W/O C &RECONS; CTA ABD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 79686**]

CTA PELVIS W&W/O C & RECONS; CT 150CC NONIONIC CONTRAST

Reason: CTA WITH MMS PROTOCOL

Field of view: 36 Contrast: OPTIRAY Amt: 150

FINAL REPORT

(Cont)

CT SCAN OF PELVIS (WITH INTRAVENOUS CONTRAST):

Marked enlargement of the prostate gland which measures up to 6.7 cm AP x 6 cm transverse. Mild concentric thickening of the moderately distended bladder. No hydronephrosis or hydroureter.

No concerning bone lesions demonstrated on bone window setting.

RECONSTRUCTIONS: Multiplanar reformations in the sagittal and coronal plane, volume rendered and MIP images of the arterial anatomy are also included.

CONCLUSION:

1. Minor (subcentimeter) residual posterior mural thickening at the site of prior intramural ulceration in the descending thoracic aorta. No residual ulceration at that point, the inferior extent of the endostent extends to that level.

2. A tiny (7 mm x 5 mm) area of ulceration along the posterior descending thoracic aorta inferior to the stent without any acute complication or wall thickening.

2. Markedly enlarged prostate gland.

"

"[**2187-3-2**] 4:58 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79787**]

Reason: r/o cardiopulm process

[**Hospital 2**] MEDICAL CONDITION:

72 year old man with cp

REASON FOR THIS EXAMINATION:

r/o cardiopulm process

FINAL REPORT

INDICATION: Chest pain.

CHEST AP: Cardiomegaly is present. There is mild linear atelectasis at the left lung base. The remaining lungs are clear. The mediastinal and hilar contours are unremarkable. There are no pleural effusions. The pulmonary vasculature is normal.

IMPRESSION: No acute process.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-17**] 12:47 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79479**]

Reason: ptx

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man Ao. stent removal/esoph repair

REASON FOR THIS EXAMINATION:

ptx

PFI REPORT

PFI: Decreasing tiny left apical pneumothorax.

"

"[**2189-7-17**] 12:47 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79479**]

Reason: ptx

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man Ao. stent removal/esoph repair

REASON FOR THIS EXAMINATION:

ptx

PROVISIONAL FINDINGS IMPRESSION (PFI): PMB FRI [**2189-7-17**] 2:20 PM

PFI: Decreasing tiny left apical pneumothorax.

FINAL REPORT

Portable semi-upright chest with indication of pneumothorax.

Left-sided chest tubes remain in place. A tiny left apical pneumothorax has decreased in size, in retrospect since recent study. Cardiomediastinal contours appear less widened, and there has been slight improvement in the degree of fluid overload. Retrocardiac opacification and bilateral pleural effusions are probably unchanged, but exclusion of left costophrenic sulcus from the radiograph limits full assessment of the left pleural effusion.

"

"[**2189-7-14**] 10:47 AM

CHEST PORT. LINE PLACEMENT; -76 BY SAME PHYSICIAN [**Name Initial (PRE) 5**] # [**Clip Number (Radiology) 79406**]

Reason: Pt had a left sided picc line placed,46cm in pt,56cm total l

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with s/p descending aortic stent graft repair who needs picc for antibiotics.

REASON FOR THIS EXAMINATION:

Pt had a left sided picc line placed,46cm in pt,56cm total length and needs tip confirmation please page [**Doctor First Name **] at [**Numeric Identifier 148**] with wet read,thanks.

PROVISIONAL FINDINGS IMPRESSION (PFI): SBNa TUE [**2189-7-14**] 2:23 PM

PICC within the right atrium. Worsening fluid overload. Persistent widened mediastinum.

FINAL REPORT

CHEST LINE PLACEMENT.

COMPARISON: 4 hours prior.

FINDINGS: There has been interval placement of a left-sided PICC, which terminates in the right atrium. A right-sided IJ terminates in the lower SVC. NG tube is seen within the stomach with its sideport still at the GE junction. Unchanged positions of multiple left-sided chest tubes. There is persistent bilateral pleural effusions with bibasilar atelectasis. Unchanged retrocardiac opacity also likely represents atelectasis. Interval increase in interstitial markings suggest worsening fluid overload. Unchanged appearance of widened mediastinum from four hours prior.

IMPRESSION:

1. Left PICC within the right atrium.

2. Appearance of fluid overload as described above.

3. Persistent widened mediastinum concerning for hematoma, unchanged from four hours prior.

Findings were discussed with PICC nurse, [**Doctor First Name **] for PICC findings and also discussed with [**First Name8 (NamePattern2) 5491**] [**Last Name (NamePattern1) 4521**] for mediastinal and lung findings.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-14**] 10:47 AM

CHEST PORT. LINE PLACEMENT; -76 BY SAME PHYSICIAN [**Name Initial (PRE) 5**] # [**Clip Number (Radiology) 79406**]

Reason: Pt had a left sided picc line placed,46cm in pt,56cm total l

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with s/p descending aortic stent graft repair who needs picc

for antibiotics.

REASON FOR THIS EXAMINATION:

Pt had a left sided picc line placed,46cm in pt,56cm total length and needs tip

confirmation please page [**Doctor First Name **] at [**Numeric Identifier 148**] with wet read,thanks.

PFI REPORT

PICC within the right atrium. Worsening fluid overload. Persistent widened

mediastinum.

"

"[**2189-7-14**] 7:18 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79405**]

Reason: infiltrate

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with aortic stent removal

REASON FOR THIS EXAMINATION:

infiltrate

PROVISIONAL FINDINGS IMPRESSION (PFI): SBNa TUE [**2189-7-14**] 2:12 PM

NG tube side port at GE junction should be advanced. Increased mediastinal

widening. Bilateral effusion with atelectasis.

FINAL REPORT

CHEST PORTABLE AP.

COMPARISON: [**2189-7-12**].

HISTORY: Thoracic aortic grafting.

FINDINGS: Interval increase in mediastinal widening when compared to exam two days prior may represent hematoma. There has been interval removal of ET tube. Multiple left- sided chest tubes are unchanged in position. There is no pneumothorax. Right-sided IJ catheter terminates within the mid SVC. The NG tube side port is located at the gastroesophageal junction and should be advanced. There are bilateral small effusions with increased retrocardiac opacity, unchanged.

IMPRESSION:

1. Increased mediastinal widening concerning for hematoma.
2. Bilateral effusions and retrocardiac opacity, likely atelectasis, is unchanged.
3. NG tube side port within the GE junction should be advanced.

Findings discussed with [**First Name8 (NamePattern2) 5491**] [**Last Name (NamePattern1) 4521**] via telephone.

"

"[**2189-7-20**] 9:26 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79407**]

Reason: s/p removal infected graft

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with

REASON FOR THIS EXAMINATION:

s/p removal infected graft

PROVISIONAL FINDINGS IMPRESSION (PFI): DJRX MON [**2189-7-20**] 6:35 PM

Interval improvement in pulmonary vascular congestion.

FINAL REPORT

CHEST X-RAY

HISTORY: Status post removal of infected graft.

One view. Comparison with previous study done [**2189-7-17**]. There is interval clearing of pulmonary vascular congestion. Hazy density at the lung bases consistent with pleural fluid appears improved. Retrocardiac area is not well penetrated, as before. The heart and mediastinal structures are unchanged. A nasogastric tube, left chest tubes and a PICC line remain in place.

IMPRESSION: Clearing of pulmonary vascular congestion and probable decrease in pleural fluid.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-20**] 9:26 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79407**]

Reason: s/p removal infected graft

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with

REASON FOR THIS EXAMINATION:

s/p removal infected graft

PFI REPORT

Interval improvement in pulmonary vascular congestion.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-14**] 7:18 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79405**]

Reason: infiltrate

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with aortic stent removal

REASON FOR THIS EXAMINATION:

infiltrate

PFI REPORT

NG tube side port at GE junction should be advanced. Increased mediastinal

widening. Bilateral effusion with atelectasis.

"

"[**2189-7-12**] 10:31 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 79404**]

Reason: Thoracic aortic grafting triple lumen placed rt. IJ

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with

REASON FOR THIS EXAMINATION:

Thoracic aortic grafting triple lumen placed rt. IJ

PROVISIONAL FINDINGS IMPRESSION (PFI): JRld SUN [**2189-7-12**] 3:17 PM

PFI: Right IJ catheter tip is in the proximal SVC. There is no pneumothorax.

Small to moderate right and moderate to large left pleural effusion stable

with associated adjacent atelectasis. Cardiomediastinum is unchanged.

FINAL REPORT

REASON FOR EXAM: Assess right IJ.

Comparison is made with prior study of [**2189-7-10**].

Right IJ catheter tip is in the proximal to mid SVC. ET tube tip is 4.1 cm

above the carina. NG tube tip is in the stomach. The side port is at the EG

junction. Left chest tube remain in place. Small to moderate right and

moderate to large left pleural effusions are unchanged with adjacent bibasilar

atelectasis worse in the left side. Cardiomediastinal silhouette is unchanged

with widened mediastinum and cardiomegaly.

DR. [**First Name (STitle) 503**] [**Initials (NamePattern4) **] [**Last Name (NamePattern4) 504**]

"

"[**2189-7-21**] 3:47 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79504**]

Reason: Lead location? Pneumothorax?

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with intermitent CHB. s/p Temp PM screw-in insertion.

REASON FOR THIS EXAMINATION:

Lead location? Pneumothorax?

FINAL REPORT

HISTORY: Temporary pacemaker, to evaluate for lead location and pneumothorax.

FINDINGS: In comparison with study of [**7-20**], there has been insertion of a temporary pacemaker with its tip in the general region of the apex of the right ventricle. No evidence of pneumothorax.

IMPRESSION: Little change.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-12**] 10:31 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 79404**]

Reason: Thoracic aortic grafting triple lumen placed rt. IJ

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with

REASON FOR THIS EXAMINATION:

Thoracic aortic grafting triple lumen placed rt. IJ

PFI REPORT

PFI: Right IJ catheter tip is in the proximal SVC. There is no pneumothorax.

Small to moderate right and moderate to large left pleural effusion stable

with associated adjacent atelectasis. Cardiomediastinum is unchanged.

"

"[**2189-7-22**] 7:19 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79540**]

Reason: Lead location? pneumothorax?

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with intermitent CHB. s/p Temp PM screw-in insertion.

REASON FOR THIS EXAMINATION:

Lead location? pneumothorax?

FINAL REPORT

HISTORY: Temporary pacemaker placement.

FINDINGS: In comparison with the study of [**7-21**], there is little change.

Pacemaker device remains in place and there is no evidence of pneumothorax.

Various other tubes are also seen as on the previous study.

"

"[**2189-7-27**] 9:24 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79599**]

Reason: f/u effusion

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with s/p thoracoabdominal removal of infected aortic stent and subsequent repair

REASON FOR THIS EXAMINATION:

f/u effusion

FINAL REPORT

HISTORY: Postoperative removal of infected aortic stent, to evaluate for effusion.

FINDINGS: In comparison with study of [**7-26**], there is little change in the appearance of the heart and lungs. Again there is volume loss on the left especially in the retrocardiac region with blunting of the costophrenic angle. There may well be a tiny residual left pneumothorax. Central catheter and pacer lead remain in place. The right lung is clear.

"

"[**2189-7-25**] 3:32 PM

CHEST (PORTABLE AP); -76 BY SAME PHYSICIAN [**Name Initial (PRE) 5**] # [**Clip Number (Radiology) 79580**]

Reason: PTX

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p CT dc'd

REASON FOR THIS EXAMINATION:

PTX

FINAL REPORT

CHEST SINGLE VIEW ON [**7-25**]

HISTORY: Chest tube removal, question pneumothorax.

FINDINGS: There has been interval removal of the left chest tube. There continues to be left retrocardiac opacity consistent with volume loss/infiltrate. There is a small left apical pneumothorax. The left subclavian PICC line tip is in the SVC. The pacemaker is again visualized.

"

"[**2189-7-26**] 12:37 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79598**]

Reason: left pl.eff.

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p OPCAB x1

REASON FOR THIS EXAMINATION:

left pl.eff.

FINAL REPORT

CHEST, SINGLE VIEW.

HISTORY: Follow up left pneumothorax.

FINDINGS: Again seen is a small left pneumothorax, similar in size compared to the film from the prior day. There continues to be volume loss/infiltrate in the retrocardiac region. The pacer is unchanged. Left subclavian PICC line is unchanged.

IMPRESSION: No significant change in small left pneumothorax.

"

"[**2189-7-25**] 10:59 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79541**]

Reason: assess L hemithorax before CT removal

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with L thoracoty

REASON FOR THIS EXAMINATION:

assess L hemithorax before CT removal

FINAL REPORT

CHEST SINGLE VIEW ON [**7-25**]

HISTORY: Assess left hemithorax before chest tube removal.

FINDINGS: One of the left chest tubes has been removed. The other left chest tube is in place. There is a small left apical pneumothorax. There is volume loss in the left lower lung. The right lung is clear. The cardiac pacer is unchanged. Gastric tube is visualized. There is some slight improvement in the aeration of the left mid lung but there continues to be a patchy area of infiltrate seen in the mid lung with retrocardiac opacity as well.

"

"[**2189-7-8**] 8:57 AM

CHEST (PRE-OP PA & LAT) Clip # [**Clip Number (Radiology) 79962**]

Reason: INFECTED STENT

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with known thoracic Ao ulcer s/p stent now infected

REASON FOR THIS EXAMINATION:

preop evaluation

PROVISIONAL FINDINGS IMPRESSION (PFI): DLnc WED [**2189-7-8**] 11:06 AM

No radiological evidence of acute cardiopulmonary process.

FINAL REPORT

REASON FOR EXAMINATION: Follow up of a patient with known thoracic aortic ulcer after insertion of an infected stent.

Pre-operative evaluation.

PA and lateral upright chest radiograph was reviewed in comparison to [**2187-4-13**].

The heart size is normal. Mediastinal position, contour and width are unremarkable. Known thoracic aortic stent is seen at the level of the aortic arch and descending aorta with unchanged appearance. The lungs are clear. There is no pleural effusion or pneumothorax.

IMPRESSION:

No evidence of acute cardiopulmonary process. Unchanged position of the thoracic stent graft.

"

"[**Last Name (LF) **],[**First Name3 (LF) **] L. VSURG FA5 [**2189-7-8**] 8:57 AM

CHEST (PRE-OP PA & LAT) Clip # [**Clip Number (Radiology) 79962**]

Reason: INFECTED STENT

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man with known thoracic Ao ulcer s/p stent now infected

REASON FOR THIS EXAMINATION:

preop evaluation

PFI REPORT

No radiological evidence of acute cardiopulmonary process.

"

"[**2189-7-3**] 10:27 PM

CTA CHEST W&W/O C&RECONS, NON-CORONARY; CTA ABD W&W/O C & RECONSClip # [**Telephone/Fax (1) 79959**]

CTA PELVIS W&W/O C & RECONS

Reason: please eval for endovasc bleed, rp bleed

Contrast: OPTIRAY Amt: 80

[**Hospital 2**] MEDICAL CONDITION:

72yo M s/p recent endovascular stent placement [**3-5**] to descending thoracic aorta for ulcerating plaque. seen in [**Country **]. transported here from [**Country **] for ? leak. describes pain in LUQ/LLQ, l flank

REASON FOR THIS EXAMINATION:

please eval for endovasc bleed, rp bleed

No contraindications for IV contrast

WET READ: DXAe FRI [**2189-7-3**] 11:04 PM

Thick (19 mm) rind of soft tissue around the descending aorta graft with locules of air is very worrisome for graft infection. No evidence of contrast extravisation.

FINAL REPORT

INDICATION: 72-year-old man with endovascular stent placement 2 months ago inside old vascular stent placed on [**4-24**], presenting with left upper quadrant pain, with possible endovascular leak.

COMPARISON: [**2187-4-3**].

TECHNIQUE: MDCT acquired images were obtained through the torso before and then immediately after the uneventful administration of 80 cc of IV Optiray contrast. Multiplanar reformats were reviewed.

CTA CHEST: The patient is post endograft stent in the descending thoracic aorta with marked soft tissue thickening around the graft measuring 17 mm (previously 8 mm). Focal areas of air within the soft tissue, are highly concerning for infection. There is no evidence of contrast extravasation or ruptured atherosclerotic plaque. The lung parenchyma is grossly unremarkable. The airways are patent to the subsegmental level. There are no pathologically enlarged central or axillary lymph nodes.

CT ABDOMEN: The liver, spleen, pancreas, gallbladder, and adrenals are grossly unremarkable. The kidneys demonstrate several subcentimeter cysts bilaterally which are stable since [**2187-4-3**]. The intra-abdominal loops of large and small bowel are unremarkable. There is no free fluid or free air.

CT PELVIS: The bladder is mildly enlarged. The prostate is markedly enlarged measuring 5.6 x 6.5 cm, unchanged. Seroma in the right inguinal region has resolved.

Bone windows demonstrate stable degenerative changes in the lower lumbar spine without evidence of suspicious lytic or blastic lesion.

IMPRESSION:

1. 8 weeks post-op from repeat thoracic aortic stent graft with increase in the peri- aortic soft tissue rind and perigraft pockets of air suggestive of

(Over)

[**2189-7-3**] 10:27 PM

CTA CHEST W&W/O C&RECONS, NON-CORONARY; CTA ABD W&W/O C & RECONSClip # [**Telephone/Fax (1) 79959**]

CTA PELVIS W&W/O C & RECONS

Reason: please eval for endovasc bleed, rp bleed

Contrast: OPTIRAY Amt: 80

FINAL REPORT

(Cont)

infection. Close follow-up is recomended.

2. Markedly enlarged prostate, unchanged.

"

"[**2189-7-9**] 9:32 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79376**]

Reason: post-op

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p thoracic aneurysm repair

REASON FOR THIS EXAMINATION:

post-op

FINAL REPORT

HISTORY: Thoracic aneurysm repair.

FINDINGS: In comparison with the study of [**7-8**], there is an endotracheal tube

in place with its tip approximately 2.7 cm above the carina. Nasogastric tube

extends only to the cardioesophageal junction with the side hole well in the distal esophagus. Left chest tubes are in place with no pneumothorax. Swan-Ganz catheter extends to the right pulmonary artery.

There is some indistinctness of pulmonary vessels suggesting some overhydration. Atelectatic changes are seen at the left and possibly also right bases.

"

"[**2189-7-7**] 2:14 PM

MR [**Name13 (STitle) 203**] W &W/O CONTRAST; MR [**Name13 (STitle) 622**] W & W/O CONTRAST Clip # [**Clip Number (Radiology) 79961**]

Reason: assess for osteo Valiant Thoracic stentGraft TF3636C 200AX

Admitting Diagnosis: INFECTED STENT

Contrast: MAGNEVIST Amt: 14

[**Hospital 2**] MEDICAL CONDITION:

74 M who underwent a descending thoracic aortic stent [**Location (un) **] [**2187-3-5**] for a penetrating ulcer thought to be [**12-20**] brucellosis, s/p leak and 2nd stent in [**Month (only) 1425**] in [**Country **] (in original stent). Now c/o back pain and hemoptysis.

REASON FOR THIS EXAMINATION:

assess for osteo Valiant Thoracic stentGraft TF3636C 200AX

No contraindications for IV contrast

WET READ: JKPe TUE [**2189-7-7**] 8:33 PM

multilevel ddd/djd without cord compression. no findings to suggest discitis/osteo in t/l spine. there is likely some enhacement to the rind of

soft tissue surrounding the aorta as seen on ct, but the post contrast images are markedly degraded by aortic pulsation/stent artifact.

FINAL REPORT

EXAM: MRI of the thoracic and lumbar spine.

CLINICAL INFORMATION: Patient with descending thoracic aortic graft with infection. For further evaluation to exclude spinal involvement.

THORACIC SPINE:

TECHNIQUE: T1, T2, and inversion recovery sagittal, and T2 axial images obtained before gadolinium. T1 sagittal and axial images obtained following gadolinium.

Correlation was made with the previous abdominal CT. Correlation was also made with the previous thoracic spine MRI of [**2187-4-13**].

FINDINGS: As seen on the CT examination of [**2189-7-3**], there is postoperative change seen in the descending aorta. At the level of T8-T10 vertebra, there is focal dilatation of the aorta. Soft tissue changes are seen surrounding the aorta, T8-T10 level. The T10 vertebral body demonstrates increased signal on the left side on inversion recovery images with decreased signal on T1-weighted images. This is adjacent to the focal dilatation of the aorta. Following gadolinium, subtle enhancement is seen in this region. These findings are indicative of periaortic inflammation with pressure erosion or early osteomyelitis of the T10 vertebral body. There is no epidural abscess identified. At T4-T5 level, there is hypertrophic change seen in the facet joint on the left side with indentation on the left side of the spinal cord.

This appears degenerative in nature. Mild multilevel degenerative changes are seen in the thoracic vertebral bodies. There is no intrinsic signal abnormality within the spinal cord. No abnormal intraspinal enhancement is seen.

IMPRESSION: 1. Findings indicative of periaortic inflammation in the lower thoracic region with abnormal signal in T10 vertebral predominantly on the

(Over)

[**2189-7-7**] 2:14 PM

MR [**Name13 (STitle) 203**] W &W/O CONTRAST; MR [**Name13 (STitle) 622**] W & W/O CONTRAST Clip # [**Clip Number (Radiology) 79961**]

Reason: assess for osteo Valiant Thoracic stentGraft TF3636C 200AX

Admitting Diagnosis: INFECTED STENT

Contrast: MAGNEVIST Amt: 14

FINAL REPORT

(Cont)

left side. The signal abnormality and subtle enhancement in the T10 vertebra could be due to pressure erosion with reactive marrow edema or due to early osteomyelitis. 2. No epidural abscess seen or intraspinal extension identified. No evidence of discitis noted. 3. Degenerative changes are seen predominantly in the upper thoracic region at T4-T5 level with facet hypertrophic change indenting the left side of the spinal cord. No intrinsic spinal cord signal abnormalities.

LUMBAR SPINE:

TECHNIQUE: T1, T2, and inversion recovery sagittal images were obtained

before gadolinium. T1 sagittal and axial images were obtained following gadolinium.

FINDINGS: At L1-2, disc degenerative changes are identified. At L2-3, there is disc bulging and a central disc protrusion resulting in mild-to-moderate spinal stenosis.

At L3-4, disc bulging and facet degenerative changes are identified with mild spinal stenosis. There is mild bilateral foraminal narrowing seen.

At L4-5, there is disc bulging identified. There is mild spinal stenosis seen with mild narrowing of the left and moderate narrowing of the right foramen.

At L5-S1 level, degenerative disc disease and mild bulging identified.

Simple-appearing cysts are seen in both kidneys. Following gadolinium, no abnormal intraspinal enhancement seen. There is no paraspinal soft tissue abnormality or abscess identified.

IMPRESSION: Degenerative changes in the lumbar region with mild-to-moderate spinal stenosis at L2-33 and mild spinal stenosis at L3-4 and L4-5 levels due to disc degenerative changes. No evidence of discitis or osteomyelitis. Other changes as described above.

"

"[**Last Name (LF) 5950**],[**First Name3 (LF) **] C. CSURG CSRU [**2189-7-10**] 2:44 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79377**]

Reason: assess ett placement

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p desc ao replaceemnt and ett change

REASON FOR THIS EXAMINATION:

assess ett placement

PFI REPORT

A suborganic since yesterday, ETT tip is 3.7 cm above the carina. Nasogastric tube tip is in the stomach with sideholes are at the gastroesophageal junction. Swan-Ganz tip is in right pulmonary artery. Two left chest tubes are in place. Volume overload decreased since yesterday. Bibasilar atelectasis, more marked on the left, increased. Small left pleural effusion is unchanged.

"

"CARDIAC PERFUSION PERSANTINE Clip # [**Clip Number (Radiology) 79960**]

Reason: 74 YR OLD MAN WITH NEEDS AORTIC SURGERY PLEASE ASSESS CARDIAC FUNCTION, PRE-OP

FINAL REPORT

RADIOPHARMACEUTICAL DATA:

9.4 mCi Tc-[**Age over 90 **]m Tetrofosmin Rest ([**2189-7-6**]);

28.3 mCi Tc-99m Tetrofosmin Stress ([**2189-7-6**]);

HISTORY: Chest pain.

SUMMARY FROM THE EXERCISE LAB:

Dipyridamole was infused intravenously for 4 minutes at a dose of 0.142

mg/kg/min.

No chest pain or EKG changes suring infusion.

IMAGING METHOD:

Resting perfusion images were obtained with Tc-[**Age over 90 **]m tetrofosmin. Tracer was injected approximately 30 minutes prior to obtaining the resting images.

Following resting images and two minutes following intravenous dipyridamole, approximately three times the resting dose of Tc-99m tetrofosmin was administered intravenously. Stress images were obtained approximately 30 minutes following tracer injection.

Imaging protocol: Gated SPECT.

This study was interpreted using the 17-segment myocardial perfusion model.

INTERPRETATION:

Left ventricular cavity size is normal.

Rest and stress perfusion images reveal uniform tracer uptake throughout the left ventricular myocardium.

Gated images reveal normal wall motion.

The calculated left ventricular ejection fraction is 69%.

IMPRESSION: Normal mycocardial perfusion study; LVEF 69%.

[**First Name8 (NamePattern2) 429**] [**Name8 (MD) 430**], M.D.

[**Initials (NamePattern4) 48**] [**Last Name (NamePattern4) 581**] [**Last Name (NamePattern1) 582**], M.D. Approved: WED [**2189-7-8**] 4:14 PM

RADLINE [**Telephone/Fax (1) 249**]; A radiology consult service.

To hear preliminary results, prior to transcription, call the

Radiology Listen Line [**Telephone/Fax (1) 250**].

"

"[**2189-7-10**] 2:44 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79377**]

Reason: assess ett placement

Admitting Diagnosis: INFECTED STENT

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p desc ao replaceemnt and ett change

REASON FOR THIS EXAMINATION:

assess ett placement

PROVISIONAL FINDINGS IMPRESSION (PFI): LCpc FRI [**2189-7-10**] 9:23 PM

A suborganic since yesterday, ETT tip is 3.7 cm above the carina. Nasogastric tube tip is in the stomach with sideholes are at the gastroesophageal junction. Swan-Ganz tip is in right pulmonary artery. Two left chest tubes are in place. Volume overload decreased since yesterday. Bibasilar atelectasis, more marked on the left, increased. Small left pleural effusion is unchanged.

FINAL REPORT

CHEST (PORTABLE AP)

FINDINGS: Since yesterday, ETT tip is 3.7 cm above the carina. Nasogastric tube ends in the stomach with the sideholes at the gastroesophageal junction.

Swan-Ganz tip is in right pulmonary artery. Two left chest tubes are in place. Small left pleural effusion is unchanged. Volume overload decreased. Bibasilar atelectasis, more marked on the left, slightly increased. Note that the right costodiaphragmatic angle was excluded.

IMPRESSION: Tubes and catheters in standard position except to note nasogastric tube sideholes at the gastroesophageal junction. Decreased volume overload. Slightly increased bibasilar atelectasis, more marked on the left. No other change.

"

"[**2189-9-22**] 10:58 AM

UGI AIR W/KUB Clip # [**Clip Number (Radiology) 79438**]

Reason: surveillance

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with

REASON FOR THIS EXAMINATION:

surveillance

FINAL REPORT

INDICATION: Feeling of suffocation, surveillance exam is requested.

COMPARISON: Upper GI from [**2189-8-11**].

DOUBLE CONTRAST UPPER GI: Barium passes freely through the esophagus, and there are normal primary peristaltic contractions. Tertiary contractions are seen throughout the esophagus. There is a small axial hiatal hernia, with gastroesophageal reflux seen during the exam. There is no secondary

peristaltic contraction that clears this reflux of the esophagus. Esophagus appears distensible throughout, and the narrowing seen on the previous study is no longer identified. There is minimal retention in the valleculae and piriform sinuses, and there is penetration of barium into the vestibule and aspiration to the level of the vocal cords.

No abnormality is seen within the stomach or duodenum.

IMPRESSION:

1. Small axial hiatal hernia with associated gastroesophageal reflux.
2. Esophageal dysmotility characterized by the presence of tertiary contractions and no secondary peristaltic contraction clearing the esophagus during episodes of reflux.
3. Aspiration of barium into the airway.
4. Normally distensible esophagus with no narrowing identified.

"

"[**2189-8-11**] 10:54 AM

UGI SGL W/O KUB Clip # [**Clip Number (Radiology) 79647**]

Reason: evaluate for dysphasia

[**Hospital 2**] MEDICAL CONDITION:

74 year old man s/p iatrogenic esphageal injury during aortic stent removal

REASON FOR THIS EXAMINATION:

evaluate for dysphasia

FINAL REPORT

INDICATION: Esophageal injury, post aortic stent removal, evaluate for dysphagia.

BARIUM ESOPHAGRAM: Barium passes freely through the esophagus without holdup.
There is a slight narrowing of the esophagus at the level of the aortic arch,
which barium freely passes through without evidence of extravasation.
Surgical clips are seen throughout the thorax.

IMPRESSION: Limited barium esophagram revealing slight esophageal narrowing
at the aortic arch with normal passage of barium and no evidence of
extravasation.

"

"[**2189-8-18**] 4:22 PM
CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 79437**]
Reason: please eval for PICC placement and pacemaker lead placement
Admitting Diagnosis: HEART BLOCK

[**Hospital 2**] MEDICAL CONDITION:
74 year old man with h/o descending aortic ulcer s/p stent and bypass surgery
now p/f possible PPM implantation
REASON FOR THIS EXAMINATION:
please eval for PICC placement and pacemaker lead placement

FINAL REPORT
PORTABLE CHEST [**2189-8-18**].

COMPARISON: [**2189-7-27**].

INDICATION: Pacemaker placement and PICC placement.

Permanent pacemaker is present in the right chest wall, with a single lead terminating in the expected location of the right ventricle. The appearance of the lead near the generator pack is different than on the prior study, with a longer looping course of the wire near the generator compared to the prior exam. As discussed with Dr. [**Last Name (STitle) 38311**], the patient is scheduled to have this removed. Left PICC terminates in the proximal superior vena cava.

Cardiomediastinal contours are unchanged. Improving left lower lobe atelectasis and small effusion but persistent elevation of left hemidiaphragm.

Right lung grossly clear, but costophrenic sulcus excluded from the study and cannot be assessed.

"

"ALTERED COMFORT

S: MOANING IN PAIN OUT LOUD

O: CARDIAC: CHB WITH VETRICULAR ESCAP 70'S-90'S WITH A FLUTTER, EP INTO SEE PT AND EVALUATE PACERS. V DEMAND AT 50 WITH MA THRESHOLD 10 S 9 SETTINGS MA 15 S4.BACK UP PACER OFF PER EP.SBP 80'S AFTER INSERTION OF FOLEY AND PT FELL ASLEEP. SBP 100-140'S. EXTREMITIES WARM AND DRY. PALP PP. TO HAVE TEMP WIRE SCREW FOR TUES. FAMILY [**Female First Name (un) **] ARRIVE THIS EVEVING AND SIGN CONSENT. EP SPOKE TO SON OVER THE PHONE.

RESP: IS 500, THICK BROWN SPUTUM X 2, BS CRACKLES LEFT BASE, DIMINISHED RIGHT BASE, CLEAR UPPER. NO CHEST TUBE LEAK. TRIGYLCERIDE OBTAINED AND SENT FROM # 2 CT. RA O2 SATS >93%.

NEURO: CALM-AFTER FOLEY PLACED,PERL,MAE,FOLLOWS COMMANDS, USING SHEETS TO COMMUNICATE WITH ME. GRASPS STRONG AND EQUAL. FAIRLY UNSTEADY GAIT GETTING BACK AND FORTH TO BED.

GI: REMAINS NPO, G TUBE TO GRAVITY DRAINING BILIOUS DRAINAGE, NGT SUTURED TO NOSE DRAINED 100 ML BILIOUS DRAINAGE, J TUBE FEEDING REMAINS AT 50ML. NO STOOL. ABD SOFT. + BOWEL SOUNDS.

GU: ADEQUATE UO AFTER FOLEY PLACED, PT WITH EXTREME PAIN PASSING URINE- UROJET AND FOLEY PLACED.

ENDO: SSI X1.

ID: ANTIBIOTICS PER FLOW, AFEBRILE.

PAIN: TO RECEIVE 5 ML OF PERCOCET FOR INCISIONAL DISCOMFORT.

SOCIAL: SPOKE TO SON OVER THE PHONE.

A: FOLEY WITH RELIEF, CALMER AND CLEARER, AWAITING PACER.

P: MONITOR COMFORT, HR AND RYTHYM-TO HAVE TEMP WIRE SCREW TUESDAY- BACK UP PACERS, SBP, PP, RESP STATUS-PULM TOIELT, NEURO STATUS-INTERETATION, I_O, LABS. AS PER ORDERS.

"

"NEURO: alert, oriented. using communication sheets at bedside. indicates incisional pain. treated wtih methadone/percocet elixr. MAE good strength. Slept good portion of noc.

CV: CHB with junctional escape beats. 2 V wires, back up pacer VVI 50 set by EP, paces and senses. sbp 90-130 overnoc. pedal pulses palp.

RESP: lungs with crackles at bases bilat. good diuresis to lasix IVsats acceptable on room air. 2 chest tubes and 1 [**Doctor Last Name 144**] drain L chest to water [**Doctor Last Name 9138**]. no leak noted. draining serous/serosang #1 with scant drainage.

GI/GU: abd soft +bowel sounds. tolerating tubefeeds at goal via J tube. G to gravity with bilious. NG sutured in place to suction with bilious drainage. foley with clear yellow urine. no further discomfort with urination.

ENDO: blood glucose wnl

ID: afebrile, doxycycline/caspofungin/zosyn/vanco/gent

SKIN: back and buttocks intact. chest tube sites with no drainage dsd changed. G/J tube site no drainage dsd changed.

SOCIAL: son and wife visited in eve. son consented for placement of temp pacing wire on Tues.

A/P: continue to monitor, pain control, skin/wound care. cont IV abx.

"

"[**7-18**] 7a-7p

neuro: speaks farsi only, per translator oriented to self only, believes he is in [**Location (un) 10774**], [**Country 1727**] and that it is Wednesday. reoriented by translator, but unable to retain time and place information. mae. will follow spoken commands in farsi per translator and follow simple charades. perrlaa, bilat wrist immobilizers this am for confusion, pt appears to follow commands-restraints untied, up to chair w/ assist x2

cv: complete heart block 50s, sbp 85-145, lisinopril held this am for sbp 85, ct draining small/moderate amts serous fluid, pacer set for vvi 50 backup, no pacing observed, afeb

resp: lungs cta, 02 sats 96-100% on RA, is to 500ml w/ encouragement, strong cough productive of thick green/tan/brown sputum

gi: abdomen soft, bowel sounds present, ng to lcs draining small amts light brown drainage, g tube to gravity draining bilious, tf per j tube at goal, loose bm x1 this am-c diff sent yesterday, no further stools since this am

gu: foley to gravity draining yellow urine w/ sediment-ua & cs sent

assess: stable

plan: possible per pacer in future if son consents, continue tf at current rate, send stool sample for c diff, pulmonary toilet, increase activity

"

"ekg currently complete heart block, has had intervals of a flutter and possible nsr, rate 50s to 80s, has rare to occ pvcs. sbp 80s to 100s, held hydralazine. afebrile. adequate uo, good response to lasix. condom catheter replaced x 2, seems to have bladder spasms with urination, clutches penis and pulls off cath. glucose stable, no insulin order, k, mag and ca repleted. breath sounds clear, deep beathes well, productive cough, small amts light tan secretions. uses spirometer to about 600cc. maintains spo2 95-98% on room air. chest tubes and esoph drain to pleurevac suction small amts serous drainage, no air leaks. abd soft, bowel sounds present, tolerating tf at goal, 50cc/hr, no stool. ngt to lws, 250cc drainage, bilious now, was red blood at beginning of shift. skin warm, occ moist, feet warm, dp and pt pulses palp bilat. skin intact on back and buttocks, sarna lotion applied as ordered. opens eyes to name and spont, mae, follows pantomimed commands, unable to assess orientation d/t language barrier. appears to be comfortable except for discomfort during urination. plan: adavnce activity as tolerated, continue tf, pulm toilet, skin care.

"

"ALTERED COMFORT

S: ""DARDEE""

O: CARDIAC: CHB THIS AM EKG IN CHART- TO HAVE TEMP WIRE SCREW [**7-21**] - HOWEVER SOME RUNS OF SR THEREFORE ? DELAY PLACXEMENT PER DR. [**Last Name (STitle) 10775**]- WILL DECIDE [**7-21**]. ISOLATED PVCS. K 3.5 RECEIVED 60 MEQ KCL TOTAL. SBP 110'S. EXTREMITIES WARM AND DRY. PALP PP. OOB TO CHAIR X 2 HOURS. COAGS SENT PRIOT TO CATH LAB.

RESP: CT WITHOUT LEAK. DRAINING SEROUS/SEROSANG DRAINAGE. BS CRACKLES LEFT BASE, CLEAR UPPER. O2 SATS>94%. C+R THICK WHITE. NO CT LEAK. IS 500.

NEURO: CALM APPROPRIATE, USING SHEETS TO COMMUNICATE, PERL, FOLLOWING COMMANDS, STEADY GAIT WHEN OOB TO CHAIR.

GI: TF VIA J TUBE CHANGED TO FS PEPTAMEN 1.5 AT 55 ML DUE TO MEDIUM CHAIN TRIGLYCERIDES NEEDED. NGT DRAINED 50 ML GREEN BILIOUS DRAINAGE. G TUBE SMALL AMOUNT OF GREEN BILIOUS DRAINAGE. ABD SOFT. NO STOOL TODAY.

GU: ADEQUATE UO

ID: ANTIBIOTICS PER ORDERS.

ENDO: HAS NOT REQUIRED ANY SSI.

PAIN: 5 ML PERCOCET X 2 WITH GOOD EFFECT.

SOCIAL: FAMILY ARRIVED AT 1830

A: STABLE AT PRESENT. AWAITING ? TEMP WIRE SCREW? WILL BE POSTPONED.

P: MONITOR COMFORT, HR AND RYTHYM WITH BACK UP PACERS, SBP, PP, CT DRAINGE, RESP STATUS-PULM TOILET, NEURO STATUS, I+O, LABS PENDING. NPO AFTER MN FOR CATH LAB. AS PER ORDERS.

"

"7P->7A

Neuro-Appears to be appropriate, uses sheet to relay his needs for pain meds, kleenex, H2O. PERRLA, follows commands. MAE =/strong.

CV-CHB->SR->CHB, 60's-90's, with lots of escape beats. Replaced K+, Ca+, and Mg+ through the night. VVI backup at 50 via external pacer. SBP 90->130's/50's->70's, WWP with PPP x 4. Hydralazine held x 2 for boarderline b/p. Negative fluid balance at MN of 1L and currently -800cc. HCT 31.7

Resp-RA with sats in high 90's, lungs clear, diminished bibasular. RR 6-16. CT's with minimal output.

GI/GU-Tolerating Peptamen at 55cc/hr until MN, NPO after for possible lead screw placement. JT clamped, GT to gravity and NGT to LCS. Positive bowel sounds, no stool,n/v or issues noted. Alb 2.7. Foley to gravity, getting lasix with good response. Octriotide started.

ID-WBC 8.3, t max 37.4o, Vanco though 14.1. ID recommends increasing Vanco dose, will pass on to team. Continues on multiple ABX.

Social-Son and wife in at change of shift. Will be back in am, son has signed consent for pacer lead placement.

Plan-? OR for lead placement, watch rhythm, B/P, UOP. Cont ABX, increase Vanco dose per ID. follow CX, restart peptamine d/t chylous effusions noted. Watch electrolytes and replace as needed. Percocet for pain.

"

"npn 23:00-07:00 (please also see carevue flownotes for objective data)

Pt afebrile, vss, v-paced per EP with external pacer, setting done by EP;

This night significant for pt's significant confusion, reportedly worse than previous; This night pt essentially did not sleep all night, continuously attempted to pull at lines and tubes; putting leg over and between siderails, kicked siderail at times; pt w/ hx opium dependence, withdrawal being managed via methadone, methadone frequency decreased yesterday; pt received Haldol as ordered to assist w/ his restlessness/confusion, did quiet pt abit, but not completely; pt continued to talk out loud, pull at lines; NGT would have been pulled out a couple times if not sutured in; pt able to wiggle and scooch down in bed to get at lines despite repositioning;

Again had good diuretic effect from 04:00 IV Lasix;

Receiving tube feedings as ordered;

During this night ? pt's heart initiating own beat; at approx 05:00, ?pt in sinus rhythm--pacer stated 'sensing' but not 'pacing'; HO paged; outcome to be determined;

Pt received K+ and Ca++ repletion this night;

serum Na+ improving, 125 at midnight;

PLAN:

1) Pt needs vanco trough, will draw a.m. labs with vanco trough as pt had partial chem panel at midnight

2) provide for pt safety, re pt pulling at own lines

3) ask team about med to assist pt to be able to sleep at night w/out restless and aggitation all night

4) all meds in NS instead of D5 unless incompatable

5) further plan per a.m. rounds

"

"npn 06:00 addendum

Covering house officer came to see pt, confirmed pt initiating own heart rhythm;

all Chest tubes patent, to be dc'd only by thoracics team plan.

"

"Neuro: alert confused per family who interprets, mae to command, is on methadone [**Hospital1 **], oob to chair with x 2 assist, attempting to pull at iv lines and drain tubes requiring wrist restraints, was able to pull out a line early in shift.

Cardiac: chb rare pac's and pvc's, bp's all wnl's, palpible pedial pulses, skin warm and dry, afebrile, +2 edema in extremities.

Resp: lungs dim in bases, on ra satting at 100%, one ct d/c'd today has other two to h2o [**Hospital1 9138**] with no air leak draining scant serous.

Skin: [**Female First Name (un) 332**] site with steri strips is cdi, ct dsd cdi, right fem approximated and healing wnl's, no skin breakdown and air mattress d/c'd to regular icu bed, [**Male First Name (un) **] stockings on.

Gi/Gu: npo, og tube to lwsxn draining scant clear, g tube to gravity draining scant billeous, j tube with feedings, making >30/hr u/o, at times urine was bloody with clots now is clear and yellow, continues tf's at goal with q 6 hr 20cc ns flushes, sodium level is increasing throughout shift which is still below 135, did have x 1 [**Last Name (un) 913**] loose stool this shift, cdiff sent.

Social: son in to visit and updated.

Plan: monitor sodium, keep arms restrained, monitor urine for increase in bloody color and clots. increase activity as tolerates, hold colace.

"

"Neuro:Patient confused according to the son. [**Name (NI) **] speaks Farsi only. Unable to assess orientation due to language barrier. He moves all extremeties spontaneously and PERRL. Received patient alert and agitated->IV haldol 1mg given x2. Later patient became more calm and less agitated. He slept most of the night and was easy to arouse. He did not appear to have pain but gave Tylenol 650mg for general comfort and patient is receiving Methadone to prevent narcotic withdrawal.

CV:Receivied patient in CHB50-60's,no Vea. Converted to Aflutter 70-low 100's for short intervals,no vea and Dr. [**Last Name (STitle) 10765**] notified-> repleted electrolytes. Heart rhythm converted back to CHB. Vent pacing x2 due to HR 30's-40's for brief self limiting episodes. NBP initially 147 gave IV Hydralazine. Later NBP mid 80's-109, Dr [**Last Name (STitle) 10765**] made aware->held IV Hydralazine and gave IV NS bolus. Only marginal improvement. Left anterior/mediastinal chest tubes drained minimal serous drainage and to water [**Last Name (STitle) 9138**]. Palpable DP/PT pulses bilat,warm csm and +1 edema. HCT 31,Na 127.

Resp:RR unlabored.Lungs clear right/left upper lobes and right base. Lungs diminished in left base. Patient has a nonproductive cough. He did not uses IS due to language barrier and confusion. Sats 100 on RA.

GU/GI: U/O decreased to 15ml->IV NS 500ml Bolus over 1 hour per

Dr.[**Last Name (STitle) 10765**]. Only margianl improvement->IV Lasix 20mg->U/O >300ml/hr. Urine clear yellow. Abdomen soft,nondistender and nontender. Positive bowel sounds.Patient tolerating tube feedings well,no residuals and rate at goal of 50ml/hr. Received patient with NGT clamped,put it to LCS per orders. No NGT drainage. G-tube to gravity->moderate bilious drainage. Tube feedings through J-tube.Incontinent loose brown stools x3 and colase held. C-diff results pending.BUN 24/CR 0.9

ID:afebrile, WBC 10.3 and patient receiving IV antibiotics. IV Vanco held due to elevated trough level. Repeat Vanco trough level with AM dose.

Skin: Left thorocotomy incision with steri-strips ,no drainage and healing well. Chest tube,J-tube/G-tube dsd dressings dry and no puralent drainage from insertion sites. No breakdown

Endo:fingersticks managed with SS regular insulin.

Social:Son called and was updated.

Plan:Monitor sodium and electrolytes,replete as needed.Monitor NBP,goal is 100-120. Monitor U/O,goal>30ml/hr.

"

"7a-7p

Neuro: Pt A&O x3 per son. Farsi/Persian speaking only. Pt [**Name (NI) 1001**] and follows commands with translation.

CV: HR-NSR 80's with periods of complete heart block. Epicardial wires in AM and working appropriately. EP up to see pt and pt down to EP lab at 1330 for screw in V wire/pacer with VVI of 60. Pt back up to unit

at 1600. SBP at 1700 160's. PA [**Location (un) 1813**] aware and pt given 10mg hydralazine IV with good effect. Epicardial wires D/C'd at 1700 per PA [**Location (un) 1813**]. VSS. Electrolytes monitored and repleted. Pt with palpable pulses to feet and palpable radial and ulnar pulses.

Resp: LS- CTA/Dim at bases. Pt on room air with sats 95-99%. No complaints of SOB and pt encouraged to cough and deep breathe.

GI/GU: Abd. soft with +BS x4. Foley intact draining adequate amounts of urine with good response to lasix. Pt remaining NPO throughout shift for procedure and tube feeds to be restarted tonight. Pt with NG tube to suction, G-tube to gravity, and J-tube clamped.

Endo: Blood sugars monitored and no insulin needed at this time.

Skin: See flow sheet.

Plan: Monitor HR and BP. Pulmonary toilet. Increase activity in AM and transfer to floor in AM.

"

"NEURO: Pt Farsi speaking, unable to assess orientation. Pt follows commands and is able to answer a few questions. Pt MAE and explains of pain. Methadone PO started today for withdrawal from opium in [**Country 1727**] (pt takes for pain). Pt also receiving roxicet PO for pain via J tube.

CV: Pt in and out of CHB and A fib/flutter. Period of V pacing with epicardial wires; 2 sets of V wires; EP sets and manipulates pacing boxes. planned for pt to go to cath lab for screw in today, however he was cancelled and is possibly going tomorrow. Mag, Ca++ & K+ repleated prn. Nitro gtt cont to keep SBP <140, SBP 120s-170s. lisinopril PO started today. Hydralazine IV given for SBP 170s with Nitro gtt @ 2 with + relief. extra dose of lisinopril given @ 1730. CVP 5-10. PP palpable.

RESP: Pt on RA, sats >95%. LS clear, dim in bases. pt does not understand how to us IS. Will deep breathe when asked. no ABG. CTs placed to H2O seal (esophageal CT remains on suction per NO Courney). All CTs draining min amt straw drainage.

GI/GU: Hypoactive BS; TF restarted @ goal when confirmed pt not going to cath lab. BM x2. guiac -. Lasix [**Hospital1 **] with + diuresis; lytes repleated prn.

ENDO: BS not tx earlier d/t pt not eating.

ID: cont multi abx. ID following pt. ? need for precautions.

SOCIAL: no family contact today.

PLAN: Cont to monitor VS, keep SBP <140, wean nitro, ? cath lab [**Doctor First Name **] for screw in wire. monitor lab lytes. pain management. cont methadone.

"

"7p-7a

Neuro: Pt alert, farsi speaking only, son in to interpret, son states father is slightly "" confused"" to place, and to time. Roxicet for pain with good relief per son, and methadone. mae's, follows commands, perrla wnl. Side rails up on air bed, safety precautions

CV: v-paced underlying chb per ep notes, v wires set per ep, see flowsheet for settings, awaiting screw for chb, palpable pulses, sbp 120's-170's with agitation, hydralazine prn, nitro drip titrated for sbp<140 per vascular team. lytes repleted

Resp: ls clear/dim at bases, productive cough thick tan secretions, sats 94-95% placed on open face tent to help loosen secretions. esophageal ct to sx, 2 pleural chest tubes to h2o [**Last Name (LF) 9138**], [**First Name3 (LF) 1569**] team in to assess chest tubes due to no orders for sx or h2o [**Last Name (LF) 9138**], [**First Name3 (LF) 1569**] team aware, no new orders, chest tubes remain to sx, and h2o [**First Name3 (LF) 9138**], see flowsheet. draining straw/some serous drainage. no leak no crepitus.

GI/GU: abd soft, + bs, lg stool/soft. g tube to grvaity, j tube tube feeds at goal, no residual, foley to gravity diuresing well from lasix, u/a c+s sent per vascular team, sodium 126, team aware, all meds in ns, free water restriction. ng tube sutures in place, to sx, flush with 20cc of saline q6h

Endo: regular insulin sliding scale per [**First Name3 (LF) **] protocol

Skin: see flowsheet, pt on air bed

Social: son in updated on poc

Plan: Continue to monitor lytes, safety precautions, wound care, npo, tube feeds thru j-tube, ? to or for screw with chb, weaning nitro drip for sbp<140

"

"11P->7A

Neuro-Appropriate per family and interperter. MAE, follows commands. PERRLA, able to point out on paper what he needs.

CV-SR->V paced. Pacer appears to not be sensing appropriately at times. Replaced electrolytes as needed. HCT 30.2, WBC 8.8, MG/Ca/K all replaced this am.

Resp-Lungs clear up top and diminished bibasular. On RA with sats in high 90's. Good cough, spitting out into kleenex. No issues noted

GI/GU-Positive bowel sounds, no stool. C/O abd pain and nausea. Given Zofran as ordered. Peptamin via JT at 55cc/hr with no residual. Foley to gravity drainage, lasix with good response.

[**Hospital **] Transfer to [**Hospital Ward Name 54**] 6, watch rhythm, electrolytes. Monitor resp status and sats. Increase activity as tolerated.

"

"Events: Seen by EP service, left double lumen picc line placed.

Neuro: Non english speaking but appears to understand ""pain"" and gestures. MAE and normal strength x4, assists with turns.

CV: CHP with perfusing ventricular response, HR 50's, SBP 123/56. Ngt gtt currently at .5mcg/kg/min. See carevue for pacemaker settings.

Pulm: 4Lnc in place, lungs clear bilaterally, decreased at left base. 02 sat 98%.

GU: Uo 25-35cc/hr, diuresis initiated this pm with good response. Urine clear yellow.

GI: Abd soft, bs hypoactive, no stool/flatus. Tube feed at goal rate 100cc/hr with minimal residuals.

Skin: All dressings dry and intact, general edema noted, peripheral pulses [**1-20**]+.

Soc: Son in the pm.

P: Communication via family and interpeter prn. Continue prn analgesics and note response to same. Keep pacemaker attached, npo after midnight for external pacemaker placement. Follow lytes, replete prn. Titrate ngt gtt to keep sbp 140-150. Increase acitivity as tolerated/to be seen by PT post procedure. Keep family up to date on poc, possible transfer out of ICU in am.

"

"Nursing Progress Note

Neuro: primary [**Doctor Last Name **] farsi, no interpreter this shift. Able to make some needs known with eng words and signs. Unable to assess orientation. MAE, strong. Gag and cough intact.

CVS: afebrile, hr 54 complete heart block. 2 sets v wires, both attatched to pacer boxes, VVI backup rate 50. CVP 10, BP volatile, 115-190's, currently on ntg at 2.0mcg/kg/min. Pulses palp x 4 ext, skin warm and dry. Left thoracotomy and upper quad incision with steristrips left OTA. Left arm PICC patent x 2 ports.

Resp: ls clear throughout, room air sats >94. Non productive strong cough.

GI: abdomen soft, distended. BS hypo. Attempt to sit on bedpan because pt kept saying toilet, smear bm.

GU: foley cath draining clear to concentrated yellow urine, received lasix 20 mg ivp at 0400, standing dose. j tube clamped, npo, g tube to gravity and ngt to suction.

Pain: medicated x 2 for yelling out with roxicet elixer 10 ml via j tube.

ID: continuing abx, antifungals for positive cultures for [**Female First Name (un) 1309**], ecoli (see lab resutls)

Social: no calls or family contact this shift.

See carevue flowsheet and [**Month (only) **] for further information.

"

"Nursing Progress Note

Neuro: unable to assess orientation, primary [**Doctor Last Name **] farsi. Previously a&ox3 per son. MAE, generalized weak, purposeful. Immobillizers removed, no interference with lines tubes or drains. Calling out ""morphine, morphine,"" no other english spoken this shift.

CVS: afebrile, vpaced 70, underlying CHB. 2 sets v wires both sense and pace, both attatched to individual pacer box. EP to float transvenous if both epicardials fail. bp 133/67, transient iv ntg for bp >140. CVP 12, pulses palp x 4 ext. Skin pale and dry.

Access: Right IJ multi lumen cvl, right radial a line required boarding for dampening. Right forearm piv x 1, patent.

Resp: weaned to nc 4 L with sats > 97%. Lungs coaerse in uppers to diminished at bases, clears with cough and deep breathing. Expectorates large thick yellow to white. Using yankauer appropriately.

GI: abdomen round, soft, distended. BS present, hypo. Left nare NGT sutured in place, no manipulation, to LCS. G tube to gravity and J tube with feeding at 20 cc hour. No BM. NPO.

GU: Foley cath draining amber cloudy urine to gravity.

Endo: fs bs not requiring ssri coverage this shift.

Pain: Very difficult to get pain under control. Pt using large amounts of narcotic at home. DC'd fentanyl drip, gave roxicet, methadone, and iv morphine over first 4 hours of shift, finally fell asleep. Comfortable untill 0400, remedicated at that time.

Social: no calls or contact from shift. Son returning to [**State **] today, may visit early in day.

Plan: OOB today if tolerated. Pain control.

See carevue flowsheets and mars for further details and values.

"

"7a-7p

Neuro: Pt alert and Fari/Persian-speaking. Interpreter up to see pt at 1030 and pt oriented x3 per interpreter. Pt c/o pain at beginning of shift and given oxycodone/tylenol 650mg elixir with effect. PERRLA [** **] and pt [**Name (NI) 1001**] with no complaints of numbness in extremities per interpreter. afebrile. Pt did state in afternoon to son that he was c/o hallucinations. NP [**Doctor Last Name **] aware and interpreter contact[**Name (NI) **]. Interpreter asked pt if he is having hallucinations and pt stated that he is not having any at 1730 per interpreter. Pt to continue on standing dose of methadone at this time.

CV: Pt [**Name (NI) 630**] at beginning of shift at 70. Pacer turned off [**Name8 (MD) 76**] NP [**Doctor Last Name **] and pt with underlying rhythm of 40's complete heart block. EKG obtained and pt kept in this rhythm until pt having nausea when pt OOB to chair with RN/physical therapy. Pt given reglan with no effect and then given 8mg zofran IV [**Name8 (MD) 76**] NP [**Doctor Last Name **] with minimal effect still c/o intermittent nausea. Pacer turned back on and pt [**Name (NI) 630**] at 70 again. SBP-120's-140's and 140's-150's OK per DR. [**Last Name (STitle) **]. Electrolytes monitored and replaced. Palpable pulses. Pt also with another epicardial pacer with vwires only as well and working appropriately and attached to another pacer box. Total of 4 vwires. No underlying rhythm at 1800, NP[**MD Number(3) 732**], continuing Vpacing at 60 [**Name8 (MD) 76**] Np via epicardial wires.

Resp: LS- CTA/Dim. 4LO2- sats 95-99%. Pt did c/o difficulty breathing to son. Pt with respirations [**9-1**] throughout shift. NP [**Doctor Last Name **] aware. Chest tubes draining minimal amounts of serosang. drainage throughout the shift.

GI/GU: Abd. soft and slightly distended. Hypoactive BS. Pt with NG tube to low wall continuous suction draining blood tinged drainage NP [**Doctor Last Name **] aware. and flushed with 10-20cc of saline q6h as ordered. Pt with G-tube draining small amounts of bilious drainage to gravity. Pt remaining NPO

and also has J-tube with tube feeds changed from replete with fiber to replete with impact with fiber 3/4 strength. Pt with no residual and feeds increased 20cc/hr q4h. Foley intact draining adequate amounts of clear, yellow urine.

Endo: Blood sugars followed and [**Doctor Last Name 10506**] ISS protocol followed.

Skin: See flow sheet. Pt also with signifigant rash on back and bleach free sheets ordered and sarna lotion ordered as well.

Plan: Pt to go for possible placement of wire (screw in) placement for pacer. NPO after midnight. Pain control and pulmonarry toilet. Continue to assess neuro status per family/interpreter services. Continue to [**Name (NI) **] pt due to underlying rhythm. Monitor blood sugars and wean nitro drip keeping SBP no greater than 140's-150's. Need peripheral access for procedure tomorrow.

"

"7P->7A

Neuro-Per interpertor, patient A&O x3. Unable to assess d/t language barrier. Follows commands, MAE =/strong. Some how he seems to know what I want him to do, sometimes I need to coach him but he catches on.

CV-V paced at 60, no ectopy noted. Replaced Ca+ and Mg+ last night. Ntg at 1mcg/kg/min, has been as high as 1.5 with HTN. - fluid balance B/P 120->160's/70->100. Good UOP all night. HCT 29.9, WBC 11.2, PTT 29, Na+ 132.

Resp-Lungs clear to coarse, good cough, nonproductive. Sats in high 90's all shift. CXR ordered for this am. CT's with increased output.

Pain- percocet elixer x 2, and Methadone this am. Patient has been pain free most of the night and slept well.

Social-Son called for update. Plan of care explained.

GI/GU- NPO since MN for possible lead placement by EP today. GT to gravity, JT clamped and NGT to LCS.

Plan- ? lead placement by EP today. NPO. Watch rhythm (asystole underlying) watch electrolytes and B/P wean NTG as tolerated.

"

"remains vpaced at 80, no ectopy, has no underlying rhythm. sbp labile, drops to 80s when asleep, up to 150s when awake. currently on epi at .02, neo is off. filling pressures on the low side, co/ci by fick is acceptable. 1000cc lr given x 1 for low sbp and fp. afebrile. adequate uo, 50-80cc/hr. glucose rx x 1, ca, mg, k repleted. wbc 21. breath sounds clear throughout, ett suctioned for scant white secretions. no vent changes overnight, abgs acceptable. apical, posterior and basilar chest tubes all draining scant amts serous, esoph [**Doctor Last Name 144**] drain draining scant serosang. abd soft, no bowel sounds heard. ngt to lis, scant bilious drainage. g tube to gravity, small amt brown drainage. j tube to gravity, small amt green drainage. no stool. abd and thoracic incision dry except for posterior section which was saturated with serosang, all changed. scant drainage at chest drain sites, g and j sites are dry. skin cool and dry, feet cool, dp and pt pulses palp bilat. back, buttocks and pressure points intact. pupils equal and brisk, have seen all extremities move spont, right more than left, and legs more than arms. opens eyes to voice, but does not follow commands - farsi speaking. sedated with versed gtt, fentanyl gtt for comfort. no family contact overnight. plan: monitor hemdynamics, uo, electrolytes, neuro status maintain comfort, pain service follows. update family, translater as needed.

"

"ALTERED CARDIOVASCULAR STATUS

O: CARDIAC: V PACED @80 WITH UNDERLYING RYTHYM CHB(AV DISSOCIATION WITH L BBB ESCAPE 40-50'S). EP INTO EVALUATE. SBP 80'S-100'S EXCEPT WHEN AWAKE SBP 140'S. NEO RESTARTED TO KEEP SBP>110. PRESENTLY AT .5 MCQ. PAD'S HIGH TEENS. CI>2 FICK. SVO2 57-60 WITH EP TESTING PACER-LOW 60'S- AFTER BLOOD SVO2 60-74. EXTREMITIES WARM AND DRY, PALP PP. K+MAG REPLACED. MIN CT DRAINAGE SEROUS. HCT 27.1 RECEIVED 1 UPC. DSGS HAVE REMAINED D+I.

RESP: REMAINS ON AC WITH 12IPS/5PEEP, PLEASE SEE VENT FLOW FOR SETTINGS+ABG. SUCTIONED FOR A SMALL AMOUNT WHITE SPUTUM. BS CLEAR UPPER,DIMINSHED BIBASILAR.+ CHEST TUBE LEAK #2 CHEST TUBE.NO CREPITUS NOTED. EITHER APNEIC OR TAHYPNEIC WITH VENT CHANGE.

NEURO:WILL OPEN EYES TO VERBAL STIMULI,PERL+[**Last Name (LF) 27**],[**First Name3 (LF) 28**] ON BED NOT TO [**Name (NI) 10773**] SON TO INTERPRET,.WITH MOVING SBP >140.VERSED AT 1 MG DECREASED TO .5MG.

GI: ? TF TO BE INITIATED, ABD SOFT, HYPOACTIVE BOWEL SOUNDS, NGT NOT MANIPULATED-SUTURED IN PLACE DRAINAGE A SMALL AMOUNT OF BILIOUS DRAINAGE LOW INTERMIITENT SUCTION. G+J TUBES TO GRAVITY <25 ML DRAINAGE. NO STOOL. IF STOOLS-? ID REQUESTS SAMPLE SENT.

GU: ADEQUATE UO 55-120ML/HR.

ENDO: FINGERSTICK GLUCOSE 110 AT 12NOON

ID: WBC 21, AFEBRILE,WHEN ASKED ID IF WARRANTED SURVEILLANCE CULTURES HE STATED NO. +YEAST AND BEING TREATED WITH MULTI ANTIOBIOTICS.

PAIN: CONTINUES ON FENTANYL@ 100MCQ TO WEAN IF TOLERATED TO ASSESS NEURO STATUS. + GRIMACING WITH TURNING. PT DOES NOT RESPOND WHEN ASKED IF HE IS IN PAIN.

SOCIAL: SPOKE TO SON OVER THE PHONE / WILL INTERPRET WHEN ARRIVES.

A: HTN WITH MOVING/SUCTIONING, CHB, REQUIRED 1UPC, AWAITING TO WEAN MEDS TO ASSESS NEURO STATUS.

P: MONITOR COMFORT, HR AND RYTHYM- REMAINS AT 80 V PACED, SBP-GOAL TO KEEP 110-140, CI, SVO2, CT DRAINAGE, DSGS, PP, KEEP HCT >30, RESP STATUS-ATTEMPT TO WEAN , NEURO STATUS- WEAN MEDS TO EVALUATE ONCE SON HAS ARRIVED, I+O? INITIATE TF VIA J TUBE,LABS. AS PER ORDERS.

"

"REspiratory Care:

Pt remains orally intubated and vented. Pt had a PS trial this shift did well, ABG within normal. Placed back on AC d/t periods of apnea, awaiting for sedation to clear out. Lung sounds clear. Suctioned for none. plan is to wean vent support as tolerated to possibly extubate in am. Will follow.

"

"remains vpaced at 80 with underlying chb. sbp labile, up to 160s when awake, drops to 100s when asleep. epi gtt is off. svo2 is in the 70s, does drop to low 60s when hypertensive. fick co/ci/svr is acceptable. afebrile. uo 50-100cc/hr. electrolytes, glucose, creat wnl. breath sounds clear, diminished at left base, ett suctioned for scant white secretions. placed on cpap [**3-25**] around 2100, decreased to [**3-23**] after good abg, subsequent abg is wnl. resp rate is [**9-3**], occ tachypneic to high 20s, addressed with extra pain med. chest tubes draining small amts serous fluid, air leak in #2 seems to have stopped. incision dry, intact. abd soft, hypoactive bowel sounds, no stool. ngt intact, sutured to nostril, no drainage. g tube and j tube to gravity, small amts serous drainage. feet warm, dp and pt pulses palp bilat. skin warm, dry, intact on back, buttocks, heels. pupils equal, [**Month/Year (2) **], opens eyes spont and to voice. noted all extremities moving, legs more than arms and right more than left, has not folled commands for me, has language barrier. no calls from family tonight. plan: possibly wean to extubate, start feeding, change swan to triple lumen, med plan for hypertension, pain.

"

"RESP CARE NOTE

PT RECEIVED ON A/C AND SWITCHED TO PSV. CURRENT SETTINGS PSV 5/5/40%. LAST ABG 7.43/41/122. AM RSBI 28. RR 15-20, TV 500-600. PLAN FOR POSSIBE EXTUBATION TODAY.

"

"ALTERED CARDIOVASCULAR STATUS

S: ""DARDEE""(PAIN)

O: CARDIAC: V PACED AT 71 EP INTO EVALUATE PACER AND PT'S RYTHYM.JUNCTIONAL ESCAPE 40'S WITH CHB.FELT WILL REQUIRE TEMPORARY PACIBNG WIRE IF NEEDED / PERM PACER LATER PER ID. MA 5 LEFT AT 13 PER DR. [**Last Name (STitle) **]. S@2. WITHOUT ARRTYHYMIAS. SBP LABILE AS TO WAKE/SLEEP/STIMULATION 90-160 TRANSIENTLY. RECEIVED ALBUMIN X1 WITH GOOD EFFECT. CT DRAIN SMALL AMOUNTS OF SEROUS FLUID. CT DSG CHANGED FOR MOD AMOUNT OF SEROUS DRAINAGE. INCISIONAL DSG D+I. EXTREMITIES WARM AND DRY. PALP PP. K,MAG,AND CALCIUM REPLACED. HCT 31. SWAN DC'D, CORDIS CHANGED TO TLC WITH CONFIRMATION OF CXR.

RESP: EXTUBATED TO OPEN FACE TENT 50% WITH GOOD O2 SAT>97%. C+R THICK BLOOD TINGED TAN SPUTUM.RR TEENS.BS CLEAR PRIOR TO EXTUBATION, COURSE UPPER,DIMINISHED BIBASILAR. NO CHEST TUBE LEAK.

NEURO: ORIENTED X3 PER SON, ANXIOUS AT TIMES. MAE, FOLLOWS COMMANDS WITH INTERPRETATION.

GI: TF AT 20ML/HR REPLETE WITH FIBER VIA J TUBE. G TUBE DRAINED 10ML BILIOUS DRAINAGE. ABD SOFT. + BOWEL SOUNDS. NO STOOL. ONLY LIQUID MEDS THROUGH J TUBE. NGT REMAINS TO LOW INTERMITTENT SUCTION WITH 100 ML THICK BLOOD TINGED DRAINAGE.

GU: AMBER CONCENTRATED URINE . WITH ALBUMIN ^ UO. CREAT 1.0

ENDO: NO SSI THIS SHIFT

ID: BRUCELLA BLOOD CULTURE PENDING, [**Female First Name (un) **] IN STENT, E COLI IN STENT? GI FLORA. BEING TREATED ANTIBIOTICS PER ID. CASPOFUNGIN CHANGED TO FLUCONAZOLE DUE TO YEAST IDENTIFIED AS [**Female First Name (un) **]. AFEBRILE, WBC DECREASED.

PAIN: CONTINUES ON 50 MCQ OF FENTANYL RECEIVED 5 MG ROXICET. AWAITING METHADONE.

SOCIAL: FAMILY INTO VISIT THIS AFTERNOON AND UPDATED.

A: STABLE AT PRESENT,AWAITING CULTURES,EXTUBATED, ALBUMIN WITH GOOD EFFECT, ? PERM / TEMP PACER, ORIENTED AND FOLLOWING COMMANDS. TF AT 20 ML.

P: MONITOR COMFORT, HR AND RYTHYM -PACER WITH BACK UP PACER, SBP KEEP 110-140, CT DRAINAGE, PP, DSGS, RESP STATUS-PULM TOILET, NEURO STATUS-INTERPRETER , I+0, LABS. AS PER ORDERS.

"

"Pt was adm from the EW at 0300 on [**7-4**] after arriving to [**Location (un) 496**] from [**Country 1727**]. Pt had a descending thoracic aortic stent placed at the [**Hospital1 3**] on [**2187-3-5**] and an additional stent placed two months ago when in [**Country 1727**]. Two weeks after stent placed in [**Country 1727**] pt developed fevers, c/o back pain, and started coughing up blood. Pt and pt family decided to return to [**Hospital1 3**].

On arrival to [**Name (NI) 999**] pt was accompained by son who translated for pt. Pt is [**Name (NI) 10772**] speaking only. Pt is alert and oriented times three, MAE, follows commands. c/o left flank pain extending to lower back, pain rating is [**6-28**] and pt recieved 1gm Tylenol and 400mg Ibuprofen. All opiates held at this time due to recent discharge from rehab due to opium addiction. Lungs are clear, O2 sat 99-100% on room air. Abd is soft, tender in lower quads, no stool this shift. Pt has known history of BPH, is voiding frequently and has refused a cath and/or condom cath. When pt voids he kneels on bed and applies pressure to prostate. Skin is intact, no breakdown noted.

POC: Antibiotic therapy for infected stent(s). Needs C.T. surgery consult to determine if stent needs to be replaced. Needs pain consult for better management of pain. ?transfer to CVICU versus transfer to [**Hospital Ward Name 54**] three [**7-4**]. Continue to monitor pain and assist with all ADL's. ?Urology consult today to place cath. Continue to offer pt and pt family emotional support throughout hospital stay. Son's to help translate.

"

"74 yo male who underwent aorta stenting here in [**2186**], readmitted due to leaking and infecteded aorta graft. Underwent a descending aorta replacement with dacron graft and repair of perforated esophagus with omental flap. Pt in OR 12hours. Arrived on neo/epi/prop. Pt vpaced (has 2 sets of wires, placed to 2 boxes) pt has no underlying rhythm. Pt on multiple antibiotics. Pt also still has double lumen ETT due to inability to change it over due to facial/neck edema. Lumbar drain capped by anesth due to non functioning in OR, to be pulled in am. Pt has large volume requirement despite gettin 8L crystalloid/4 pc/4 ffp/1 cryo in OR. Pt given lasix and diuresed 3L in OR. While in [**Name (NI) 10506**] pt has received 5L crystalloid/hespan/albumin with improving hemodynamics. Pt wht on OR pumps off by 18 kg so initial dose of epi increased to 0.05mcg/kg/min (^ from).03) Assessment is as follows:

Neuro: Pt sedated on propofol. Pt reversed and woken at 0100. Pt is Farsi speaking. Opened eyes to name and witnessed all extrem move. Rt leg>lt. Resedated due to svo2 in 40's. PERRLA. Morphine for pain.

Cv: Pt continues to be 100% vpaced. P waves under. SBP goal 110-140

Neo titrated. SVO2 improving >60 after volume. CI by Fick>2. Dopplerable pedal pulses. Lactate rising up to 3.7--will recheck

Resp: Orally intubated, cont on CMV. ABG WNL. FIO2 50%--lungs dim lt base. Pt has 3 pleural CT Lt anterior to sx, intermittent leak in #2. Minimal drng

GI: NGT sutured lt nare, LIWS, minimal brown drng. G and J tube to gravity no drng. No bs, abd soft. LFT nml.

GU: Foley patent, uop imprves with IVF, 25-80cc/hr

ENDO: Insulin gtt started per protocol, see flowsheet

ID: Pt on vanco/gent/zosyn/fluconazole/doxycycline--WBC ^26 afebrile

SOCIAL: WIfe and son here when first out but never called or visted.

Plan: Cont assess cardio/resp status. Follow lactate. Q1hr BS. keep sbp 110-140. ? change over ETT if no extubate today. No leak noted. Lumbar drain to be pulled by anesth

"

"Respiratory Care:

Pt received orally intubated after post-op resection of infected descending aorta replacement & seaphageal repair, on full ventilatory suppor with an oral DL ETT 37 mm into L main bronchus. We made vent change to keep ABG WNL, See Careview. DL ETT retaped. No suction done. Plan: wean as tol & keep cardio resp VS stable. Will follow.

"

"Respirtaory care:

Pt remains orally intubated and vented. RR decreased to 12 from 14, ABG showed mild respiratory alkalosis. Double lumen ETT changed to a standard ETT 8.5 without incident. Lung sounds scatered expiratory wheezes. Suctioned for none. Plan is to wean vent support as tolerated.

"

"7am-7pm update

neuro: pt sedated on propofol gtt this am. propfol gtt weaned to off this evening at 1700 for nuero check. pt opening eyes spontaneously. No movement of extremities noted at this time. PT RR up into the mid 30's with sedation off so the pt was started on fentanyl gtt at 50 mcg/hr at 1830 for pain control. plan to use versed gtt for sedation if the pt becomes restless/aggiated. PERRL. Lumbar drain dc'd by Dr [**Last Name (STitle) **] this afternoon

CV: pt remains V paced, underlything rhythm CHB. EP consulted and into see the patient this am. SBP 90-140's. MAP 60-80's. neo gtt weaned to keep MAP > 65 per team. neo gtt currently off. pt continues on epi gtt. epi gtt weaned to off breifly today -> after epi gtt weaned off off Svo2 in the high 50's to 60. epi gtt restarted at 0.02 mcg/kg/min per team. since epi gtt has been restarted Svo2's > 60 and CI by Fick > 2.0. Hct stable. femoral Aline dc'd today -> no hematoma noted. +pp by doppler. pt on maintain fluid LR at 50 cc/hr continuous. Lactate down to 1.7.

resp: LS clear throughout with dim RLL. Pt currently on AC 40% 550 x 14 with 5 peep. last abg 7.48/33/150/25/2 -> RR decreased from 16 to 14 -> repeat abg pending. pt with 1 [**Doctor Last Name 144**] and 3 CT to suction, no airleak noted. pt with dual lumen ETT this am-> changed to 8.5 ETT today

at bedside -> propofol gtt increased and pt given propofol bolus prior to changing ETT. pt given 10 mg vecuronium IV per team prior to ETT changed -> procedure uneventful.

gi/gu: abd soft. BS absent. pt with Right NG to LIWS (sutured in place) -> draining scant amount of billious drainage. pt with J tube and G tube to gravity. Pt remains NPO -> all PO meds held (per team).

foley draining clear yellow urine. UO brisk.

endo: pt on insulin gtt this am. insulin gtt stopped for glucose of 79. BS this afternoon 80-110's.

ID: afebrile. WBC's elevated. pt continues on vanco, gentamicin, doxycycline hyclate, Vanco and zoysn. fluconazole dc'd and started on caspofungin. ID following

plan: monitor hemodynamics, continue epi gtt, continue fentayl gtt for pain management, start versed gtt if restless/aggitated, monitor neuro status, antibiotics, monitor labs/culture

"

"RESPIRATORY CARE:

Pt remain orally intuabted & sedated on full ventilatory support, occ overbreathe set rate. No vent changes done. Bs are bil clear. Wea re sxtn for scant thick white secretions from ETT. Plan: Continue present iCU monitoring & wean as tol. See Careview for further details.

"

"Neuro: confused per interpreter, unable to understand or speak english, roxicet and methadone for pain, mae, to command, oob to chair with max 2 person assist and [**Doctor Last Name **] back to bed.

Cardiac: chb per ep team, bp's all wnl's, palpible pedial pulses, skin warm and dry, afebrile, +1 edema in extremities.

Resp: x3 ct's from left flank all to h2o [**Doctor Last Name 9138**] and all draining small amounts of serous, per thorasic that the esophegeal ct system is only to be d/c'd by them, lungs dim in bases, on ra satting at 96%.

Skin: left [**Female First Name (un) 332**] with steri strips is cdi, left ct dsds are cdi, chest with dsd that is cdi.

Gi/Gu: npo, og tube to lwsxn and to be on lwsxn per thorasic, abd is soft round and nontender with hypoactive bowel sounds, g-tube to gravity and draing small amounts of billeous, j-tube with feedings, on riss, making good u/o, sodium is 123-urine os and urine sodium sent, tf's are mixed with ns insteady of h2o.

Social: son in to visit and updated.

Plan: ? npo at mdnight for ? pacer lead placement in am, gent trough and peaks are pending, monitor sodium levels, ? that if sodium does not correct that ? starting hypertonic saline, mix tf's with ns not h2o.

"

"7p-11p

Pt recieved with increasing confusion per son interpreting. Son thinks he is ""overmedicated"" explained to son teaching about low sodium, pa [**Doctor Last Name **] aware of increasing confusion. equal grasps bilat, perrla wnl, mae's. Sodium 122, all meds changed to ns, no free water, sodium tabs started/ montior sodium q4h, pt was incontinent of large stool, colace held. No roxicet given this shift. Ep in to see pt see note, still pending screw in for chb. 4 V-wires set per ep to external pacing boxes. Plan: Monitor sodium levels q4h, monitor for increasing confusion, antibiotics, vanco trough in am. Safety precautions, soft wrist restraints applied for pt pulling at ng tube/ lines.

"