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12/26/1996 12:00:00 AM
HYPERPARATHYROIDISM .
Unsigned
DIS
Report Status :
Unsigned
DISCHARGE SUMMARY
NAME :
HOUGHTJESCSLEM , RIESHINJIN R
UNIT NUMBER :
948-14-32
ADMISSION DATE :
12/26/96
DISCHARGE DATE :
01/01/97
PRINCIPAL DIAGNOSIS :
hyperparathyroidism .
ASSOCIATED DIAGNOSIS :
1. status post mitral valve replacement ,
2. hypertension ,
3. atrial fibrillation ,
4. hypertrophic obstructive cardiomyopathy ,
5. osteoarthritis ,
6. right cheek basal cell carcinoma ,
7. glaucoma ,
8. non-insulin dependent diabetes mellitus ,
9. status post laparoscopic cholecystectomy ,
10. status post dilation and curettage ,
11. status post cataract surgery ,
12. status post left breast biopsy .
PRINCIPAL PROCEDURE :
Parathyroidectomy on 12-27-96 .
HISTORY OF PRESENT ILLNESS :
The patient is an 83-year-old female who presents for surgical evaluation for he
r hyperparathyroidism .
This is an 83-year-old female with a history of hypertrophic obstructive cardiom
yopathy , status post mitral valve replacement in 1988 , chronic atrial fibrilla
tion , hypertension , who presents for parathyroidectomy .
In August of 1996 while the patient was at Retelk County Medical Center for repl
acement of her knees bilaterally , and on preoperative evaluation she was noted
to have a high calcium and therefore the surgery was canceled .
Further testing revealed hyperparathyroidism as evidenced by an elevated PTH .
The patient reports no masses in her neck .
She has noticed some generalized hoarseness in her voice for the past 5-6 months
 .
In addition , she has some dysphagia , particularly has had some difficulties wi
th swallowing .
She has been seen by Dr. Tokbelb , her primary care physician in Itgreenredan Ho
spital , and also Dr. Kotefyfechird , her cardiologist , and also an endocrinolo
gist at Retelk County Medical Center .
PAST MEDICAL HISTORY :
1. status post mitral valve replacement in 1988 .
She has a St. Jude 's mechanical valve and has been on Coumadin since then
,
2. hypertension , she has had hypertension for 15 years ,

3. atrial fibrillation , she is status post cardioversion 3-25-94 ,
4. hypertrophic obstructive cardiomyopathy ,
5. osteoarthritis ; she is to receive bilateral total knee replacements at some time in the near future ,
6. right cheek basal cell carcinoma to be removed in the future ,
7. history of glaucoma ,
8. non insulin dependent diabetes mellitus which was diagnosed in March , 1995 ,

9. shingles .
PAST SURGICAL HISTORY :
1. laparoscopic cholecystectomy 03/93 by Dr. Sapmal ,
2. dilation and curettage in 1992 for polyps ,
3. left breast biopsy which was benign ,
4. cataract surgery .
ALLERGIES :
No known drug allergies .
MEDICATIONS ON ADMISSION :
1. Lopid 600 mg PO b.i.d. ,
2. K-Dur 20 mg PO q.day ,
3. Lasix 40 mg PO q.day ,
4. Coumadin 2.5 mg PO q.day which was last taken two days prior to admission ,
5. Norvasc 500 mg PO q.day ,
6. Digoxin .25 mg PO q.day ,
7. Lopressor 50 mg PO b.i.d. ,
8. Glucotrol 10 XL qam ,
9. Timoptic 0.5% b.i.d. to both eyes ,
10. Pilocarpine gel qhs to both eyes .
FAMILY HISTORY :
There is no family history of parathyroid or thyroid diseases .
SOCIAL HISTORY :
The patient is widowed .
She lives alone but is completely independent .
She visits her daughter once a week .
No ethanol or tobacco use .
REVIEW OF SYSTEMS :
The review of systems is significant for a history of dyspnea on exertion .
At present , she can walk one to two blocks before having to stop because of shortness of breath .
When walking outside , she stops multiple times because of shortness of breath .

She sleeps with two pillows at night .
She gets short of breath walking up steps .
PHYSICAL EXAMINATION :
On physical examination , she is a pleasant woman in no acute distress .
Her pulse is 72 , irregularly irregular , blood pressure 96/60 , temperature 97.9 , respirations 18 .
The head , eyes , ears , nose and throat examination is notable for pupils which have irregular border and are very sluggishly reactive .
The patient reports that she will have revision of cataract surgery .
Neck and lungs are unremarkable .
Cardiovascular exam :
III / VI systolic click and irregularly irregular rhythm .
The abdomen was benign .
She is guaiac negative on rectal examination .
Extremities :
unremarkable .
LABORATORY DATA :
Admission white blood count 4.3 , hematocrit 31.0 , electrolytes were all within normal limits , glucose 218 , prothrombin time on admission was 15.1 with INR of 1.5 , partial thromboplastin time 23.3 .

The electrocardiogram showed atrial fibrillation with slow ventricular response and digitalis effect as well as left ventricular hypertrophy .
IMPRESSION ON ADMISSION :
Impression was that this was an 83-year-old female with cardiac history , dyspne a on exertion , increased calcium and hyperparathyroidism who presents for parat hyroidectomy .
HOSPITAL COURSE AND TREATMENT :
On the day of admission , the patient was brought to the operating room for para thyroidectomy .
The right superior parathyroid gland was found to be markedly enlarged and consi stent with an adenoma .
Her right superior parathyroid gland was removed and the rest of her parathyroid glands were left in place .
Postoperatively , the patient did well and was able to cough and phonate complet ely with no changes from preoperative .
The plan was to start her on heparin and Coumadin and discontinue her heparin wh en her Coumadin levels became therapeutic as judged by the prothrombin time / IN R .
However , on postoperative day number two , the patient in the afternoon noticed some tingling in her hands and also some tingling hear her perioral region .
She had a negative Chvostek 's and negative Trousseau 's sign .
She had no muscular weakness noted .
An ionized calcium was drawn which was low at 1.0 .
As a result , the patient was started on Os-Cal 250 mg PO q.i.d. On postoperativ e day number three , her ionized calcium was 1.06 and her Os-Cal was increased t o 500 q.i.d.
However , her ionized calcium decreased to 0.97 and she was given one amp of cal cium gluconate .
On postoperative day number five , the patient felt fine and had an INR of 1.9 w ith a prothrombin time of 16.6 .
Her calcium was 8.5 , albumin 3.6 , and phosphate 4.5 .
She had had no further episodes of tingling in her fingers after the initial epi sode which had prompted us originally to draw the ionized calcium .
CONDITION ON DISCHARGE :
Good .
MEDICATIONS ON DISCHARGE :
1. Coumadin 5 mg PO q.day , then she will follow up with her primary care physic ian and decide the dosage thereafter ,
2. Lopid 600 mg PO b.i.d. ,
3. K-Dur 20 mg PO q.day ,
4. Os-Cal 500 mg PO q.i.d. ,
5. Rocaltrol 0.25 mg PO b.i.d. ,
6. Lasix 40 mg PO q.day ,
7. Norvasc 5 mg PO q.day ,
8. Digoxin .25 mg PO q.day ,
9. Lopressor 50 mg PO b.i.d. ,
10. Glucotrol 10 mg qam .
FOLLOW UP :
For follow up , the patient is to call for an appointment with Dr. Sapmal .
In addition , she is to follow up with her primary care physician to check her p rothrombin time / INR as well as calcium , albumin and phosphate levels .
She will be sent home with home Arnsperni Health .
LENNI BREUTZOLN , M.D.
DICTATING FOR :
_____ RIEEA SAPMAL , M.D.
TR :
hzu
DD :
New Years Day
TD :

01/06/97 2:48 P
cc :
RIEEA ODEE SAPMAL , M.D. CEALME LEOE MARESSYTHE Dr. Tokbelb Welle Health Sonsant
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[report_end]