194830718 YC
29157608
520377
10/25/1997 12:00:00 AM
DIVERTICULITIS , S / P AORTIC VALVE REPLACEMENT
Signed
DIS
Admission Date :
10/25/1997
Report Status :
Signed
Discharge Date :
11/03/1997
CHIEF COMPLAINT :
Diverticulitis , presenting for sigmoid colectomy .
HISTORY OF PRESENT ILLNESS :
The patient is a 67-year-old woman with occasional abdominal pain in the right l ower quadrant and left lower quadrant .
She has not complained of any fever , shaking , or chills .
No nausea or vomiting , no change in her bowel movements .
She has had attacks treated with antibiotics in the past notably in 12/96 and 08 /97 .
She has had a diagnosis of diverticulitis flairs and baseline diverticulosis fla iring in 09/96 .
Also , three years prior in 1993 , she had an attack of diverticulitis .
She has been worked up with barium enema in 09/97 which showed multiple divertic ula throughout the colon , but mostly in the sigmoid .
At this time , there was diverticulosis with no acute diverticulitis .
There was also no obstruction .
The patient is also status post aortic valve replacement in 1996 , and presented for heparinization prior to her elective valve surgery .
PAST MEDICAL HISTORY :
The patient has hypothyroidism , hypertension , and rheumatic fever age 6 with a ortic stenosis .
PAST SURGICAL HISTORY :
Aortic valve replacement in 11/96 with a St. Jude valve and chronic Coumadin the rapy ; breast biopsy negative in 1984 ; appendectomy age 15 ; tonsillectomy and adenoidectomy age 6 ; hysterotomy age 30 ; C-section age 37 due to placenta prev ia .
MEDICATIONS :
Lopressor 50 mg q.a.m. , 25 mg q.p.m. , and 25 mg q.h.s.; Synthroid 88 mcg q.d.; Norvasc 5 mg q.d.; Lescol 20 mg q.p.m. with meal ; Coumadin is usually 4 mg p.o . 3x a week and 3 mg 4x a week .
It was held the day prior to admission .
ALLERGIES :
Percodan and codeine .
SOCIAL HISTORY :
Alcohol and tobacco histories are negative .
REVIEW OF SYSTEMS :
Negative for congestive heart failure , positive for occasional dyspnea on exert ion , negative for dyspnea and she has excellent exercise tolerance .
There is occasional left chest tightening which is brief .
No bleeding in her urine or stool .
Occasional bleeding when she flosses and occasional dizziness secondary to a dro p in blood pressure transiently at home .
PHYSICAL EXAMINATION :
VITAL SIGNS - Temp 98.8 , pulse 60 , BP 150/94 , respiratory rate 18 , and satur ation 96% on room air .
GENERAL - The patient is a pleasant older woman in no acute distress .
HEENT - Normocephalic , atraumatic .

Oropharynx is not injected .
NECK - No carotid bruits , with 2+ carotid pulses .
LUNGS - Clear .
HEART - Regular , with a III / VI murmur at the upper left sternal border .
ABDOMEN - There is a soft abdomen with a question of eventful hernia .
RECTAL - Guaiac negative with normal tone .
EXTREMITIES - Bilateral radial , dorsalis pedis , posterior tibial , and femoral pulses are all 2+ .
No clubbing , cyanosis , or edema of the extremities .
LABORATORY DATA :
Coagulation profile notable for a PT 18 , PTT 36.7 and an INR of 2.4 .
HOSPITAL COURSE :
The patient was admitted and begun on cefotetan and Flagyl , as well as heparin .
Her INR dropped to 1.6 prior to surgery , and her PTT was in the mid 80s prior to surgery .
She was admitted and placed on a bowel prep two days before surgery and was taken to the Operating Room on hospital day # 3 , 10/28/97 .
At that time , she underwent sigmoid colectomy and ventral hernia repair . (A full account of this operation can be found in the Operative Note) .
She tolerated this procedure without complications initially and was taken to the Recovery Room in stable condition .
Postoperatively , she had her heparin restarted , and had a PTT rising to 142.8 and then down to 92 .
Her primary postoperative development was the passage of some blood clots and blood per rectum on postoperative day # 2 .
She continued to pass blood per rectum and was transfused with one unit of packed red blood cells .
Her preoperative hematocrit was 41 and her hematocrit dropped to 30.4 on postoperative day # 2 .
This was a drop from an immediate postoperative hematocrit of 35.4 .
Upon receiving the one unit of red blood cells , her hematocrit returned to 33 , and in the two days subsequent to the transfusion , returned to 34 .
Otherwise , her postoperative course was uneventful with gradual resolution of the passage of blood per rectum .
Her heparin was discontinued when it was noted that she was bleeding per rectum and her PTT drifted to a normal range of 35 by postoperative day # 3 .
On postoperative day # 1 , the patient was restarted on 2 mg of Coumadin .
However , due to the episode of bleeding on postoperative day # 2 , the Coumadin was held for two consecutive days , and then restarted on postoperative day # 4 .
At this time , she is given 3 mg and was gradually increased to her regular regimen of 4 mg alternating with 3 mg.
The patient 's INR had dropped to 1.7 at the time of operation , and remained in this range initially , but began to rise to 2.0 with her Coumadin dosing .

At the time of discharge , it was 1.9 , for which she received 4 mg.
On the next day , it was 1.6 and she returned to a normal dosing of 4 mg followed by outpatient draws to determine the further Coumadin dosing .
This was postoperative day # 6 , at which time she is ready for discharge .
The rest of her hospital course was unremarkable , with perioperative ampicillin , gentamicin and Flagyl discontinued on postoperative day # 1 .
She had some initial nausea but had no emesis .
Her nasogastric tube was discontinued on postoperative day # 1 , and she tolerated a regular diet by postoperative day # 3 .
She had flatus and regular bowel movements by postoperative day # 5 .
She also complained of some slight dizziness upon getting up .
For this reason , her normal Lopressor and Norvasc were held .
It was felt that this was re-equalibration after being sedentary and mostly in bed following the operation .

She had some slight headaches which resolved with Tylenol , and the dizziness re solved as well .
She was ready for discharge on postoperative day # 6 .
Her wound remained benign and was healing nicely at the time of discharge .
DISCHARGE MEDICATIONS :
Lopressor 50 mg q.a.m. , 25 mg q.p.m. , and 25 mg q.h.s. , Synthroid 88 mcg q.d. , Norvasc 5 mg q.d. , Lescol 20 mg q.p.m. with meal , Coumadin is usually 4 mg p.o. 3x a week and 3 mg 4x a week ; Percocet 1-2 tabs q.4h. p.r.n. pain .
DISCHARGE FOLLOW-UP :
Follow-up with Dr. Jesc in the office .
DISCHARGE DISPOSITION :
Her disposition was to home .
CONDITION ON DISCHARGE :
Stable .
Estimated disability was none .
Dictated By :
BELL REXBEATHEFARST , M.D. NM82
Attending :
LINEMASE D. JESC , M.D. ZP2 SF477/5317
Batch :
31967
Index No. PAWU09891C
D :
11/07/97
T :
11/07/97
[report_end]