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CMC
19153629
6/3/1993 12:00:00 AM
Discharge Summary
Signed
DIS
Admission Date :
06/03/1993
Report Status :
Signed
Discharge Date :
06/06/1993
DISCHARGE DIAGNOSIS :
UTERINE PROLAPSE .
HISTORY OF PRESENT ILLNESS :
This is a 70 year old gravida IV , para 4 who presented for a vaginal hysterecto my secondary to uterine prolapse and also presented for evaluation of a suspicio us lesion seen on a mammogram .
Patient 's problem started four years ago when she first experienced a push ing forward of her uterus .
The patient described this sensation as uncomfortable and becoming more prominen t over the following three years with increasing pressure and pain .
Two months ago , the patient slipped and fell with valsalva that precipitated an exacerbation of her prolapse .
She subsequently could not urinate and was in pain secondary to her problem .
At this time , she decided that she needed the prolapse fixed and actually wrote to the Norri Hospital to try and find a Gynecologist .
Her letter was referred to Dr. Earllamarg Para who saw her in the office and rec ommended vaginal hysterectomy .
Patient has never had a pessary and refused one and denies nausea , fever , chil ls , dysuria , or stress incontinence on her current admission .
PAST MEDICAL HISTORY :
Significant for a lower left saphenous vein thrombosis diagnosed with lower extr emity non-invasives and on May 2 , 1993 with no evidence of deep venous thrombos is and clearance by Dr. Ribreefcheampner for further intervention .
She also has a heart murmur since childhood .
PAST SURGICAL HISTORY :
Negative .
PAST OBSTETRICAL HISTORY :
Significant for vaginal deliveries times four .
PAST GYNECOLOGICAL HISTORY :
Last menstrual period was at age fifty , the patient is not on hormonal replacem ent and she has a four history of uterine prolapse .
CURRENT MEDICATIONS :
Aspirin one per day which the patient quit taking two weeks prior to admission .

ALLERGIES :
None .
SOCIAL HISTORY :
Patient lives on Sauxdo Lo with her husband and denies alcohol and denies drug a buse .
PHYSICAL EXAMINATION :
GENERAL :
This was a well-developed , well-nourished female in no acute distress .
Patient had a blood pressure of 128/72 , a pulse of 84 that was regular , and sh e was afebrile at 98.4 .
SKIN :
Examination showed right axillary and right posterior axillary skin tags and cru sted lesions .

HEENT :
Pupils were equal , round , and reactive to light , extraocular muscles were int act , and no lymphadenopathy .
CARDIAC :
Examination showed regular rate and rhythm with no S3 or S4 heard and a grade II /VI holosystolic murmur loudest at the left sternal border .
LUNGS :
Examination was clear to auscultation .
BREASTS :
Examination showed a right upper mid small breast mass which was detected actual ly by Dr. Para .
ABDOMEN :
Soft and non-tender .
PELVIC :
Deferred until the Operating Room .
EXTREMITIES :
She had left lower leg varicose veins , no venous cords , and bilateral 2+ pedal pulses .
LABORATORY EXAMINATION :
The patient had a BUN and creatinine of 12 and 1.2 , a white count of 6.7 , a he matocrit of 39.4 , negative urinalysis , and a potassium of 4.6 .
Her CA-125 was 20 and she had a chest X-Ray that showed no infiltrates and a mam mogram that showed a left upper quadrant large calcified fibroadenoma and right upper mid area of calcification .
She had an EKG that showed a question of an old inferior myocardial infarction .

HOSPITAL COURSE :
Cardiology was consulted to evaluate this and felt that the changes seen on the EKG were not significant .
The patient was also seen by Dr. Nusc from General Surgery for evaluation of mic ro calcifications in the right breast .
The patient refused a biopsy for this admission and desires follow-up mammograms .
She is to be followed up by General Surgery .
The patient underwent a total vaginal hysterectomy on June 4 , 1993 which she to lerated without complications .
Her post-operative course has been uncomplicated .
She remained afebrile throughout her admission tolerating a regular diet by post -operative day two and was discharged on June 6 , 1993 with Percocet for pain .
The Foley was discontinued and the patient was urinating on her own .
DISPOSITION :
DISCHARGE MEDICATIONS :
Percocet one to two tablets p.o. q.4-6h. p.r.n. , Iron Sulfate 325 mg p.o. b.i.d . , Colace 100 mg b.i.d. , and one Aspirin q.d.
She is to follow-up with Dr. Para for follow-up .
Dictated By :
RIMARVNAA D. KUSHDREPS , M.D. AV94
Attending :
EARLLAMARG S. PARA , M.D. FT99 OH475/4059
Batch :
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