ALISTER A. GEORGE, M.D.
GASTROENTEROLOGY & HEPATOLOGY

Board Certified
Internal Medicine and Gastroenterology

GASTROENTEROLOGY CONSULTATION

Patient: **Patrick Lachapelle**
DOB: 03/14/1997
Sex: **Male**
Age: 18y
Date: 12/23/2015

Chief Complaint
Patrick is a 18year old Male who presents with a primary complaint of post hospital

History of Present Illness
Patrick is here after he was in the hospital for having foreign object stuck in his esophagus. The food subsequently passed. He underwent EGD and biopsy shows eosinophilic esophagitis as well as acid reflux. He feels like food is still getting stuck but it goes down easily when he drinks fluids with it. He does have acid reflux or heartburn symptoms.

Past Medical History
acid reflux

Family History
Mother- asthma
Grandfather- heart disease

Social History
Does not consume alcohol.
Does not consume tobacco.
Employed: serving food
Marital Status: Single
Exercise- yes

Review of Systems
Constitutional: Good general health. No Fever. No Headaches. No Fatigue. No Weight Loss. No Weight gain. No Chills. No Malaise. No Night sweats. No Hematuria
Cardiovascular: No Chest Pain. No Palpitations. No Syncope. No Dyspnea on Exertion. No Edema. No Nocturnal paroxysmal dyspnea. No Heart Murmurs. No swelling of feet, ankles, or hands. No Cyanosis. No Hypertension. No Lightheadedness. No TIA/Stroke. No Vascular Claudication.
Respiratory: No Shortness of Breath. No Asthma or Wheezing. No Hemoptysis. No Dry or Productive Cough.
Gastrointestinal: Reports dysphagia. Reports heartburn. Denies loss of appetite. Denies abdominal pain. Denies hematemesis. Denies jaundice. Denies constipation. Denies diarrhea. Denies abnormal stools. Denies hemorrhoids. Denies rectal bleeding / blood in stool or with wiping. Denies anorexia. Denies indigestion. Denies excessive burping. Denies recent changes in bowel habits. Denies excessive flatulence. Denies vomiting. Denies nausea. Denies sore throat. Denies hoarseness. Denies melena.

Vitals
Added vitals entry: Measurement date: 2015-12-23 09:22 Weight: 186.0 lbs Height: 5 ft 8.0 in BMI:

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28.3 Heart rate: 50 bpm Blood pressure: 132 / 59 mmHg

Physical Exam

Constitutional: The patient appears to be stated age, cooperative and in no distress. The patient is well nourished and hydrated with moist mucous membranes.
Ears, Nose, Mouth, Throat: Normal external appearance of the ears and nose. Normal bilateral auditory acuity.
Eyes: Externally: Normal appearance of the conjunctiva, eyelids with normal ocular symmetry. Sclera are normal without hemorrhage or icterus. Pupils are equal round and reactive to light and accommodation. Extraoccular movements are intact.
Neck: Grossly normal exam of neck without palpable masses, tenderness or nodules. No palpable lymphadenopathy. No JVD.
Respiratory: Normal respiratory effort, no respiratory distress. Normal external appearance of the chest. Normal breath sounds without wheezing, rhonchi or rales.
Cardiovascular: No jugular venous elevation. Normal S1 and S2 without any obvious murmurs or gallops. Regular rate and rhythm. Normal carotid artery pulses without bruits. No lower extremity edema.
Abdomen: Normal external appearance of the abdomen. Normal bowel sounds on auscultation. The abdomen is soft and non-tender, not distended. No hepatomegaly or splenomegaly.
Extremities: Normal appearance of the upper and lower extremities without obvious deformity. There is no digital clubbing, cyanosis or edema.

Impression

1. Eosinophilic Esophagitis
2. GERD
3. Hiatal Hernia

Plan

Discussion: The patient's dysphagia is due to Eosinophilic esophagitis is possible and is more commonly diagnosed in the last decade. It is an excessive accumulation of eosinophils in the mucosa, probably caused by an external stimulus such as food allergy. This can cause a spasm or corrugated folds and furrows seen on endoscopy. More importantly, it can cause a dysmotility resulting in dysphagia to solids and liquids. Over time in some patients it can also lead to diffuse fibrosis and thickening of the esophagus. The recommended treatments are dilatation an steroid preparations especially inhaled Rx.

This patient has chronic acid reflux disease, which appears to be adequately treated at this time. There is a subset of reflux patients that get Barrett's esophagus and another subset that get ulcers, strictures and severe esophagitis; however, the far majority of GERD patients have little endoscopic evidence of severe disease. We recommend going to the lowest dose PPI therapy that's effective. Recently however, there have been a few reports regarding the long-term use of PPI's causing severe hypomagnesemia and hypoparathyroidism. There are some minimal concern for patients on a PPI for over several years about osteoporosis leading to hip fractures. This may be counteracted with oral calcium supplementation. The magnesium levels should be checked every few months or so. Please note that there are only a handful of reports and there are no randomized controlled studies in the literature, but we are encouraged to decrease dosages when possible and appropriate and check magnesium levels on a regular basis. In general the PPIs are very safe and well tolerated as class of drugs that's vastly used, all over the world. Furthermore, they have been around for over 2 dozen years and are associated with very few serious side effects; this is better than most other medications.

Counseling

Patient was counseled regarding Acid-reflux Diet & Behaviors.

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Risk of Complications: The patient states that they understand the current plans and the alternatives and agree with the current plans. The patient further states that all of their questions have been answered to their satisfaction.Risk of Complications: The current plans and side effects of all medications prescribed were also discussed in great detail and the patient states that they understand and accept the risks and complications and agree with the current plans.

Signed Electronically By: Roma C. Dasalla, ANP-C

Diagnosis and Coding

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Los Robles Hospital and Medical Center
Thousand Oaks, CA 91360

REPORT NAME: OPERATIVE REPORT

PATIENT'S NAME: LACHAPELLE, PATRICK
DOB: 03/14/1997 SEX: M
ATTENDING PHYS: George, Alister
ADMISSION DATE: 11/10/2015
DISCHARGE DATE: 11/10/2015

UNIT NO: G000254424

ACCOUNT NO: G00218675811
PT TYPE: IN
LOCATION: G.TOPACU

DICTATED BY: Alister George, MD
DATE OF SURGERY: 11/10/2015
SURGEON: Alister George, MD

PROCEDURE:
Upper endoscopy with biopsy.

INDICATIONS FOR PROCEDURE:
This is an 18-year-old gentleman who comes into the hospital with foreign body obstruction of the esophagus. The patient has had this on multiple occasions in the past, now comes in with eating Chinese food today, i.e. a day ago and being unable to swallow anything since then. He has to cough and throw up, regurgitate everything he swallows. The patient has the sensation of fullness in his chest. He denies having any chest pain, chest pressure. He denies shortness of breath. This has happened on multiple occasions, but heart rate has been getting progressively worse. Upper endoscopy discussed with the patient and his mom. They state they understand the procedure and the complications,. They agree with the procedure, accept the risks, and give informed consent.

PURPOSE FOR UPPER ENDOSCOPY:
To remove the foreign body as well as take biopsies. The patient had said that right before I came in to see him for evaluation, he thinks he has already passed it, swallowed it, but he was told that he probably should get an upper endoscopy anyways to determine the cause of his symptoms and to check for obstruction and blockage or significant esophagitis. All complications associated with this procedure, including, but not limited to bleeding, infection, perforation, cardiopulmonary arrest, abdominal pain, the need for urgent surgery, prolonged hospitalization. He states he understands these and all others, agrees with the procedure, accepts the risks, and gives informed consent.

DESCRIPTION OF PROCEDURE:
After obtaining informed consent for this procedure and for intravenous sedation, he was placed in the left lateral decubitus position and sedated with propofol by the anesthesiologist, Dr. Jefferson. After achieving adequate sedation, Olympus video upper endoscope was inserted in his mouth, advanced through the esophagus, stomach, and duodenum. Duodenum was unremarkable. Stomach was seen to have mild gastritis and some liquid food was seen in the stomach was easily aspirated. Biopsy of the antrum was done to check for H. pylori. Subsequently, the esophagus was looked at. There was an esophageal hiatal hernia noted at 40

Draft Copy

PATIENT NAME: PATRICK G LACHAPELLE ACCOUNT NO: LR00218675811

cm from the incisors. The hernia was 2 cm in size and it was not biopsied. Above the hernia, though, there were some strictures noted and they looked like they could be peptic stricture, but the rest of the esophagus also had some _____ mark fissures, which is consistent with eosinophilic esophagitis. There were no classic concentric or circular ___ or scarring, but biopsies of the distal esophagus were obtained to check for eosinophilic esophagitis. Scope was then withdrawn. The patient tolerated the procedure well, and there were no complications. There was no obstruction per se, but there is definitely circumferential scarring and what looks like where the food was stuck. The stomach was deflated prior to complete withdrawal of the instrument. The patient tolerated the procedure quite well. Vitals and pulse oximetry were continuously monitored through the entire procedure and acceptable and normal.

IMPRESSION:
1. Esophageal scarring consistent with eosinophilic esophagitis.
2. Hiatal hernia.
3. Incompetent lower esophageal sphincter muscle.
4. Gastritis.

DISCUSSION:
The patient was told that he should see me in the office in 2 weeks to go over the biopsy results and probably should be treated with fluticasone for eosinophilic esophagitis. In the meantime, though, he was advised that he should be on Nexium OTC once a day for 3 weeks and to be a soft diet for the next 24 to 48 hours and call me for any post-procedure discomfort or symptoms.

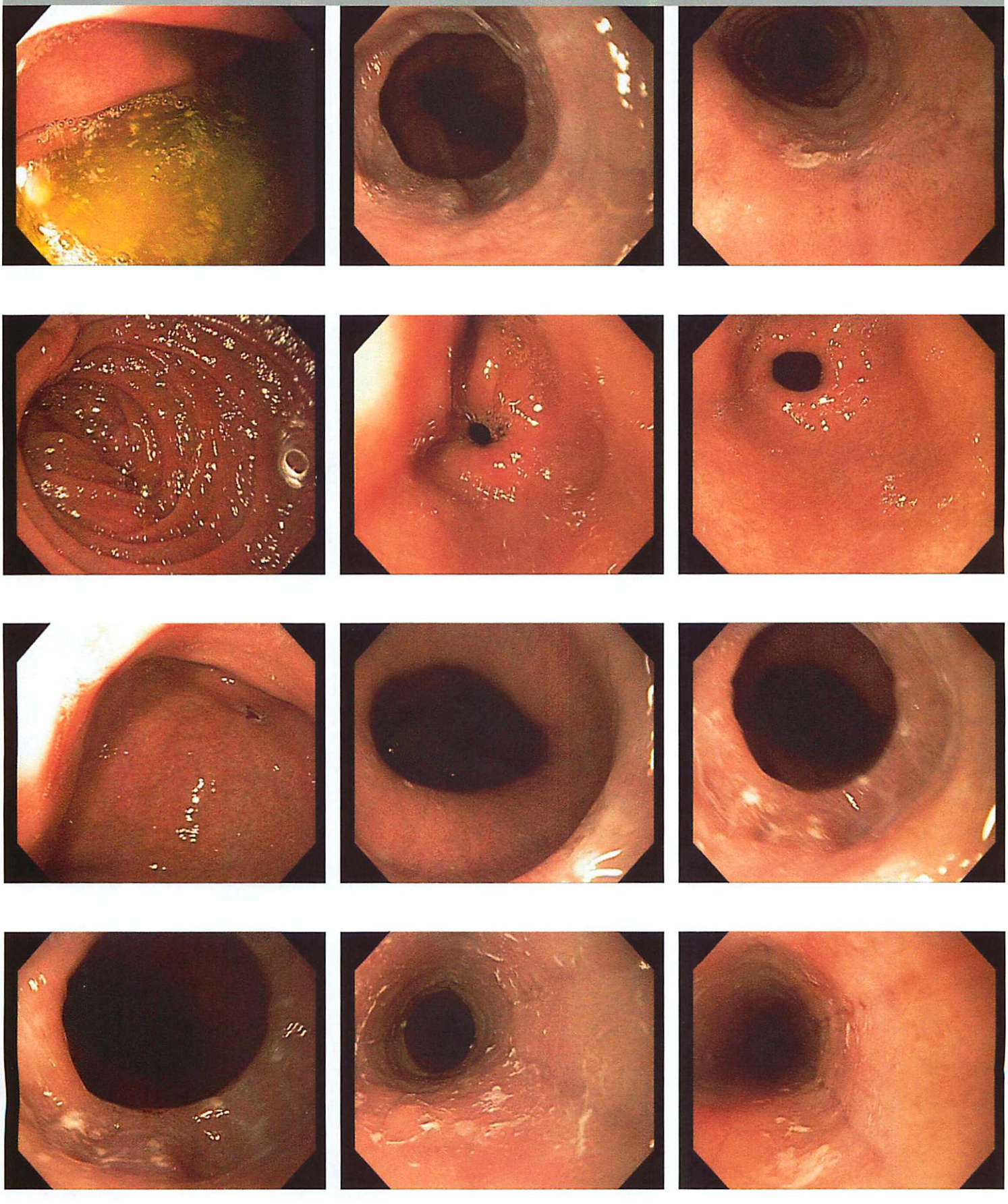
Dictated By: Alister George, MD

DD: 11/10/2015 18:36:48
DT: 11/10/2015 20:44:25
Dictation ID: 2969441 / Confirmation#: 104098

Draft Copy

Patient: LACHAPELLE, PATRICK G G000254424
Doctor: George, A.
Facility: G00215087544

Proc: EGD
Date: 11/10/2015
Time: 17:08



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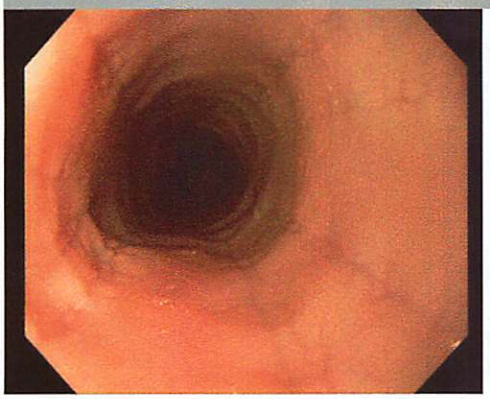

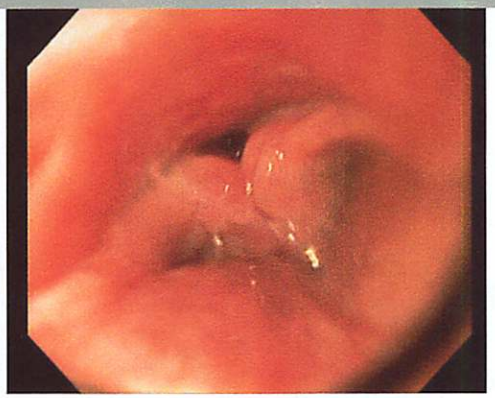

LOS ROBLES HOSPITAL & MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
Medical Director: Wayne Schultheis, M.D.

215 West Janss Road, Thousand Oaks, Ca. 91360 Ph: 805-370-4697 Fax: 805-370-4489

SURGICAL PATHOLOGY REPORT RX:S-5291-15

Patient: LACHAPELLE,PATRICK G
DOB: 03/14/97 Age/Sex: 18/M
Pt Type: DIS IN
Loc.: G.TOPACU Room/Bed: G.5PACU-1
Acct. #: G00218675811
Unit #: G000254424

Surgery/Collection Date: 11/11/15
Accession Date: 11/11/15
Completion Date: 11/12/15

Surgeon/Doctor: George,Alister A MD

Specimens

1. FOREIGN BODY - ANTRUM
2. ESOPHAGUS - ESOPHAGEAL STRICTURE

DIAGNOSIS

1. STOMACH, ANTRUM, BIOPSY:
   - Chronic gastritis, mild, non-specific
   - No evidence of intestinal metaplasia or ulceration
   - No evidence of dysplasia or malignancy
   - Giemsa stain is negative for Helicobacter

2. ESOPHAGUS, BIOPSY:
   - Active esophagitis with increased intraepithelial eosinophils (up to 35 eosinophils per high power field)
   - No intestinal metaplasia, dysplasia, or malignancy identified
   - Alcian blue stain is negative for intestinal type goblet cells
   - PAS stain is negative for fungal forms

Dictated by: Schmidt,Michael T

Microscopic Description

1. Gastric mucosa shows mild chronic inflammation. There is no evidence of acute inflammation, intestinal metaplasia, dysplasia, or malignancy. Giemsa stain is negative for Helicobacter.

☐ FILE ☐ FULL CHART
☐ CALL, THEN FILE

☐ PATIENT CALLED DATE 11/17
INITIAL

11-20-15 mailed results RS

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Microscopic Description (Continued)

2. Sections show fragments of gastroesophageal junction mucosa and esophageal squamous mucosa with markedly increased intraepithelial eosinophils (up to 35 eosinophils per high power field). The epithelium shows reactive changes. No intestinal metaplasia, fungal forms, dysplasia or malignancy identified.

Dictated by: Schmidt,Michael T

Clinical History

Possible foreign body removal, biopsies

Procedure

Esophagogastroduodenoscopy, biopsy

Gross Description

Specimen 1 is received in formalin and labeled Lachapelle, Patrick and labeled enterim. The specimen consists of three fragments of tan-pink soft tissue that measure from 0.2 to 0.4 cm in greatest dimension. TE-1.

Specimen 2 is received in formalin and labeled Lachapelle, Patrick and labeled esophageal stricture. The specimen consists of four fragments of tan-pink soft tissue that measure 0.3 cm each in greatest dimension. TE-1.

CM:dc

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Copies To

George,Alister A MD
PATHOLOGY LRHMC FILE

Signature

Report Electronically Signed Schmidt,Michael T 11/12/15