Advanced Inference Testing Medical Records - Set 2

CASE 2: Complex Revision Case with Scattered Documentation

Patient: Chen, Stephanie
MRN: 9384-2025-772
DOB: 07/23/1985 (40 years old)
Date of Service: October 15, 2025

PAGE 1 - EMERGENCY DEPARTMENT NOTE

ARRIVAL TIME: 02:45
PROVIDER: Jackson, Mark DO - Emergency Medicine
CHIEF COMPLAINT: Throwing up everything I eat

HPI:
40F brought in by husband around 3am with complaints of persistent vomiting for the past 3 days. Pt states she had that stomach surgery a few years back where they put the band around her stomach. She's been doing okay until recently. Started noticing food getting stuck about 2 months ago. At first just with bread and meat, but now even liquids are coming back up. Hasn't been able to keep anything down for 72 hours. Feels weak and dizzy. Denies fever. Some pain in upper belly. Says the port area on her abdomen has been bothering her lately - feels like it shifted or something.

Husband reports she's lost a lot of weight recently but not in a good way - looks gaunt and exhausted.

PMH:
Per patient:

- Had lap band surgery back in 2020 at some other hospital (records not available)
- Was doing great for first couple years, lost like 80 pounds
- Has gained back about 30 pounds over last year
- Gets heartburn a lot
- High BP - on meds
- Prediabetes they told her

MEDS:
Lisinopril something, not sure of dose. Takes prilosec over the counter.

PHYSICAL EXAM:

VS: T 99.1, BP 108/68, HR 112, RR 20, O2 98% RA
GEN: Thin-appearing woman, uncomfortable, dry mucous membranes
ABD: Thin, scaphoid, epigastric tenderness, port site TTP with some surrounding firmness, no rebound but guarding present
Otherwise unremarkable

ED COURSE:
IV started, fluids running. Labs drawn. Surgical consult called.

PAGE 2 - ED LABORATORY RESULTS

COLLECTED: 02:50
RESULTED: 03:45

BASIC METABOLIC PANEL:

- Sodium: 148 mEq/L [HIGH]
- Potassium: 3.1 mEq/L [LOW]
- Chloride: 110 mEq/L [HIGH]
- Bicarbonate: 31 mEq/L [HIGH]
- BUN: 28 mg/dL [HIGH]
- Creatinine: 1.3 mg/dL [HIGH]
- Glucose: 88 mg/dL
- Calcium: 8.9 mg/dL

CBC:

- WBC: 11.2 K/uL [SLIGHTLY HIGH]
- Hemoglobin: 10.8 g/dL [LOW]
- Hematocrit: 33% [LOW]
- MCV: 76 fL [LOW - microcytic]
- Platelets: 312 K/uL

ADDITIONAL:

- Albumin: 3.1 g/dL [LOW]
- Prealbumin: 16 mg/dL [LOW]

PAGE 3 - ED IMAGING

CT ABDOMEN/PELVIS WITH CONTRAST
ORDERED: 03:15
PERFORMED: 04:20

INDICATION: S/p gastric banding, persistent vomiting, eval for obstruction

TECHNIQUE: Axial images acquired after IV contrast

FINDINGS:

Gastric band identified in expected location around proximal stomach. However, band appears to have migrated/slipped with significant angulation. Marked dilation of esophagus measuring up to 5.2 cm. Stomach proximal to band markedly distended. Contrast passes slowly through band region.

Port site: Subcutaneous port appears displaced from original position. Surrounding inflammatory changes noted.

Liver: Mildly enlarged with decreased attenuation suggesting steatosis. No focal lesions.

Small bowel: Normal caliber, no obstruction

Large bowel: Unremarkable

No free air, no free fluid

IMPRESSION:

1. Gastric band slippage with malposition causing high-grade outlet obstruction
2. Severe esophageal dilation
3. Port site complications with displacement and surrounding inflammation
4. Hepatic steatosis

RECOMMENDATION: Urgent surgical evaluation

PAGE 4 - SURGICAL CONSULTATION NOTE

TIME: 05:30
PROVIDER: Anderson, Rebecca MD - General Surgery (on call)

CONSULTED FOR: Gastric band complications

HPI:
Called to ED to see this 40yo woman who had adjustable gastric banding done elsewhere around 5 years ago (2020). Per patient, she did really well initially - lost significant weight, felt great. Band adjustments were done periodically. However, she moved here about 18 months ago and didn't establish care with a bariatric surgeon locally. Started having issues with reflux about a year ago, managed with OTC PPIs. Progressive dysphagia over past 2 months, now in acute distress with inability to tolerate PO intake and dehydration.

Reviewed CT - clear band slippage with esophageal dilation and obstruction. This is a known complication of adjustable banding. Port also appears problematic.

EXAM:
Ill-appearing, dehydrated. Abd exam notable for port site tenderness and abnormal positioning of port.

ASSESSMENT:
Gastric band complication - band slippage causing obstruction. This is surgical emergency requiring band removal. Given esophageal dilation and patient's overall status, recommend band removal without immediate conversion to another procedure. Can consider staged approach with conversion later once recovered.

PLAN:

1. Admit to surgery service
2. NPO, IVF, correct electrolytes
3. Schedule for urgent band removal in AM
4. Discussed risks with patient and husband - understand this is complication of original surgery requiring intervention

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PAGE 5 - HOSPITAL ADMISSION NOTE

DATE: October 15, 2025
ADMITTING PROVIDER: Anderson, Rebecca MD

ADMISSION DIAGNOSIS:
Gastric band slippage with obstruction, dehydration, malnutrition

HOSPITAL COURSE - DAY 1:
Admitted from ED. Patient made NPO. Aggressive IV hydration initiated. Electrolyte repletion started - K+ and Mg++ protocols. GI decompression with NG tube placed - immediately drained 800mL gastric contents. Patient more comfortable after NG placement.

Nutrition consulted given labs showing protein-calorie malnutrition. Anemia workup - likely nutritional given

microcytosis and h/o malabsorption.

Scheduled for OR tomorrow AM for laparoscopic band removal.

VITAL SIGNS FLOW:

- 06:00: BP 118/72, HR 98, T 98.8
- 12:00: BP 122/76, HR 88, T 98.6
- 18:00: BP 128/78, HR 82, T 98.4
- 24:00: BP 124/74, HR 78, T 98.2

Patient tolerating NG decompression. I/Os monitored. Electrolytes will recheck in AM.

PAGE 6 - OPERATIVE REPORT

DATE OF SURGERY: October 16, 2025
SURGEON: Anderson, Rebecca MD
ASSISTANT: Chen, David MD
ANESTHESIA: General endotracheal

PREOPERATIVE DIAGNOSIS:
Gastric band slippage with obstruction

POSTOPERATIVE DIAGNOSIS:
Same, plus band erosion into gastric wall

PROCEDURE PERFORMED:
Laparoscopic removal of gastric band and port system

INDICATIONS:
Patient with history of laparoscopic adjustable gastric banding performed in 2020 presenting with acute obstruction due to band slippage. Imaging shows malpositioned band. Requires emergent removal.

FINDINGS:
Upon laparoscopic exploration, gastric band found slipped significantly with prolapse of stomach through band. Band severely angulated. Upon mobilization, noted that band had partially eroded through gastric wall posteriorly - approximately 30% circumference embedded in gastric tissue. Significant inflammatory reaction surrounding band. Esophagus markedly dilated. Port tubing intact but port displaced subcutaneously.

PROCEDURE DETAILS:
[Standard operative technique details omitted for brevity]

Band successfully removed along with all tubing and port components. Gastric wall defect from erosion

Band successfully removed along with all tubing and port components. Gastric wall defect from erosion repaired primarily with 3-0 vicryl suture in two layers. No leak on methylene blue test. Hemostasis achieved. Drains placed. Fascia and skin closed.

EBL: 75mL
SPECIMENS: Gastric band and port system
COMPLICATIONS: None intraoperative
DISPOSITION: To PACU in stable condition

PAGE 7 - POST-OP HOSPITAL COURSE

POST-OPERATIVE DAY 1 (October 17, 2025):
Patient doing reasonably well. Some incisional pain controlled with IV medications. NG tube removed this AM. Started on clear liquids - tolerating small sips. Drain output minimal, serosanguinous. Ambulating with PT. No fever.

Labs: Improving electrolytes. Hemoglobin stable at 10.4.

POST-OPERATIVE DAY 2 (October 18, 2025):
Continued improvement. Advanced to full liquids. Tolerating PO intake. Drain removed. Pain better, transitioned to PO meds. Plans for discharge tomorrow.

DISCHARGE DAY (October 19, 2025):
Patient ready for discharge. Tolerating diet. Pain controlled orally. Ambulating independently. Incisions clean, dry, intact.

DISCHARGE DIAGNOSES:

1. Gastric band slippage with obstruction
2. Gastric band erosion
3. Dehydration, resolved
4. Electrolyte abnormalities, corrected
5. Malnutrition
6. Anemia

DISCHARGE INSTRUCTIONS:

- Soft diet for 2 weeks then advance as tolerated
- Incision care
- Activity as tolerated

- F/u with Dr. Anderson in 2 weeks
- Will need nutrition follow-up
- Iron supplementation for anemia
- PPI for reflux

DISCHARGE MEDICATIONS:

- Omeprazole 40mg daily
- Ferrous sulfate 325mg daily
- Hydrocodone-acetaminophen 5/325 PRN pain
- Multivitamin daily

PAGE 8 - POST-OP FOLLOW-UP VISIT

DATE: November 2, 2025 (2 weeks post-op)
PROVIDER: Anderson, Rebecca MD

INTERVAL HISTORY:
Patient doing much better since band removal. Tolerating regular diet without difficulty. No more vomiting. No dysphagia. Incisions healing well. Still feels weak but improving. Concerned about weight - has continued to lose weight since surgery, now down to 158 lbs.

CURRENT WEIGHT: 158 lbs
HEIGHT: 64 inches (5'4")
BMI: 27.1

PHYSICAL EXAM:
GENERAL: Thin woman, appears somewhat malnourished
VITALS: BP 132/84, HR 76
ABDOMEN: Incisions well-healed. Soft, non-tender. No masses.

LABS FROM TODAY:

- Albumin: 3.3 (improving)
- Hemoglobin: 11.1 (improving)
- Glucose: 118 (fasting)
- A1C: 6.1%

ASSESSMENT/PLAN:

Doing well from surgical standpoint. Band removal successful. However, patient has several ongoing issues:

1. Nutritional deficiency - improving but needs continued monitoring. Referral to dietitian.
2. Weight trajectory concerning - patient has lost 30+ lbs in unhealthy manner over past few months due to band complications. Prior to that, she had regained about 30 lbs from her nadir weight after initial band placement.
3. Recurrence of metabolic issues - blood sugars trending up (was told prediabetes before, numbers confirm), BP elevated today.
4. Patient asking about revision surgery - wants to consider conversion to another bariatric procedure as she's concerned about weight regain. Explained need to recover first, optimize nutrition, then can reassess in future.

PLAN:

- Continue current medications
- Nutrition follow-up scheduled
- Will see back in 6 weeks
- Can discuss revisional surgery options once medically optimized

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PAGE 9 - NUTRITION FOLLOW-UP

DATE: December 15, 2025
PROVIDER: Williams, Sandra RD - Registered Dietitian

NUTRITION ASSESSMENT:

Patient referred post gastric band removal for nutritional optimization and guidance. She's interested in pursuing another weight loss surgery once cleared.

WEIGHT HISTORY: Per patient report:

- Pre-band surgery weight (2020): 268 lbs, BMI 46
- Lowest weight post-band (2022): 188 lbs, BMI 32.3 - excellent result
- Started regaining weight 2023: back up to 218 lbs by early 2024
- Current weight: 162 lbs (lost dramatically d/t band complications)

So essentially, she lost 80 lbs with band initially (30% total body weight loss), regained 30 lbs, then lost 56 lbs in unhealthy manner due to obstruction.

DIETARY RECALL

DIETARY RECALL:

Currently eating 3 meals daily. Appetite improved since band removal. Portions still smaller than pre-surgery. Protein intake adequate. Taking vitamins as prescribed.

CONCERNS:

Patient worried about continued weight regain now that she can eat normally again. Already gained 4 lbs since last visit (was 158, now 162). Says she "knows herself" and without the restriction, she'll gain all the weight back. That's why she's very motivated for revision surgery.

COMORBIDITY STATUS: Reviewing records:

- Blood sugar issues have returned - A1C was 6.1% at last visit (prediabetic range)
- BP running high again - was on meds before initial surgery, needed them again
- Reports reflux symptoms ongoing despite PPI

ASSESSMENT:

Patient is appropriate candidate for revision bariatric surgery consideration once medically cleared. Has history of:

- Significant initial weight loss with prior procedure (30% TBWL)
- Weight regain of portion of lost weight
- Surgical complication requiring band removal
- Recurrence of comorbid conditions

RECOMMENDATIONS:

Continue current dietary plan. Scheduled for monthly follow-ups to monitor weight and nutrition status. Discussed that most insurance require 6 months documented weight management for revision procedures. Patient agreeable to continued program participation.

PAGE 10 - BARIATRIC SURGERY REVISION CONSULTATION

DATE: May 10, 2026
PROVIDER: Martinez, Joseph MD - Bariatric Surgery
LOCATION: Regional Bariatric Center

CHIEF COMPLAINT:

Revision bariatric surgery consultation

HPI:

41yo woman presents for evaluation of revision bariatric surgery. She underwent laparoscopic adjustable gastric banding in 2020 at outside facility for morbid obesity (BMI 46). Initial results were excellent - lost 80

gastric banding in 2020 at outside facility for morbid obesity (BMI 46). Initial results were excellent - lost 80 lbs reaching BMI of 32. However, developed band complications including slippage and erosion requiring removal in October 2025 by Dr. Anderson. Since band removal, she has gained 26 lbs over 6 months. Currently weighs 188 lbs.

WEIGHT TRAJECTORY:

- Pre-initial surgery (2020): 268 lbs, BMI 46
- Nadir post-band (2022): 188 lbs, BMI 32.3
- Pre-band removal (2024): 218 lbs, BMI 37.4 (regained)
- Immediately post-removal (2025): 162 lbs, BMI 27.8 (lost d/t complications)
- Current (2026): 188 lbs, BMI 32.3 (regained again)

CURRENT COMORBIDITIES: Patient now has recurrence of metabolic problems:

1. Glucose metabolism issues - A1C today is 6.4% (definitely prediabetic), fasting glucose 126 (meeting criteria for diagnosis). Was in better control after initial surgery, worsened with weight regain.
2. Blood pressure problems - currently on amlodipine 5mg and HCTZ, BP today 138/88. Was off meds completely 2022-2023, restarted 2024.
3. Reflux - persistent despite high-dose PPI, likely related to esophageal changes from prior band complications.
4. Joint pain - knees and back, limiting exercise tolerance.
5. Lipid abnormalities - recent lipid panel shows total cholesterol 232, LDL 156, triglycerides 198, HDL 38.

WEIGHT MANAGEMENT DOCUMENTATION:
Patient has been followed by dietitian monthly since December 2025 (now 6 months documented). Seen by Dr. Thompson (PCP) monthly as well for weight management program. Records provided show consistent attendance, dietary counseling, exercise recommendations. Despite adherence, gaining weight steadily - average 4-5 lbs per month.

PREVIOUS SURGICAL COMPLICATIONS:
Band slippage and erosion (10/2025) - serious complication requiring removal. Operative report reviewed showing significant erosion requiring repair of gastric wall. Patient recovered well from removal surgery.

ASSESSMENT:

This is a revision case. Patient previously underwent LAGB with initial success but developed significant surgical complication (band slippage and erosion) requiring removal. Now experiencing:

- Weight regain approaching pre-initial surgery levels

- Recurrence of multiple comorbidities (impaired fasting glucose/prediabetes, HTN, dyslipidemia, reflux, arthropathy)
- Failure to maintain weight loss after band removal despite 6 months documented medical management
- Anatomic issues from prior surgery (esophageal changes, gastric wall scarring)

Criteria for revision surgery: ✓ Prior bariatric procedure (LAGB 2020) ✓ Surgical complication requiring intervention (band removal 2025)
✓ Weight regain with recurrence of comorbidities ✓ 6+ months documented physician-supervised weight management post-band removal ✓ BMI 32.3 with multiple comorbidities ✓ Psychological clearance (scheduled)

DISCUSSION:
Extensively discussed revision options. Given her history and current anatomy:

- Sleeve gastrectomy possible but reflux is concerning
- RYGB likely best option given metabolic benefits and lower reflux risk
- Higher risk procedure given prior surgery and complications
- Will need careful pre-op workup

Patient understands risks including but not limited to: higher complication rate with revision (leak, bleeding, infection), possibility of need for further surgery, nutritional deficiencies, need for lifelong supplementation and follow-up. Patient motivated and understands this is her "second chance."

PLAN:

1. Pre-op labs, EGD, psych clearance, cardiac clearance
2. Submit for authorization for revision RYGB
3. Continue medical weight management pending surgery
4. Multidisciplinary team review

MEDICAL NECESSITY STATEMENT:
Patient meets criteria for revision bariatric surgery. Previous procedure failed due to surgical complication (band erosion/slippage) requiring explantation. Now has recurrent obesity (BMI 32.3) with multiple recurrent comorbidities including impaired glucose metabolism progressing toward diabetes, hypertension requiring medications, dyslipidemia, and reflux. Has completed 6 months supervised medical weight management program without success at maintaining weight loss. Revision surgery is medically necessary to address recurrent obesity and prevent progression of metabolic disease.

ELECTRONIC SIGNATURE: Jacob Martinez, MD

ELECTRONIC SIGNATURE: Joseph Martinez, MD

Date/Time: 05/10/2026 16:20

INFERENCE CHALLENGES IN THIS CASE:

1. **Weight calculations scattered across timeline** - requires tracking BMI changes over multiple years
2. **Comorbidity terminology variations:**
   - "Blood sugar issues" / "prediabetic" / "impaired fasting glucose" / "glucose metabolism issues" → Type 2 Diabetes/Prediabetes
   - "Blood pressure problems" / "HTN" → Hypertension
   - "Reflux" / "heartburn" → GERD
3. **Surgical complication evidence spread across multiple documents** (ED, imaging, operative report)
4. **Weight management documentation** scattered across nutrition and PCP notes
5. **Time intervals** requiring calculation from various dates
6. **Revision criteria** must be inferred from: prior surgery + complication + weight regain + comorbidity recurrence + documented management
7. **Lab values** requiring interpretation (A1C 6.4% = prediabetes, fasting glucose 126 = diabetes threshold)
8. **No explicit statement of "meets criteria"** until final note - agent must determine eligibility from scattered evidence