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6519PAGES
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5/17/2024 12:42

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Torrance Memorial Medical Cent

RRD→16573482482

001/103

Torrance Memorial Medical Center**FAX OF PROTECTED HEALTH INFORMATION COVER SHEET****CASE MANAGEMENT DEPARTMENT**

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DATE: 5/17/2024 12:41:52 PM

TO: Ad Hoc1 (dial 1 + #)

FAX NUMBER: 16573482482

Number of Pages Including Cover Sheet: 103

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TORRANCE MEMORIAL MEDICAL CENTER
3330 WEST LOMITA BLVD
TORRANCE, CA 90505-5073
(310) 325-9110

VISIT NO	MRN	PATIENT TYPE
57614509	4452315	INPATIENT
ADMIT DATE/TIME		ARRIVAL DATE/TIME
05/08/2024 03:58 PM		05/08/2024 01:26 PM

REGISTRATION RECORD***** C O N F I D E N T I A L I N F O R M A T I O N *****

Patient Information								
PATIENT NAME and ADDRESS ARIAS, DAVID J 4107 W 164TH ST LAWNDALE, 902603020		AGE 68 Y	SEX M	BIRTHDATE 07/06/1955	DX CD	ADMIT REASON ANEMIA,CONFUSON,ACUTE RENAL FAILURE		ACO None
		MARITAL Married		RACE White	ETHNICITY Hispanic	LANGUAGE English	RELIGION No Preference	
HOME PHONE (424) 250-5722	MOBILE PHONE (424) 250-5722	MEDICAL SERVICE Medical		ADMIT TYPE Emergency	NURSE UNIT 6WMSU	ROOM/BED 6124 / A		
ACCIDENT DATE/TIME		STATE		ACCIDENT TYPE	SOURCE OF ADMISSION Other	ADMIT BY MBUENORODRIGUEZ		

Patient Employer Information		Guarantor Information			
EMPL NAME and ADDRESS Unknown Employment	EMPL PHONE () -	GUAR NAME and ADDRESS ARIAS, DAVID J 4107 W 164TH ST LAWNDALE, CA (424) 250-5722	REL TO PATIENT Self	EMPL NAME and ADDRESS Unknown Employment	EMPL PHONE () -
	Occupation		GUAR DOB 07/06/1955		

Emergency Contacts				
RELATIVE NAME	ADDRESS	PREFERRED	ALTERNATE PHONE	PATIENT'S RELTN TO EC
ARIAS, SHIRLEY	4107 W 164TH ST LAWNDALE, CA 902603020	(424) 250-5722	() -	Spouse
		() -	() -	

Insurance Information					
INSURANCE PLAN	ADDRESS	FIN CLASS CD	GROUP NUMBER POLICY NUMBER	EFFECTIVE DATES AUTHORIZATION #	SUBSCRIBER
Alignment PPO Sr	PO BOX 14010 Orange, CA 92863 (866) 634-2247	OS	H4961 00000195916	05/08/24 -	ARIAS, DAVID J
				-	

Physician Information			Visit Alert Information	
TYPE	PHYSICIAN NAME	PHONE	FAX NUMBER	DESCRIPTION
ADMITTING	Patel, MD, Keyur A	(310) 891-6623	(310) 891-6673	
PCP	Madani, MD, Mahsa	(310) 378-2234	(310) 378-9795	
ATTENDING	Patel, MD, Keyur A	(310) 891-6623	(310) 891-6673	



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

DOB / Age: 7/6/1955 / 68 years

Admitting Physician: Patel,MD,Keyur A

Consulting Physician: Kaing,DO,Henry J ; Shum,
DPM,Karen C ; So,MD,George
J ; Deen,MD,Omer J

Discharge Summary

DOCUMENT NAME:

Discharge Summary

SERVICE DATE/TIME:

5/13/2024 17:00 PDT

RESULT STATUS:

Auth (Verified)

PERFORM INFORMATION:

Patel,MD,Keyur A (5/14/2024 07:36 PDT)

SIGN INFORMATION:

Patel,MD,Keyur A (5/14/2024 07:36 PDT)

Date of Admission

05/08/2024 13:26

Date of Discharge

5/13/2024

Diagnoses

1. Weakness
2. Metabolic encephalopathy likely due to uremia
3. AKI on CKD stage III from urinary retention
improved with foley placement
4. Acute right lower extremity DVT
-Status post IVC filter as not good anticoagulation candidate
5. Calvarial lesions/lytic lesions. As well as spiculated nodule in right upper lobe of lung
-Workup suspicious for MM. patient is s/p IR bone bx
6. Fevers
7. Anemia
8. Acute blood loss anemia from epistaxis
9. Epistaxis
10. Chronic left lower extremity wound
11. Coronary artery disease status post PCI 2020
12. Hypertension
13. Alcohol use
14. COPD

Problem List/Past Medical History**Ongoing**

Abrasion of right lower leg

Aftercare

Alcohol abuse

Anemia

CAD in native artery

Chronic renal insufficiency, stage III (moderate)

COPD type A

Diarrhea

Elevated transaminase level

Falls

History of heart artery stent

History of TIA (transient ischemic attack)

HTN (hypertension)

Hyponatremia

Mixed hyperlipidemia



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Discharge Summary

Peripheral vascular disease

Thrombocytopenia

Tobacco use

Tobacco user

Weight loss

Historical

History of shingles

Consultations

Clinical Nutrition Consultation 05/13/2024 17:27 Auth (Verified) By Deen, MD, Omer J TMMC Physician - Hospitalist

Surgical Consultation 05/09/2024 12:30 Auth (Verified) By Shum, DPM, Karen C TMMC Physician - Surgery Venue

Spiritual Care 05/09/2024 10:32 Auth (Verified) By Junker, Karen Spiritual Care

Oncology/Hematology Consultation 05/09/2024 09:57 Auth (Verified) By Lowe, MD, Thomas E Physician - Oncology

Other Consulting Personnel

Deen, MD, Omer J

So, MD, George J

Shum, DPM, Karen C

Kaing, DO, Henry J

Medication Reconciliation

New medication

Home medications to be continued with changes

Home medications to be continued

acetaminophen-hydrocodone (acetaminophen-hydrocodone 325 mg-10 mg oral tablet)1 tablet(s) by mouth every 4 hours as needed for as needed for pain

amLODIPine (Norvasc 10 mg oral tablet)1 tablet(s) by mouth once daily. SBP>160.

ascorbic acid (Vitamin C 1000 mg oral tablet)1 tablet(s) by mouth once daily

aspirin (aspirin 81 mg oral delayed release tablet)1 tablet(s) by mouth once daily

atorvastatin (Lipitor 80 mg oral tablet)1 tablet(s) by mouth once daily

cyanocobalamin (Vitamin B12 250 mcg oral tablet)2 tablet(s) by mouth once daily

folic acid (folic acid 0.8 mg oral tablet)1 tablet(s) by mouth once daily

mirtazapine (mirtazapine 15 mg oral tablet)1 tablet(s) by mouth at bedtime

pantoprazole (pantoprazole 40 mg oral delayed release tablet)1 tablet(s) by mouth once daily

pregabalin (pregabalin 25 mg oral capsule)1 capsule(s) by mouth every 8 hours. start at bed time only. If not to sleepy after 5 days take BID for 5 days, if not sleepy can take TID.

tamsulosin (tamsulosin 0.4 mg oral capsule)1 capsule(s) by mouth once daily

zinc acetate (zinc (as acetate) 50 mg oral capsule)1 capsule(s) by mouth three times a day

Home medications to be discontinued

cephalexin (cephalexin 500 mg oral capsule)1 capsule(s) by mouth twice a day

Procedures/Diagnostic Testing

Procedures at TMMC (this visit only)



Patient Name: ARIAS, DAVID J
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Discharge Summary

No qualifying data available.

CT Biopsy 05/13/2024 15:49:25 * Final *

IMPRESSION: CT-GUIDED CORE BIOPSIES OF THE SMALL LEFT ILIAC WING BONE LYtic LESION.

CT Brain/Head without Contrast 05/08/2024 15:01:50 * Final *

IMPRESSION: NO SIGNIFICANT ACUTE INTRACRANIAL ABNORMALITY. MILD TO MODERATE GLOBAL PARENCHYMAL VOLUME LOSS. MILD TO MODERATE AGE-UNDETERMINATE SMALL VESSEL ISCHEMIC DISEASE IN THE WHITE MATTER. NONSPECIFIC RIGHT PARIETAL CALVARIAL LUENT LESIONS, POSSIBLY REPRESENTING PROMINENT ARACHNOID GRANULATIONS, WITH OTHER ETIOLOGIES INCLUDING METASTATIC DISEASE OR MYELOMA NOT ENTIRELY EXCLUDED. CORRELATION WITH PREVIOUS AVAILABLE STUDIES IS RECOMMENDED TO ASSESS FOR STABILITY. ALTERNATIVELY, BONE SCAN MAY BE PERFORMED FOR FURTHER EVALUATION.

CT Chest without Contrast 05/09/2024 08:32:38 * Final *

IMPRESSION: 6 X 12 X 9 MM HIGHLY IRREGULAR SPICULATED NONCALCIFIED NODULE IN THE POSTERIOR SEGMENT OF THE RIGHT UPPER LOBE BORDERING ON THE MAJOR FISSURE WITH MILD FOCAL PLEURAL THICKENING. 15 X 8 X 13 MM GROUNDGLASS NODULE IN THE MEDIAL LINGULA ADJACENT TO THE MEDIASTINAL PLEURA. SMALL AREAS OF PERIBRONCHIAL NODULARITY/BRONCHIAL WALL THICKENING IN THE RIGHT UPPER LOBE AS WELL AS SCATTERED AREAS OF TREE-IN-BUD MICRONODULARITY IN THE RIGHT UPPER AND LOWER LOBES WITH A FEW SCATTERED SMALL SUB-4 MM PULMONARY NODULES, EXCEPT FOR A 6 MM NONCALCIFIED GROUNDGLASS NODULE IN THE POSTERIOR RIGHT LOWER LOBE SUPERIOR SEGMENT ON SERIES 3-52. IMAGING DEGRADATION NOTED DUE TO MOTION ARTIFACT. MODERATE CORONARY ARTERIAL CALCIFICATIONS. POSSIBLE ESOPHAGEAL WALL THICKENING.

CT Abd/Pelv NO IV/NO GI Contrast 05/09/2024 08:58:25 * Final *

IMPRESSION: MULTIPLE SMALL SUBTLE LYtic LESIONS INCLUDING THE LEFT SUPERIOR ILIAC BONE, RIGHT POSTERIOR 11TH AND 12TH RIBS, AND LEFT L2 PEDICLE. SUGGEST CLINICAL CORRELATION TO EXCLUDE MULTIPLE MYELOMA VERSUS METASTASES. INTERVAL APPEARANCE OF MILD TO MODERATE RIGHT AND MILD LEFT HYDRONEPHROSIS AND HYDROURETER IS LIKELY DUE TO BLADDER OBSTRUCTION WITH NOW ELONGATED BUT DECOMRESSED BLADDER CONTAINING A FOLEY BALLOON CATHETER. INTERVAL APPEARANCE OF ANASARCA. RENAL CYSTS. POSSIBLE CONSTIPATION. STATUS POST VASECTOMY.

XR Ankle Complete Right (4V) 05/08/2024 16:58:52 * Final *

IMPRESSION: NEGATIVE.

XR Tibia/Fibula Right 05/08/2024 16:58:22 * Final *

IMPRESSION: RIGHT TOTAL KNEE PROSTHESIS.

XR Chest Portable 05/08/2024 15:03:11 * Final *

IMPRESSION: NEW HAZY THE AIRSPACE DISEASE/OPACITIES ALONG THE RIGHT PERIHLAR AND INFRAHLAR REGIONS. THERE IS NO VISIBLE PLEURAL EFFUSION OR PNEUMOTHORAX. THE CARDIOMEDIASTINAL SILHOUETTE IS STABLE. NO ACUTE OSSEOUS ABNORMALITIES ARE IDENTIFIED.

IR Percutaneous Placement Of IVC Filter 05/09/2024 18:29:28 * Final *

IMPRESSION: STATUS POST PLACEMENT OF CELECT RETRIEVABLE-TYPE INFRARENAL INFERIOR VENA CAVA FILTER. NOTE THAT THE PROBABILITY OF SUCCESSFUL FILTER RETRIEVAL DIMINISHES WITH INCREASING FILTER DWELL TIMES



Patient Name: ARIAS, DAVID J
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Discharge Summary

GREATER THAN 6 MONTHS. IF A LONGER DURATION OF FILTER PROTECTION IS REQUIRED AND RETRIEVABILITY IS TO BE MAINTAINED, THE FILTER CAN BE REMOVED AND REPLACED AT A FUTURE SESSION.

IR Conscious Sedation 05/10/2024 14:21:43 * Final *

MODERATE SEDATION: UNDER PHYSICIAN SUPERVISION, ANALGESICS AND/OR ANXIOLYTICS WERE ADMINISTERED INTRAVENOUSLY FOR MODERATE SEDATION. PULSE OXIMETRY, HEART RATE, AND BP WERE CONTINUOUSLY MONITORED BY THE CIRCULATING RN PRESENT. THE PHYSICIAN SPENT 30 MINUTES OF FACE-TO-FACE SEDATION TIME WITH THE PATIENT.

US Renal 05/08/2024 17:25:22 * Final *

IMPRESSION: ECHOPHASIC, CYSTIC KIDNEYS CONSISTENT WITH CHRONIC RENAL DISEASE. MILD RIGHT HYDRONEPHROSIS. BLADDER DECOMRESSED BY FOLEY CATHETER.

Reason for Admission

68-year-old male with a history of alcohol abuse, TIA, coronary artery disease status post PCI many years ago, hypertension, COPD not on home oxygen who presents to the emergency room due to weakness/confusion as well as nose bleed.

Hospital Course

68-year-old male admitted for above complaints. Patient is acute kidney injury/uremia likely from urinary retention. Foley catheter placed which showed 1 L out. Creatinine, as well as mentation slowly started to improve. Patient's encephalopathy was likely due to uremia as well. Workup included lytic lesions as well as calvarial lesions. Patient was seen by hematologist/oncologist Dr. Lowe who recommended workup as well as bone biopsy. Workup seems to point towards likely myeloma. Bone biopsy was done on May 13, with path pending. Patient also had a right lower extremity DVT diagnosed a few days prior to admission. Given his anemia, prior GI bleed as well as now nosebleed is seen the patient is not a good candidate for anticoagulation and therefore IVC filter was placed. Overall patient's mentation improved, and his pain was controlled as well. He was seen by his podiatrist Dr. SHum regarding his chronic wounds. Culture was positive, and advised him to continue finishing his course of Bactrim. After multiple discussions with family/patient regarding goals of care initially want to forego bone biopsy. Eventually, they change her mind and underwent bone biopsy. Patient however also met with hospice team/palliative team and will be discharged home under hospice care.

#weakness/confusion likely due to uremia

#AKI on CKD stage

Cr: >4. baseline around 1-1.5

-hold home lisinopril

-Advised RN in the ED to do bladder scan, which was greater than 1 L Foley catheter replaced in ER(5/8)

-check renal US --> Echogenic, cystic kidneys consistent with chronic renal disease. Mild right hydronephrosis. Bladder decompressed by Foley.

-check urine lytes --> 3%. Likely intrinsic.

-Monitor confusion. improved. mentation nearly back to baseline

-PT/OT eval

#acute RLE DVT

Calvarial lesions on CT scan

recent US on 5/3 showing + DVT soleus vein. Patient started on Eliquis as an outpatient.

-Due to nosebleed, will hold eliquis for now and likely indefinitely.

-Due to DVT, though possible etiology could be immobility, as well as calvarial lesions will check SPEP/UPEP elevated PSA noted as well light chain ratio

-check CT chest and CTAP --> CT chest: Highly irregular spiculated noncalcified nodule in the posterior segment the right upper lobe. Groundglass nodule in the medial lingula adjacent to the mediastinal pleura. CTAP: Multiple small subtle lytic lesions include the left superior leg bone, right posterior 11th and 12th ribs.



Patient Name: ARIAS, DAVID J
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Discharge Summary

- s/p IVC filter on 5/9
- s/p IR bone bx on 5/13, path pending. will follow up Dr. Lowe as o.p
- patient to be discharged home under hospice care

#febrile

unsure of exact etiology. Abnormal UA noted, but urine culture negative. Therefore will discontinue ceftriaxone. Wound culture positive for Stenotrophomonas maltophilia

- blood cx negative.
- resume home bactrim and finish course
- fever likely from cancer/ DVT

#anemia

- #acute blood loss
- downtrend in Hgb noted. s/p 1 unit PRBC

Epistaxis

- H&H stable. Monitor
- hold ASA and eliquis due to bleed

#chronic LLE wound

Mainly involving right lower extremity. Recent ER visit on May 3, and was prescribed Keflex as well as Bactrim. Given no overt cellulitic area noted, as well as normal white blood cell count we will hold off on antibiotics at this time.

- check xray R ankle to eval for osteo --> negative
- appreciate, DPM. Dr. Shum, continue wound care. No surgical plan needed.
- follow up with vasc as o.p

History of TIA

- hold ASA due to nosebleed.

Hyperkalemia

#metabolic acidosis

- Elevated potassium noted. Hold home lisinopril. Lokelma x 1 dose. Start sodium bicarb given low CO₂

Coronary artery disease

S/p PCI in 2020

#HTN

- continue home: amlodipine 10 mg po daily
- cont statin
- resume asa when nosebleeds stops

Alcohol use disorder, mild, without withdrawal

- monitor

Chronic obstructive pulmonary disease: emphysema

- stable
- PRN bronchodilators

General: Alert and oriented, well nourished, no acute distress.

Lungs: Clear to auscultation and percussion, non-labored respiration.

Heart: Normal rate, regular rhythm, no murmur, gallop or edema.



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Discharge Summary

Abdomen: Soft, non-tender, non-distended, normal bowel sounds, no masses.

Skin: Skin is warm, dry and pink, no rashes or lesions.

Neurologic: Awake, alert, and oriented X3, CN II-XII intact.

Extremities: no cyanosis, clubbing or edema.

Goals of Care

Code Status: **Code Status** (Original Order Date/Time: **05/10/2024 16:08**) 05/10/24 16:08:00 PDT,

DNR/DNI (No CPR or Intubation)

Current Status: Discontinued. Ordered By: **Kaing, DO, Henry J**

Serious Illness Questions Answered By:

Prognostic Understanding:

Prognosis Timeframe Communicated:

Information Preferences:

Goals if Health Worsens:

Fears/Worries:

Critical Functions for Patient:

Unacceptable Tradeoffs for More Time:

Family Discussion:

Clinical Recommendations:

Decisions Made: . In-depth discussion with patient, patient's wife as well as patient's sister. Given imaging finding concerning for malignancy, likely metastatic goals of care were had. Patient wishes to be a DNR. Does not want to go through any workup, or treatment if this ends up being cancer.

Therefore, there open to changing to more comfort focused treatment and therefore hospice was consulted. Patient likely discharged under hospice care.. **05/11/2024 11:55**. Documented by: **Patel, MD, Keyur A**

Discharge Plan/Follow-Up

Patient advised to follow up with PCP within 1-2 weeks. PCP listed in power chart per patient/family is Madani, MD, Mahsa with Dr. Lowe as directed

Discharge Condition/Destination

stable to home under hospice care

Activity

as tolerated



Patient Name: ARIAS, DAVID J
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Discharge Summary

Diet

No qualifying data.

Time Spent Coordinating Discharge

>30 mins

Electronically Signed On: 05/14/2024 07:36 PDT

By: Patel, MD, Keyur A

E.D. Documentation

DOCUMENT NAME:	ED Physician Notes
SERVICE DATE/TIME:	5/8/2024 15:04 PDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Bracken,DO,Richard H (5/8/2024 15:04 PDT)
SIGN INFORMATION:	Bracken,DO,Richard H (5/8/2024 18:13 PDT)

Chief Complaint

weak x 3 days, c/o leg pain, recent dx dvt, on blood thinners, bloody nose last night

History of Present Illness/Chronic Conditions Affecting Care

This is a 68-year-old male who presents emergency department for evaluation of generalized weakness for the last 2 to 3 days associated with intermittent confusion and nosebleeding. Patient was recently found to have a blood clot to the right lower extremity and was started on oral anticoagulation. Last night he was having a blood clot and he was intermittently confused today. 911 was called. The family says that he has been slowly declining over the last several weeks. He denies any chest pain shortness of breath fevers chills abdominal pain. Nothing make symptoms better or worse.

Social determinants of health significantly affecting care

Tobacco user

Discussion with independent historian

Clinical information obtained from an independent historian.

History obtained from or confirmed by: Family members

Review of External (Non-ED) Record

Primary care note from 4/5/2024 reviewed

Physical Exam

Vitals & Measurements

Respiratory Rate: 22br/min (05/08/24 13:37:00)
Temperature Oral: 99.3DegF (05/08/24 13:37:00)
Oxygen Saturation: 95% (05/08/24 13:37:00)
Primary Pain Intensity: 7 (05/08/24 13:37:00)
Heart Rate Monitored: 105bpm (05/08/24 13:37:00)
Pain Scale Used: Numeric Pain Scale (05/08/24 13:37:00)
Systolic Blood Pressure NIBP: 133mmHg (05/08/24 13:37:00)

Problem List/Past Medical History

Ongoing

Abrasions of right lower leg
Aftercare
Alcohol abuse
Anemia
CAD in native artery
Chronic renal insufficiency, stage III (moderate)
COPD type A
Diarrhea
Elevated transaminase level
Falls
History of heart artery stent
History of TIA (transient ischemic attack)
HTN (hypertension)
Hyponatremia
Mixed hyperlipidemia
Peripheral vascular disease
Thrombocytopenia
Tobacco use
Tobacco user
Weight loss

Historical

History of shingles

Immunizations

Vaccine	Date	Status
SARS-CoV-2 (COVID-19) Ad26 vacc, recomb	04/09/2021	Recorded
pneumococcal 23-valent vaccine	09/17/2020	Recorded
influenza virus vaccine, inactivated	09/17/2020	Recorded



Patient Name: ARIAS, DAVID J

MRN: 4452315

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E.D. Documentation

Diastolic Blood Pressure NIBP: 57mmHg (05/08/24 13:37:00)

ED Calculated MAP: 82mmHg (05/08/24 13:37:00)

INITIAL VITAL SIGNS: Reviewed by me

GENERAL: Frail thin temporal wasting present chronically ill

HEAD: atraumatic, normocephalic

EYES: No scleral icterus

NECK: No JVD

CV: regular rate and rhythm

LUNGS: CTAB, no wheezes, rales, rhonchi. Normal respiratory effort.

GI: soft, non-tender, non-distended, no masses. No rebound, guarding or peritonitis.

GU: Deferred

MSK: The lower extremities swollen when compared to the left. There is a wound on the anterior shin as well as the right lateral malleolus. They do not obviously probe to bone.

NEURO: Alert and oriented x person place situation. Intermittently confused per family. Face is symmetric. Speech is normal. Moves all extremities equally.

PSYCH: calm

SKIN: no rashes on extremities or face

Discussion of Management with Physician, Other Health Care Provider, or Appropriate Source

I discussed the case with Dr. Patel who agrees admit the patient

Medical Decision Making

Labs as interpreted by me show hyperkalemia acute renal failure, uremia. Suspect patient's anemia uremia possibly related to epistaxis however given history of upper GI bleed I did give a dose of Protonix here. Rectal exam reveals guaiac negative stool that is hard was positive. Chest x-ray shows no acute findings. CT scan of the head also obtained shows no acute findings. Patient's temporal wasting and generalized weakness highly concerning for malignancy I did discuss my concerns with the patient's family. The CT scan of the head did reveal lytic lesions of unclear etiology. Patient to be admitted for further treatment of his acute renal failure and symptomatic anemia.

Differential Diagnosis

The differential diagnosis associated with the patient's presentation includes: As above or below

Escalation of care including admission/obs considered**Tests considered but not performed**

The following testing was considered but ultimately not selected:

CT scan of the abdomen pelvis considered to be obtained as an inpatient.

Prescription medication considered but not given

I considered prescription management with:

Opioids not given because _

Antibiotics not given because _

Vaccine	Date	Status
influenza virus vaccine, inactivated	09/25/2018	Recorded
influenza virus vaccine, inactivated	01/18/2018	Recorded
tetanus/diphtheria/pertussis, acel (Tdap)	10/07/2016	Recorded

Medications**Emergency and Inpatient (completed)**

NS - Bolus, 500 mL, IVPB, 1xonly
Protonix injection, 80 mg= 20 mL, IVP, 1xonly

Emergency and Inpatient (active)

No active ED or Inpatient medications

Home

acyclovir 800 mg oral tablet, 800 mg= 1 tab(s), PO, 3xdaily
aspirin 81 mg oral delayed release tablet, 81 mg= 1 tab(s), PO, daily
Bactrim DS 800 mg-160 mg oral tablet, 1 tab(s), PO, 2xdaily
cephalexin 500 mg oral capsule, 500 mg= 1 capsule(s), PO, 2xdaily
doxazosin 2 mg oral tablet, 2 mg= 1 tab(s), PO, daily

Eliquis 2.5 mg oral tablet, 2.5 mg= 1 tab(s), PO, 2xdaily
lidocaine 5% topical ointment, 5 grams, topically, q12hrs, PRN, 1 refills
Lipitor 80 mg oral tablet, 80 mg= 1 tab(s), PO, daily

lisinopril 40 mg oral tablet, 40 mg= 1 tab(s), PO, daily
mirtazapine 15 mg oral tablet, 15 mg= 1 tab(s), PO, bedtime

nicotine 21 mg/24 hr transdermal film, extended release, 1 patch(es), transdermal, daily

Norvasc 10 mg oral tablet, 10 mg= 1 tab(s), PO, daily

pantoprazole 40 mg oral delayed release tablet, 40 mg= 1 tab(s), PO, daily
pregabalin 25 mg oral capsule, 25 mg= 1 capsule(s), PO, q8hrs

Allergies

NKA

Social History

Smoking Status - 05/19/2010

Current

Alcohol

Alcohol Use: Current. Frequency: Occasionally., 02/24/2023

Tobacco



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

*E.D. Documentation***Impression and Plan****1. Acute renal failure** (N17.9: Acute kidney failure, unspecified)**2. Leg wound, right** (S81.801A: Unspecified open wound, right lower leg, initial encounter)**3. Right leg DVT** (I82.401: Acute embolism and thrombosis of unspecified deep veins of right lower extremity)**4. Weight loss** (R63.4: Abnormal weight loss)**5. Lytic lesion of bone on x-ray** (M89.9: Disorder of bone, unspecified)**Appetite impaired** (R63.0: Anorexia)**Gastrointestinal bleed** (K92.2: Gastrointestinal hemorrhage, unspecified)**Right leg pain** (M79.604: Pain in right leg)**Aftercare Instructions**

Take all medications as prescribed. Return to the ED with any new or worsening symptoms, concern for adverse reaction to your medication, concern for your safety, or any other symptoms or concerns as discussed.

Critical Care Time

I spent approximately 30 minutes of critical care time in the care of this critically ill patient. This time excluded other billable procedure time. This time included my initial evaluation, multiple re-evaluations, interpretation of laboratories, imaging studies and EKG(s), discussion with consultant(s) and with the admitting physician. This patient had significant probability of severe morbidity and mortality.

Tobacco Use: 4 or less cigarettes(less than 1/4 pack)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 02/24/2023

Lab Results**Chemistry**

Sodium: 134mmol/L Low (05/08/24 14:35:05)

Potassium: 5.6mmol/L High (05/08/24 14:35:05)

Chloride: 107mmol/L Normal (05/08/24 14:35:05)

CO2: 17mmol/L Low (05/08/24 14:35:05)

Anion Gap: 10 Normal (05/08/24 14:35:05)

Glucose: 105mg/dL High (05/08/24 14:35:05)

BUN: 105mg/dL High (05/08/24 14:35:05)

Creatinine: 4.44mg/dL High (05/08/24 14:35:05)

eGFR: 14 N/A (05/08/24 14:35:05)

Calcium: 8.9mg/dL Normal (05/08/24 14:35:05)

Total Protein: 6.5gm/dL Normal (05/08/24 14:35:06)

Albumin: 3.0gm/dL Low (05/08/24 14:35:06)

Globulin: 3.5gm/dL Normal (05/08/24 14:35:06)

Bilirubin Total: 0.4mg/dL Normal (05/08/24 14:35:06)

Bilirubin Direct: 0.3mg/dL Normal (05/08/24 14:35:06)

Alkaline Phosphatase:

79units/L Normal (05/08/24 14:35:06)

AST: 34units/L Normal (05/08/24 14:35:06)

ALT: 32units/L Normal (05/08/24 14:35:06)

Cardiovascular Assays

Troponin I High Sensitivity:

15ng/L Normal (05/08/24 14:35:43)

Complete Blood CountWBC $\times 10^{12}$: 11.2/CMM Normal (05/08/24 14:06:49)

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***E.D. Documentation*

RBC $\times 10^6$: 2.38/CMM Low (05/08/24 14:06:49)
Hemoglobin: 7.5gm/dL Low (05/08/24 14:06:49)
Hematocrit: 22.5% Low (05/08/24 14:06:49)
MCV: 94.6fL Normal (05/08/24 14:06:49)
MCH: 31.7pg Normal (05/08/24 14:06:49)
MCHC: 33.5gm/dL Normal (05/08/24 14:06:49)
RDW: 17.5% High (05/08/24 14:06:49)
Platelets $\times 10^3$: 190/CMM Normal (05/08/24 14:06:49)
MPV: 8.6fL Normal (05/08/24 14:06:49)

Differential Automated

Neutrophils: 88.1% High (05/08/24 14:06:49)
Lymphocytes: 3.9% Low (05/08/24 14:06:49)
Monocytes: 5.1% Normal (05/08/24 14:06:49)
Eosinophils: 2.5% Normal (05/08/24 14:06:49)
Basophils: 0.4% Normal (05/08/24 14:06:49)
Neutrophils Absolute: 9.8x10⁹/mcL High (05/08/24 14:06:49)
Lymphocytes Absolute: 0.4x10⁹/mcL Low (05/08/24 14:06:49)
Monocytes Absolute: 0.6x10⁹/mcL Normal (05/08/24 14:06:49)
Eosinophils Absolute: 0.3x10⁹/mcL Normal (05/08/24 14:06:49)
Basophils Absolute: 0.0x10⁹/mcL Normal (05/08/24 14:06:49)

PT & or PTT

Prothrombin Time:
14.6second(s) High (05/08/24 14:17:40)
INR: 1.3 N/A (05/08/24 14:17:40)



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

E.D. Documentation

PTT: 38.4second(s) High (05/08/24
14:17:39)

Diagnostic Results

ED EKG Interpretation
12-lead EKG Interpretation by R Bracken,
DO
Rate 100
Normal sinus rhythm
No significant ST changes
Overall impression: No STEMI

Radiology

CT Brain/Head without Contrast
05/08/2024 15:01:50 * Final *
IMPRESSION:No significant acute intracranial abnormality.Mild to moderate global parenchymal volume loss.Mild to moderate age-indeterminate small vessel ischemic disease in the white matter.Nonspecific right parietal calvarial lucent lesions, possibly representing prominent arachnoid granulations, with other etiologies including metastatic disease or myeloma not entirely excluded. Correlation with previous available studies is recommended to assess for stability. Alternatively, bone scan may be performed for further evaluation.

XR Chest Portable 05/08/2024 15:03:11 *
Final *
IMPRESSION:New hazy the airspace disease/opacities along the right perihilar and infrahilar regions.There is no visible pleural effusion or pneumothorax.The cardiomedastinal silhouette is stable.No acute osseous abnormalities are identified.



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

E.D. Documentation

*Electronically Signed On: 05/08/2024 18:13 PDT
By: Bracken, DO, Richard H*

*Updated On: 05/08/2024 15:23 PDT
By: Bracken, DO, Richard H*

*Updated On: 05/08/2024 18:07 PDT
By: Bracken, DO, Richard H*

*Updated On: 05/08/2024 18:13 PDT
By: Bracken, DO, Richard H*

Scanned E.D. Records

ARIAS, DAVID 4452315

* Auth (Verified) *

ARIAS, DAVID

ID: 004452315 8-May-2024 13:44:23

TOKIACE MEMORIAL HOSPITAL

5/614509 US E
ARIAS, DAVID J.
Ma 68Y 07/06/1955 05/08/2024
44523155

Digitized by srujanika@gmail.com

Witai Sining



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

History & Physical

DOCUMENT NAME: History and Physical
 SERVICE DATE/TIME: 5/8/2024 16:11 PDT
 RESULT STATUS: Modified
 PERFORM INFORMATION: Patel,MD,Keyur A (5/8/2024 16:25 PDT)
 SIGN INFORMATION: Patel,MD,Keyur A (5/8/2024 16:32 PDT); Patel,MD,Keyur A (5/8/2024 16:25 PDT)

Chief Complaint

weak x 3 days, c/o leg pain, recent dx dvt, on blood thinners, bloody nose last night

History of Present Illness

68-year-old male with a history of alcohol abuse, TIA, coronary artery disease status post PCI many years ago, hypertension, COPD not on home oxygen who presents to the emergency room due to weakness/confusion as well as nose bleed.

Patient is accompanied by his sister, as well as daughter at bedside. Patient was admitted to our service mid March for GI bleed. At that time patient's hemoglobin remained stable, and he was to follow with GI as an outpatient. Recommendations at that time, as well as per patient's cardiologist Plavix was discontinued. Overall patient has been doing okay up until last few weeks which started experiencing confusion, weakness as well as falling down. He also has chronic lower extremity wounds which are managed by his podiatrist Dr.Shum. Recently, home health nurse ordered right lower extremity duplex due to swelling of his right lower extremity. This came back positive for acute DVT in the soleus vein. Patient was started on Eliquis as an outpatient. Shortly thereafter where she started experiencing nosebleed, which lasted for the past couple days. Due to his continued bleeding, as well as worsening confusion and weakness to a point where he has been unable to walk he presented to emergency room. Patient's nosebleed appears to be subsided. He denies chest pain, shortness of breath.

Review of Systems

10 points were asked for review of systems and are all negative except for which is mentioned in the history and physical.

Physical Exam**Vitals & Measurements**

T: 99.3 °F (Oral) HR: 105(Monitored) RR: 22 BP: 133/57 SpO2: 95% WT: 65 kg

Oxygen Saturation: 95 % (05/08/24 13:34:00)

Oxygen Therapy: Room air (05/08/24 14:06:00)

General: Alert and oriented, well nourished, no acute distress.

HEENT: Dried blood noticed on both nares. No active bleeding noted.

Lungs: Clear to auscultation and percussion, non-labored respiration.

Heart: Normal rate, regular rhythm, no murmur, gallop or edema.

Abdomen: Soft, non-tender, non-distended, normal bowel sounds, no masses.

Skin: Skin is warm, dry and pink, no rashes or lesions.

Neurologic: Awake, alert, and oriented X3, CN II-XII intact.

Extremities: Right lower extremity edema. Multiple wounds noted, mainly in shin, knee as well as lateral ankle.

rectal: Rectal exam done in ER by ER physician. Negative guaiac

Assessment/Plan

68-year-old male with a history of alcohol abuse, TIA, coronary artery disease status post PCI many years ago, hypertension, COPD not on home oxygen who presents to the emergency room due to weakness/confusion as well as nose bleed.

Problem List/Past Medical History**Ongoing**

Abrasions of right lower leg

Aftercare

Alcohol abuse

Anemia

CAD in native artery

Chronic renal insufficiency, stage III (moderate)

COPD type A

Diarrhea

Elevated transaminase level

Falls

History of heart artery stent

History of TIA (transient ischemic attack)

HTN (hypertension)

Hyponatremia

Mixed hyperlipidemia

Peripheral vascular disease

Thrombocytopenia

Tobacco use

Tobacco user

Weight loss

Historical

History of shingles

Medications**Home**

acyclovir 800 mg oral tablet, 800 mg= 1 tab(s), PO, 3xdaily

aspirin 81 mg oral delayed release tablet, 81 mg= 1 tab(s), PO, daily

Bactrim DS 800 mg-160 mg oral tablet, 1 tab(s), PO, 2xdaily

cephalexin 500 mg oral capsule, 500 mg= 1 capsule(s), PO, 2xdaily

doxazosin 2 mg oral tablet, 2 mg= 1 tab(s), PO, daily

Eliquis 2.5 mg oral tablet, 2.5 mg= 1 tab(s), PO, 2xdaily

lidocaine 5% topical ointment, 5 grams, topically, q12hrs, PRN, 1 refills

Lipitor 80 mg oral tablet, 80 mg= 1 tab(s), PO, daily

lisinopril 40 mg oral tablet, 40 mg= 1 tab(s), PO, daily

mirtazapine 15 mg oral tablet, 15 mg= 1 tab(s), PO, bedtime



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

History & Physical

#weakness/confusion likely due to uremia

#AKI on CKD stage

Cr: >4. baseline around 1-1.5

-hold home lisinopril

-Advised RN in the ED to do bladder scan, which was greater than 1 L Foley catheter replaced in ER.

-check renal US

-check urine lytes

-Monitor confusion. If patient's creatinine does not improved with Foley placement, will consult nephrology

-PT/OT eval

#acute RLE DVT

Calvarial lesions on CT scan

recent US on 5/3 showing + DVT soleus vein. Patient started on Eliquis as an outpatient.

-Due to nosebleed, will hold eliquis for now

-Due to DVT, though possible etiology could be immobility, as well as calvarial lesions will check SPEP/UPEP as well as light chains. check PSA

-check CT chest and CTAP

-Patient has appointment coming up with Dr. Lowe. will consult in-house for recommendations regarding treatment for his DVT and workup for MM?

-monitor H.h. appears at baseline

-NPO after midnight for possible IVC filter placement

Epistaxis

-H&H stable. Monitor

-hold asa and eliquis due to bleed

#chronic LLE wound

Mainly involving right lower extremity. Recent ER visit on May 3, and was prescribed Keflex as well as Bactrim. Given no overt cellulitic area noted, as well as normal white blood cell count we will hold off on antibiotics at this time.

-check xray R ankle to eval for osteo

-consult DPM. Dr.Shum, appreciate input

-follow up with vasc as o.p

History of TIA

-hold ASA due to nosebleed.

Hyperkalemia

#metabolic acidosis

-Elevated potassium noted. Hold home lisinopril. Lokelma x 1 dose. Start sodium bicarb given low CO2

Coronary artery disease

S/p PCI in 2020

#HTN

- continue home: amlodipine 10 mg po daily

- cont statin

- resume asa when nosebleeds stops

nicotine 21 mg/24 hr transdermal film, extended release, 1 patch(es), transdermal, daily

Norvasc 10 mg oral tablet, 10 mg= 1 tab(s), PO, daily

pantoprazole 40 mg oral delayed release tablet, 40 mg= 1 tab(s), PO, daily

pregabalin 25 mg oral capsule, 25 mg= 1 capsule(s), PO, q8hrs

Allergies

NKA

Social HistorySmoking Status - 05/19/2010

Current

Alcohol

Alcohol Use: Current. Frequency: Occasionally., 02/24/2023

Tobacco

Tobacco Use: 4 or less cigarettes(less than 1/4 pack)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 02/24/2023

Lab Results**Chemistry**

Sodium: 134 mmol/L Low (05/08/24 14:35:05)

Potassium: 5.6 mmol/L High (05/08/24 14:35:05)

Chloride: 107mmol/L (05/08/24 14:35:05)

CO₂: 17 mmol/L Low (05/08/24 14:35:05)

Anion Gap: 10 (05/08/24 14:35:05)

Glucose: 105 mg/dL High (05/08/24 14:35:05)

BUN: 105 mg/dL High (05/08/24 14:35:05)

Creatinine: 4.44 mg/dL High (05/08/24 14:35:05)

eGFR: 14 (05/08/24 14:35:05)

Calcium: 8.9mg/dL (05/08/24 14:35:05)

Total Protein: 6.5gm/dL (05/08/24 14:35:06)

Albumin: 3.0 gm/dL Low (05/08/24 14:35:06)

Globulin: 3.5gm/dL (05/08/24 14:35:06)

Bilirubin Total: 0.4mg/dL (05/08/24 14:35:06)

Bilirubin Direct: 0.3mg/dL (05/08/24 14:35:06)

Alkaline Phosphatase: 79units/L (05/08/24 14:35:06)

AST: 34units/L (05/08/24 14:35:06)

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509*****History & Physical***

Alcohol use disorder, mild, without withdrawal
-monitor

Chronic obstructive pulmonary disease: emphysema
-stable
-PRN bronchodilators

ALT: 32units/L (05/08/24 14:35:06)

Cardiovascular Assays

Troponin I High Sensitivity: 15ng/L (05/08/24 14:35:43)

Complete Blood Count

WBC x 10³: 11.2/CMM (05/08/24 14:06:49)
RBC x 10⁶: 2.38 /CMM Low (05/08/24 14:06:49)
Hemoglobin: 7.5 gm/dL Low (05/08/24 14:06:49)
Hematocrit: 22.5 % Low (05/08/24 14:06:49)
MCV: 94.6fL (05/08/24 14:06:49)
MCH: 31.7pg (05/08/24 14:06:49)
MCHC: 33.5gm/dL (05/08/24 14:06:49)
RDW: 17.5 % High (05/08/24 14:06:49)
Platelets x 10³: 190/CMM (05/08/24 14:06:49)
MPV: 8.6fL (05/08/24 14:06:49)

Differential Automated

Neutrophils: 88.1 % High (05/08/24 14:06:49)
Lymphocytes: 3.9 % Low (05/08/24 14:06:49)
Monocytes: 5.1% (05/08/24 14:06:49)
Eosinophils: 2.5% (05/08/24 14:06:49)
Basophils: 0.4% (05/08/24 14:06:49)
Neutrophils Absolute: 9.9 x10e3/mcL High (05/08/24 14:06:49)
Lymphocytes Absolute: 0.4 x10e3/mcL Low (05/08/24 14:06:49)
Monocytes Absolute: 0.6x10e3/mcL (05/08/24 14:06:49)
Eosinophils Absolute: 0.3x10e3/mcL (05/08/24 14:06:49)
Basophils Absolute: 0.0x10e3/mcL (05/08/24 14:06:49)

PT & or PTT

Prothrombin Time: 14.6 second(s) High (05/08/24 14:17:40)
INR: 1.3 (05/08/24 14:17:40)
PTT: 38.4 second(s) High (05/08/24 14:17:39)

Blood Type

ABORh: O POS (05/08/24 15:45:21)

Antibody Screen/Identification

Antibody Screen: Negative (05/08/24 15:45:22)



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

History & Physical

Diagnostic Results

CT Brain/Head without Contrast 05/08/2024
15:01:50 * Final *

IMPRESSION: NO SIGNIFICANT ACUTE INTRACRANIAL ABNORMALITY. MILD TO MODERATE GLOBAL PARENCHYMAL VOLUME LOSS. MILD TO MODERATE AGE-UNDETERMINATE SMALL VESSEL ISCHEMIC DISEASE IN THE WHITE MATTER. NONSPECIFIC RIGHT PARIETAL CALVARIAL LUENT LESIONS, POSSIBLY REPRESENTING PROMINENT ARACHNOID GRANULATIONS, WITH OTHER ETIOLOGIES INCLUDING METASTATIC DISEASE OR MYELOMA NOT ENTIRELY EXCLUDED. CORRELATION WITH PREVIOUS AVAILABLE STUDIES IS RECOMMENDED TO ASSESS FOR STABILITY. ALTERNATIVELY, BONE SCAN MAY BE PERFORMED FOR FURTHER EVALUATION.

XR Ankle Complete Right (4V) * New *

XR Tibia/Fibula Right * New *

XR Chest Portable 05/08/2024 15:03:11 *
Final *

IMPRESSION: NEW HAZY THE AIRSPACE DISEASE/OPACITIES ALONG THE RIGHT PERIHILAR AND INFRAHILAR REGIONS. THERE IS NO VISIBLE PLEURAL EFFUSION OR PNEUMOTHORAX. THE CARDIOMEDIASTINAL SILHOUETTE IS STABLE. NO ACUTE OSSEOUS ABNORMALITIES ARE IDENTIFIED.

US Renal * New *

Electronically Signed On: 05/08/2024 16:25 PDT
By: Patel, MD, Keyur A

Electronically Signed On: 05/08/2024 16:32 PDT
By: Patel, MD, Keyur A

Updated On: 05/08/2024 16:32 PDT
By: Patel, MD, Keyur A

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***History & Physical*



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

History & Physical

DOCUMENT NAME: History and Physical
 SERVICE DATE/TIME: 5/13/2024 14:07 PDT
 RESULT STATUS: Auth (Verified)
 PERFORM INFORMATION: So,MD,George J (5/13/2024 14:07 PDT)
 SIGN INFORMATION: So,MD,George J (5/13/2024 14:07 PDT)

History & Physical Update

The History & Physical and subsequent events were reviewed and a Physical Exam was performed. No significant change from the Admission History & Physical was found.

*Electronically Signed On: 05/13/2024 14:07 PDT
By: So, MD, George J*

Consultations

DOCUMENT NAME: Clinical Nutrition Consultation
 SERVICE DATE/TIME: 5/13/2024 16:10 PDT
 RESULT STATUS: Auth (Verified)
 PERFORM INFORMATION: Deen,MD,Omer J (5/13/2024 16:12 PDT)
 SIGN INFORMATION: Deen,MD,Omer J (5/13/2024 17:27 PDT)

Reason for Consultation

Malnutrition

Requesting Provider

Dr. Keyur Patel

Chief Complaint

weak x 3 days, c/o leg pain, recent dx dvt, on blood thinners, bloody nose last night

History of Present Illness

This patient is known to me from a previous hospitalization in March 2024. He is a 68-year-old male with a history of hypertension, tobacco use, alcohol use, history of TIA, coronary artery disease, stage III chronic kidney disease and chronic obstructive pulmonary disease who was hospitalized with epistaxis, lethargy and weakness for several days. He states that he has not been eating well at home and has been drinking beer more regularly. He states that he has lost weight over the past few months although he is unable to quantify the degree of weight loss. During the second half of 2023, he had lost 60 pounds unintentionally. He has had a steady decline in appetite and oral intake over the past 6 months but this has been most pronounced over the past week. He was n.p.o. for a bone marrow biopsy but is now being started on a diet. He states his last colonoscopy was 5 years ago or so but cannot remember details about what they found.

Review of Systems

Positive for generalized weakness, fatigue, lethargy, anorexia, unintentional weight loss, nausea, vomiting, diarrhea.

Physical Exam

Vitals & Measurements

T: 98.5 °F (Temporal Artery) TMIN: 98 °F (Temporal Artery) TMAX: 100.6 °F (Oral) HR: 85(Monitored) RR: 16 BP: 100/49 SpO2: 95% WT: 59.8 kg

Problem List/Past Medical History

Ongoing

- Abrasions of right lower leg
- Aftercare
- Alcohol abuse
- Anemia
- CAD in native artery
- Chronic renal insufficiency, stage III (moderate)
- COPD type A
- Diarrhea
- Elevated transaminase level
- Falls
- History of heart artery stent
- History of TIA (transient ischemic attack)
- HTN (hypertension)
- Hyponatremia
- Mixed hyperlipidemia
- Peripheral vascular disease
- Thrombocytopenia
- Tobacco use
- Tobacco user
- Weight loss

Historical

History of shingles

Procedure/Surgical History

- cardiac stent placement
- femoral stent placement
- L knee replacement



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

General: Alert and oriented, cachectic appearing, weak but in no acute distress.
HEENT: Hair loss, PERRLA, EOMI, moist oral mucosa, no scleral icterus, no sinus tenderness.
Lungs: Clear to auscultation and percussion, non-labored respiration.
Heart: Normal rate, regular rhythm, no murmur, gallop or edema.
Abdomen: Soft, non-tender, non-distended, normal bowel sounds, no masses.
Extremities: No evidence of cyanosis, clubbing, or edema. Sarcopenia evident.

Assessment/Plan

Severe protein calorie malnutrition
 Anorexia
 Unintentional weight loss
 Cachexia
 Alcohol abuse

The patient currently weighs 59.8 kg and has a body mass index of 19.5. He has lost 60 pounds unintentionally over the second half of 2023. He has had a decline in appetite and oral intake. He has numerous chronic comorbidities, raising baseline metabolic demand. He has a history of alcohol abuse and is an active smoker. He does have evidence of hair loss and muscle wasting on exam. Based on limited history and physical exam, I would characterize him acutely as having severe protein calorie malnutrition.

Check prealbumin level, 25-hydroxy vitamin D level as well as iron studies. Monitor H&H closely. Increase mirtazapine to 30 mg daily. Regular unrestricted diet. Nutrition supplement twice daily along with vitamin/mineral repletion, including thiamine and folic acid. Saccharomyces boulardii twice daily. Monitor oral intake closely. Follow stool volume/consistency as well. Bowel regimen as needed. Daily adjustments based on glucose, fluid and electrolyte status will be made. Appreciate RD assistance.

Thank you, Dr. Patel. I appreciate the opportunity to assist in the care of this patient. I will continue to follow along and make recommendations based on his clinical course.

Medications

Inpatient

acetaminophen tablet - 650 mg by mouth every 4 hours.
 albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution - 3 mL hand held nebulizer every 4 hours.
 AtiVAN tab - 1 mg by mouth every 8 hours.
 Bactrim DS Tab - 1 tab(s) by mouth twice a day.
 doxazosin - 2 mg by mouth once daily.
 fentaNYL - 25 mcg IVP every 5 minutes as needed.
 fentaNYL - 75 mcg IVP every 5 minutes as needed.
 fentaNYL - 50 mcg IVP every 5 minutes as needed.
 hydrALAZINE injection - 10 mg IVP every 10 minutes as needed.
 hydrALAZINE injection - 10 mg IVP every 6 hours.
 hydrALAZINE tab - 25 mg by mouth every 6 hours.
 labetalol injection - 15 mg IVP every 5 minutes as needed.
 Lipitor 80 mg oral tablet - 80 mg by mouth once daily.
 mirtazapine - 15 mg by mouth at bedtime.
 morphine inj dose 2mg or less - 2 mg IVP every 4 hours.
 Nicoderm 21mg/24hr patch - 21 mg transdermally once daily.
 Normal saline - Infusion 1,000 mL - 1,000 mL by intravenous infusion .
 Norvasc - 10 mg by mouth once daily.
 omeprazole delayed release cap - 40 mg by mouth once daily.
 ondansetron injection - 4 mg IVP every 4 hours.
 ondansetron injection - 4 mg IVP every 6 hours.
 ondansetron SL tab - 4 mg under the tongue as needed.
 Percocet 10 mg-325 mg oral tablet - 1 tab(s) by mouth every 4 hours.
 Phytoplex Clear-Aid 71.5%-1% topical ointment - 1 application topically twice a day.
 pregabalin - 25 mg by mouth every 8 hours.
 remove patch - 1 patch(es) topically every 24 hours.
 Rena-Vite - 1 tab(s) by mouth once daily.
 Senokot S 50 mg-8.6 mg oral tablet - 2 tab(s) by mouth once daily.
 Seroquel - 25 mg by mouth at bedtime.
 sodium bicarbonate tab - 650 mg by mouth

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509**

Consultations

three times a day.

traMADol - 50 mg by mouth every 6 hours.
Transfer of Level of Care Notification - 1 each
miscellaneous Take note..

Vitamin C tab - 250 mg by mouth once daily.
zinc sulfate - 220 mg by mouth once daily.

Home

acetaminophen-hydrocodone 325 mg-10 mg
oral tablet - 1 tab(s) by mouth every 4 hours
as needed for as needed for pain.

aspirin 81 mg oral delayed release tablet - 81
mg by mouth once daily.

Bactrim DS 800 mg-160 mg oral tablet - 1
tab(s) by mouth twice a day.

cephalexin 500 mg oral capsule - 500 mg by
mouth twice a day.

folic acid 0.8 mg oral tablet - 0.8 mg by
mouth once daily.

Lipitor 80 mg oral tablet - 80 mg by mouth
once daily.

mirtazapine 15 mg oral tablet - 15 mg by
mouth at bedtime.

Norvasc 10 mg oral tablet - 10 mg by mouth
once dailySBP>160.

pantoprazole 40 mg oral delayed release
tablet - 40 mg by mouth once daily.

pregabalin 25 mg oral capsule - 25 mg by
mouth every 8 hoursstart at bed time only. If
not to sleepy after 5 days take BID for 5
days, if not sleepy can take TID.

tamsulosin 0.4 mg oral capsule - 0.4 mg by
mouth once daily.

Vitamin B12 250 mcg oral tablet - 500 mcg
by mouth once daily.

Vitamin C 1000 mg oral tablet - 1,000 mg by
mouth once daily.

zinc (as acetate) 50 mg oral capsule - 50 mg
by mouth three times a day.

Allergies

NKA

Social History

Smoking Status - 05/19/2010

Current

Alcohol

Alcohol Use: Current. Type: Beer.

Frequency: Weekly. Amount: 1 can beer
5/7/2024., 05/08/2024

Alcohol Use: Current. Frequency:
Occasionally., 02/24/2023

Substance Abuse

Drug Use: None., 05/08/2024

Tobacco

Tobacco Use: 10 or more cigarettes (1/2
pack or more)/day in last 30 days. Type:

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509*****Consultations***

Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 05/08/2024

Tobacco Use: 4 or less cigarettes(less than 1/4 pack)/day in last 30 days. Type:

Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 02/24/2023

Family History

Asthma: Child.

High blood pressure: Father.

Joint: Child.

Lab Results**Chemistry**

Sodium: 137mmol/L (05/13/24 06:56:05)

Potassium: 4.6mmol/L (05/13/24

06:56:05)

Chloride: 109 mmol/L High (05/13/24
06:56:05)

CO2: 22mmol/L (05/13/24 06:56:05)

Anion Gap: 6 (05/13/24 06:56:05)

Glucose: 99mg/dL (05/13/24 06:56:05)

BUN: 25mg/dL (05/13/24 06:56:05)

Creatinine: 1.34 mg/dL High (05/13/24
06:56:05)

eGFR: 58 (05/13/24 06:56:05)

Calcium: 7.4 mg/dL Low (05/13/24
06:56:05)Total Protein: 5.0 gm/dL Low (05/13/24
06:56:05)Albumin: 2.1 gm/dL Low (05/13/24
06:56:05)

Globulin: 2.9gm/dL (05/13/24 06:56:05)

Bilirubin Total: 0.3mg/dL (05/13/24
06:56:05)Alkaline Phosphatase: 47units/L
(05/13/24 06:56:05)AST: 39 units/L High (05/13/24
06:56:05)

ALT: 42units/L (05/13/24 06:56:05)

Complete Blood CountWBC x 10³: 8.3/CMM (05/13/24
06:49:59)RBC x 10⁶: 2.31 /CMM Low (05/13/24
06:49:59)Hemoglobin: 7.2 gm/dL Low (05/13/24
06:49:59)Hematocrit: 21.4 % Low (05/13/24
06:49:59)

MCV: 92.6fL (05/13/24 06:49:59)

MCH: 31.2pg (05/13/24 06:49:59)

MCHC: 33.7gm/dL (05/13/24 06:49:59)



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
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Consultations

RDW: 17.2 % High (05/13/24 06:49:59)
Platelets x 10³: 154/CMM (05/13/24
06:49:59)
MPV: 9.2fL (05/13/24 06:49:59)

Differential Automated

Neutrophils: 81.5 % High (05/13/24
06:49:59)
Lymphocytes: 8.4 % Low (05/13/24
06:49:59)
Monocytes: 4.1% (05/13/24 06:49:59)
Eosinophils: 5.7% (05/13/24 06:49:59)
Basophils: 0.3% (05/13/24 06:49:59)
Neutrophils Absolute: 6.7x10e3/mcL
(05/13/24 06:49:59)
Lymphocytes Absolute: 0.7x10e3/mcL
(05/13/24 06:49:59)
Monocytes Absolute: 0.3x10e3/mcL
(05/13/24 06:49:59)
Eosinophils Absolute: 0.5x10e3/mcL
(05/13/24 06:49:59)
Basophils Absolute: 0.0x10e3/mcL
(05/13/24 06:49:59)

Hematology other

Sedimentation Rate: 15mm/hr (05/13/24
07:27:36)

PT & or PTT

Prothrombin Time: 14.0 second(s) High
(05/13/24 06:40:59)
INR: 1.2 (05/13/24 06:40:59)

Immunology

CRP Non-Cardiac: 5.96 mg/dL High
(05/13/24 06:56:04)

Diagnostic Results

CT Biopsy 05/13/2024 15:49:25 *

Transcribed *

IMPRESSION: CT-GUIDED CORE
BIOPSIES OF THE SMALL LEFT ILIAC
WING BONE LYtic LESION.



Patient Name: ARIAS, DAVID J

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FIN: 57614509

Consultations

DOCUMENT NAME:
 SERVICE DATE/TIME:
 RESULT STATUS:
 PERFORM INFORMATION:
 SIGN INFORMATION:

Oncology/Hematology Consultation
 5/9/2024 09:16 PDT
 Auth (Verified)
 Lowe,MD,Thomas E (5/9/2024 09:57 PDT)
 Lowe,MD,Thomas E (5/9/2024 09:57 PDT)

Reason for Consultation

DVT, bleeding

Requesting Provider

ER

Chief Complaint

weak x 3 days, c/o leg pain, recent dx dvt, on blood thinners, bloody nose last night

History of Present Illness

History is obtained from the chart as the patient is confused and unable to give a good history. I also spoke to his wife on the phone.

This is a 68-year-old male with multiple comorbidities and active health issues. Per available records, he has history of alcohol abuse, TIA, coronary artery disease with history of PCI, COPD but not oxygen dependent who has had multiple admissions this year.

He was admitted 03/10/2024 03/15/2024 with melena and guaiac positive stool for which she stopped his Plavix and was recommended to see GI as an outpatient. He also had lower extremity wounds with cellulitis and received wound care at that time and treated with antibiotics. He presented back to the emergency room on 05/03/2024 with increased swelling of the right lower extremity. He was placed on low-dose Eliquis at just 2.5 mg twice daily due to his history of bleeding issues but then presented back to the emergency room and admitted on 05/08/2024 with confusion and nosebleeds. He was found to have urinary retention with acute renal failure also very confused. CT imaging incidentally showed possible bony lesions. Further CT scans have shown a small 12 mm suspicious right upper lobe spiculated lung nodule and multiple small subtle lytic lesions. He also had interval appearance of moderate right and mild left hydronephrosis likely due to bladder obstruction.

His wife said that he is been deteriorating for the last couple months. He still drinks occasional alcohol but averaging about 3 beers per week. He has had intermittent confusion which is markedly worsening over the past 2 months and more recently has actually been having some hallucinations. He has not been able to feed himself recently.

Review of Systems

Unable to obtain

Physical Exam**Vitals & Measurements**

T: 98.0 °F (Oral) TMIN: 97.1 °F (Oral) TMAX: 99.3 °F (Oral) HR: 90(Monitored)
 RR: 20 BP: 127/66 SpO2: 95% WT: 64.3 kg

Gen: Awake. Confused. Knows year and his name but does not know who I am or where he is.

Cardiac: RRR

Problem List/Past Medical History**Ongoing**

Abrasions of right lower leg
 Aftercare
 Alcohol abuse
 Anemia
 CAD in native artery
 Chronic renal insufficiency, stage III (moderate)
 COPD type A
 Diarrhea
 Elevated transaminase level
 Falls
 History of heart artery stent
 History of TIA (transient ischemic attack)
 HTN (hypertension)
 Hyponatremia
 Mixed hyperlipidemia
 Peripheral vascular disease
 Thrombocytopenia
 Tobacco use
 Tobacco user
 Weight loss

Historical

History of shingles

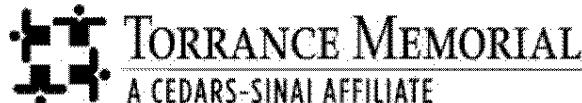
Procedure/Surgical History

Procedures performed at TMMC - last 20 years

Procedure: VIDEO ARTHROSCOPY KNEE (05/19/10)

Medications**Inpatient**

acetaminophen tablet - 650 mg by mouth every 4 hours.
 acetaminophen-hydrocodone 325 mg-5 mg oral tablet - 1 tab(s) by mouth every 4 hours.
 albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution - 3 mL hand held nebulizer every 4 hours.
 doxazosin - 2 mg by mouth once daily.
 hydrALAZINE injection - 10 mg IVP every 6 hours.
 hydrALAZINE tab - 25 mg by mouth every 6 hours.
 Lipitor 80 mg oral tablet - 80 mg by mouth once daily.
 magnesium sulfate IVPB - 2 gm IV piggyback



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Abd: Soft, NTND

One Time Only.

mirtazapine - 15 mg by mouth at bedtime.

Ext: No c/c. \mild R>L edema. + bandages and L protective boot.

Nicoderm 21mg/24hr patch - 21 mg

transdermally once daily.

Norvasc - 10 mg by mouth once daily.

omeprazole delayed release cap - 40 mg by mouth once daily.

ondansetron injection - 4 mg IVP every 4 hours.

pregabalin - 25 mg by mouth every 8 hours. remove patch - 1 patch(es) topically every 24 hours.

Senokot S 50 mg-8.6 mg oral tablet - 2 tab(s) by mouth once daily.

sodium bicarbonate tab - 650 mg by mouth three times a day.

trAMADol - 50 mg by mouth every 6 hours.

Home

acetaminophen-hydrocodone 325 mg-10 mg oral tablet - 1 tab(s) by mouth every 4 hours as needed for as needed for pain.

aspirin 81 mg oral delayed release tablet - 81 mg by mouth once daily.

Bactrim DS 800 mg-160 mg oral tablet - 1 tab(s) by mouth twice a day.

cephalexin 500 mg oral capsule - 500 mg by mouth twice a day.

folic acid 0.8 mg oral tablet - 0.8 mg by mouth once daily.

Lipitor 80 mg oral tablet - 80 mg by mouth once daily.

mirtazapine 15 mg oral tablet - 15 mg by mouth at bedtime.

Norvasc 10 mg oral tablet - 10 mg by mouth once dailySBP>160.

pantoprazole 40 mg oral delayed release tablet - 40 mg by mouth once daily.

pregabalin 25 mg oral capsule - 25 mg by mouth every 8 hoursstart at bed time only. If not to sleepy after 5 days take BID for 5 days, if not sleepy can take TID.

tamsulosin 0.4 mg oral capsule - 0.4 mg by mouth once daily.

Vitamin B12 250 mcg oral tablet - 500 mcg by mouth once daily.

Vitamin C 1000 mg oral tablet - 1,000 mg by mouth once daily.

zinc (as acetate) 50 mg oral capsule - 50 mg by mouth three times a day.

Allergies

NKA

Social History

Smoking Status - 05/19/2010

Current

Assessment/Plan

Acute renal failure (N17.9: Acute kidney failure, unspecified)

Appetite impaired (R63.0: Anorexia)

Gastrointestinal bleed (K92.2: Gastrointestinal hemorrhage, unspecified)

Leg wound, right (S81.801A: Unspecified open wound, right lower leg, initial encounter)

Lytic lesion of bone on x-ray (M89.9: Disorder of bone, unspecified)

Right leg DVT (I82.401: Acute embolism and thrombosis of unspecified deep veins of right lower extremity)

Right leg pain (M79.604: Pain in right leg)

Weight loss (R63.4: Abnormal weight loss)

This is a 68-year-old male with multiple comorbidities and active health issues. Per available records, he has history of alcohol abuse, TIA, coronary artery disease with history of PCI, COPD but not oxygen dependent who has had multiple admissions this year. He was admitted 03/10/2024 03/15/2024 with melena and guaiac positive stool for which he stopped his Plavix and was recommended to see GI as an outpatient. He also had lower extremity wounds with cellulitis and received wound care at that time and treated with antibiotics. He presented back to the emergency room on 05/03/2024 with increased swelling of the right lower extremity. He was placed on low-dose Eliquis at just 2.5 mg twice daily due to his history of bleeding issues but then presented back to the emergency room and admitted on 05/08/2024 with confusion and nosebleeds. He was found to have urinary retention with acute renal failure also very confused. CT imaging incidentally showed possible bony lesions. Further CT scans have shown a small 12 mm suspicious right upper lobe spiculated lung nodule and multiple small subtle lytic lesions. He also had interval appearance of moderate right and mild left hydronephrosis likely due to bladder obstruction. His wife said that he is been deteriorating for the last couple months. He still drinks occasional alcohol but averaging about 3 beers per week. He has had intermittent confusion which is markedly worsening over the past 2 months and more recently has actually been having some hallucinations. He has not been able to feed himself recently.

#. RLE DVT.

Right lower extremity Doppler ultrasound 05/03/2024 showed an occlusive thrombus in the right soleus vein.

He was placed on low-dose Eliquis at 2.5 mg twice daily due to his history of abnormal bleeding and CKD. He developed epistaxis and was admitted through the ER on 05/08/2024.



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Consultations

I do not think he will tolerate further anticoagulation and therefore recommended an IVC filter.

#. Possible bone metastasis. Suspicious small lung lesion which may or may not be related.

Small subtle lytic lesion in the endosteal left superior iliac bone with cortical thinning on series 2-142 and series 2-143. Focal lytic expansile lesion of the right posterior 12th rib on series 2-113 and additional possible subtle endosteal lytic lesion in the posterior right 11th rib on series 2-93. Possible subtle lytic lesions at the base of the left L2 pedicle on series 2-114. Suggest clinical correlation to exclude multiple myeloma versus metastases.

The patient CT of the brain done for confusion on 05/08/2024 was negative for acute changes but incidentally reported nonspecific right calvarial lucent lesions which radiology felt could be benign but cannot rule out metastatic disease.

CT C/A/P 05/08/2024: small areas of sclerosis in the right anterior sixth rib near the costochondral cartilage which was felt to be posttraumatic and benign. There is a 6 x 12 x 9 mm highly irregular spiculated noncalcified nodule in the posterior segment of the right upper lobe bordering on the major fissure with mild focal pleural thickening. 15 x 8 x 13 mm groundglass nodule in the medial lingula adjacent to the mediastinal pleura. Small areas of peribronchial nodularity/bronchial wall thickening in the right upper lobe as well as scattered areas of tree-in-bud micronodularity in the right upper and lower lobes with a few scattered small sub-4 mm pulmonary nodules, except for a 6 mm noncalcified groundglass nodule in the posterior right lower lobe superior segment on series 3-52. Small subtle lytic lesion in the endosteal left superior iliac bone with cortical thinning on series 2-142 and series 2-143. Focal lytic expansile lesion of the right posterior 12th rib on series 2-113 and additional possible subtle endosteal lytic lesion in the posterior right 11th rib on series 2-93. Possible subtle lytic lesions at the base of the left L2 pedicle on series 2-114. Suggest clinical correlation to exclude multiple myeloma versus metastases.

Myeloma workup has been ordered. I will also order a PSA. A CT guided bone biopsy should be considered at some point when pt stabilized enough-defer when deemed appropriate to hospitalist.

#. ARF/hydronephrosis/bladder obstruction

The patient's baseline creatinine 03/2024 was in the low ones. His creatinine had increased to 1.4 x 04/13/24 at that up to 1.7 on 05/03/2024. On this admission his creatinine was 4.44 and he was found to have urinary retention and hydronephrosis and a Foley catheter was placed. Creat now improving. PSA was mildly elevated at 6.8 (05/09/2024).

Defer workup to hospitalist +/- urology.

#. Normocytic anemia.

This appears multifactorial. His baseline hemoglobin was 10.4 (03/10/2024). It decreased down to the eights during his 03/2024 admission and now down to the sixes.

Alcohol

Alcohol Use: Current. Type: Beer.
Frequency: Weekly. Amount: 1 can beer
5/7/2024., 05/08/2024

Alcohnl Use: Current. Frequency:
Occasionally., 02/24/2023

Substance Abuse

Drug Use: None., 05/08/2024

Tobacco

Tobacco Use: 10 or more cigarettes (1/2 pack or more)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 05/08/2024

Tobacco Use: 4 or less cigarettes/less than 1/4 pack)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 02/24/2023

Family History

Asthma: Child.

High blood pressure: Father.

Joint: Child.

Lab Results

Chemistry

Sodium: 135 mmol/L Low (05/09/24 05:43:33)
Potassium: 4.2mmol/L (05/09/24 05:43:33)
Chloride: 111 mmol/L High (05/09/24 05:43:33)
CO₂: 16 mmol/L Low (05/09/24 05:43:33)
Anion Gap: 8 (05/09/24 05:43:33)
Glucose: 112 mg/dL High (05/09/24 05:43:33)
BUN: 83 mg/dL High (05/09/24 05:43:33)
Creatinine: 3.00 mg/dL High (05/09/24 05:43:33)
eGFR: 22 (05/09/24 05:43:33)
Calcium: 8.3 mg/dL Low (05/09/24 05:43:33)
Magnesium: 1.7mg/dL (05/09/24 05:43:32)
Total Protein: 5.2 gm/dL Low (05/09/24 05:43:33)
Albumin: 2.4 gm/dL Low (05/09/24 05:43:33)
Globulin: 2.8gm/dL (05/09/24 05:43:33)
Bilirubin Total: 0.4mg/dL (05/09/24 05:43:33)
Bilirubin Direct: 0.3mg/dL (05/09/24 05:43:33)
Alkaline Phosphatase: 65units/L (05/09/24 05:43:33)
AST: 29units/L (05/09/24 05:43:33)
ALT: 27units/L (05/09/24 05:43:33)



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He likely has some baseline anemia due to anemia of CKD and then developed bleeding with a GI bleed 03/2024 and then admitted with epistaxis 05/2024.

#. Alcohol abuse. Patient has history of heavy alcohol use but per the patient's wife he now only averages about 3 beers per week. LFTs are normal. CT abdomen was negative for evidence of cirrhosis and spleen size was described as normal.

I do not see a reticulocyte count in the past so I will order this but notably this will be posttransfusion. His previous iron labs 03/12/2024 reported an iron saturation of 36% with a UIBC of 115 and a ferritin 334. His high ferritin also is supportive of chronic disease/inflammation.

We are also working up his bone lesions as above.

Recommend transfusions as needed.

#-Miscellaneous/social. The patient lives with his wife. I spoke to her on the phone. She understands that he is very ill and has multiple different active medical issues. We discussed that he might have bone metastasis. He is already DNR though intubation okay. We discussed that with his multiple comorbidities and fragile state and possible cancer, that DNI may also be appropriate. I expressed that we will do our best to help him but it may be difficult to get to a meaningful recovery should he have metastatic cancer.

I thank my colleagues for allowing me to participate in this patient's care. As above, plan transfusions as needed for his anemia and avoid further blood thinners. If he stabilizes and deemed appropriate, I would recommend a CT-guided bone biopsy under sedation. Please contact me when/if that is done.

Cardiovascular Assays

Troponin I High Sensitivity: 15ng/L
(05/08/24 14:35:43)

Tumor Marker

Prostatic Specific Antigen (PSA):
6.80 ng/mL High (05/09/24 06:23:05)

Urine Random Chemistry

Creatinine Random Urine: 59.0mg/dL
(05/08/24 17:15:42)
Potassium Random Urine: 27.6mmol/L
(05/08/24 17:15:32)
Sodium Random Urine: 54mmol/L
(05/08/24 17:15:33)

Complete Blood Count

WBC $\times 10^3$: 7.7/CMM (05/09/24 05:25:56)
RBC $\times 10^6$: 2.91 /CMM Low (05/09/24
05:25:56)
Hemoglobin: 6.4 gm/dL Low (05/09/24
05:25:56)
Hematocrit: 18.9 % Low (05/09/24
05:25:56)
MCV: 93.8fL (05/09/24 05:25:56)
MCH: 31.8pg (05/09/24 05:25:56)
MCHC: 33.9gm/dL (05/09/24 05:25:56)
RDW: 17.1 % High (05/09/24 05:25:56)
Platelets $\times 10^3$: 164/CMM (05/09/24
05:25:56)
MPV: 8.7fL (05/09/24 05:25:56)

Differential Automated

Neutrophils: 84.1 % High (05/09/24
05:25:56)
Lymphocytes: 6.8 % Low (05/09/24
05:25:56)
Monocytes: 5.2% (05/09/24 05:25:56)
Eosinophils: 3.4% (05/09/24 05:25:56)
Basophils: 0.5% (05/09/24 05:25:56)
Neutrophils Absolute: 6.5x10e3/mcL
(05/09/24 05:25:56)
Lymphocytes Absolute: 0.5 x10e3/mcL
Low (05/09/24 05:25:56)
Monocytes Absolute: 0.4x10e3/mcL
(05/09/24 05:25:56)
Eosinophils Absolute: 0.3x10e3/mcL
(05/09/24 05:25:56)
Basophils Absolute: 0.0x10e3/mcL
(05/09/24 05:25:56)

Hematology other

Eosinophil Smear: None Seen (05/08/24
18:20:53)

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Eosinophil Smear Source: URINE
(05/08/24 18:20:53)

PT & or PTT

Prothrombin Time: 14.6 second(s) High
(05/08/24 14:17:40)
INR: 1.3 (05/08/24 14:17:40)
PTT: 38.4 second(s) High (05/08/24
14:17:39)

Macroscopic Urinalysis

Source UA: Urine Foley (05/08/24
17:22:09)
Clarity UA: Clear (05/08/24 17:22:09)
Color UA: Light-Yellow (05/08/24 17:22:09)
Specific Gravity UA: 1.013 (05/08/24
17:22:09)
pH UA: 6 (05/08/24 17:22:09)
Protein UA: 30 (1+)mg/dL (05/08/24
17:22:09)
Glucose UA: Normal (<30)mg/dL (05/08/24
17:22:09)
Ketones UA: Negative mg/dL (05/08/24
17:22:09)
Blood UA: 0 ? (?+)mg/dL (05/08/24
17:22:09)
Nitrite UA: Negative (05/08/24 17:22:09)
Bilirubin UA: Negative (<0.5)mg/dL
(05/08/24 17:22:09)
Urobilinogen UA: Normal (<2)mg/dL
(05/08/24 17:22:09)
Leukocyte Esterase UA: 250
(2+)WBCs/microLiter (05/08/24 17:22:09)

Microscopic Urinalysis

Urine Microscopy?: Auto (05/08/24
17:22:09)
WBC/hpf: 21-50/HPF (05/08/24 17:22:09)
RBC/hpf: >20/HPF (05/08/24 17:22:09)
Bacteria: Few (1+)/HPF (05/08/24
17:22:09)
Squamous Epithelial Cells: Rare (Tr)/LPF
(05/08/24 17:22:09)
Urinalysis Culture Reflex: Indicated
(05/08/24 17:22:09)

Blood Type

ABORh: O POS (05/08/24 15:45:21)

Antibody Screen/Identification

Antibody Screen: Negative (05/08/24
15:45:22)

Blood Products

Crossmatch: Compatible (05/09/24



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08:19:20)

of Units: 1 (05/09/24 08:19:19)

Point of Care - Urines

Clarity UA POC: Clear (05/08/24 16:30:20)
Color UA POC: Yellow (05/08/24 16:30:20)
Specific Gravity UA POC: 1.015 (05/08/24 16:30:20)
pH UA POC: 6.0 (05/08/24 16:30:20)
Glucose UA POC: Neg (05/08/24 16:30:20)
Ketones UA POC: Neg (05/08/24 16:30:20)
Blood UA POC: 2+ (05/08/24 16:30:20)
Protein UA POC: 1+ (05/08/24 16:30:20)
Nitrite UA POC: Neg (05/08/24 16:30:20)
Leukocyte Esterase UA POC: Trace (05/08/24 16:30:20)

Prostatic Specific Antigen (PSA): 6.8 ng/mL High (05/09/24)

Diagnostic Results

CT Brain/Head without Contrast 05/08/2024
15:01:50 * Final *

IMPRESSION: NO SIGNIFICANT ACUTE INTRACRANIAL ABNORMALITY. MILD TO MODERATE GLOBAL PARENCHYMAL VOLUME LOSS. MILD TO MODERATE AGE-DETERMINATE SMALL VESSEL ISCHEMIC DISEASE IN THE WHITE MATTER. NONSPECIFIC RIGHT PARIETAL CALVARIAL LUENT LESIONS, POSSIBLY REPRESENTING PROMINENT ARACHNOID GRANULATIONS, WITH OTHER ETIOLOGIES INCLUDING METASTATIC DISEASE OR MYELOMA NOT ENTIRELY EXCLUDED. CORRELATION WITH PREVIOUS AVAILABLE STUDIES IS RECOMMENDED TO ASSESS FOR STABILITY. ALTERNATIVELY, BONE SCAN MAY BE PERFORMED FOR FURTHER EVALUATION.

CT Chest without Contrast 05/09/2024
08:32:38 * Final *

IMPRESSION: 6 X 12 X 9 MM HIGHLY IRREGULAR SPICULATED NONCALCIFIED NODULE IN THE POSTERIOR SEGMENT OF THE RIGHT UPPER LOBE BORDERING ON THE MAJOR FISSURE WITH MILD FOCAL PLEURAL THICKENING. 15 X 8 X 13 MM GROUNDGLASS NODULE IN THE MEDIAL LUNGULA ADJACENT TO THE MEDIASTINAL PLEURA. SMALL AREAS OF PERIBRONCHIAL NODULARITY/BRONCHIAL WALL



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Consultations

THICKENING IN THE RIGHT UPPER LOBE AS WELL AS SCATTERED AREAS OF TREE-IN-BUD MICRONODULARITY IN THE RIGHT UPPER AND LOWER LOBES WITH A FEW SCATTERED SMALL SUB-4 MM PULMONARY NODULES, EXCEPT FOR A 6 MM NONCALCIFIED GROUNDGLASS NODULE IN THE POSTERIOR RIGHT LOWER LOBE SUPERIOR SEGMENT ON SERIES 3-52. IMAGING DEGRADATION NOTED DUE TO MOTION ARTIFACT. MODERATE CORONARY ARTIFICIAL CALCIIFICATIONS POSSIBLY ESOPHAGEAL WALL THICKENING.

CT Abd/Pelv NO IV/NO GI Contrast
05/09/2024 08:58:25 * Final *
IMPRESSION: MULTIPLE SMALL SUBTLE LYtic LESIONS INCLUDING THE LEFT SUPERIOR ILIAC BONE, RIGHT POSTERIOR 11TH AND 12TH RIBS, AND LEFT L2 PEDICLE. SUGGEST CLINICAL CORRELATION TO EXCLUDE MULTIPLE MYELOMA VERSUS METASTASES. INTERVAL APPEARANCE OF MILD TO MODERATE RIGHT AND MILD LEFT HYDRONEPHROSIS AND HYDROURETER IS LIKELY DUE TO BLADDER OBSTRUCTION WITH NOW ELONGATED BUT DECOMRESSED BLADDER CONTAINING A FOLEY BALLOON CATHETER. INTERVAL APPEARANCE OF ANASARCA. RENAL CYSTS. POSSIBLE CONSTIPATION. STATUS POST VASECTOMY.

XR Ankle Complete Right (4V) 05/08/2024
16:58:52 * Final *
IMPRESSION: NEGATIVE.

XR Tibia/Fibula Right 05/08/2024 16:58:22 *
Final *



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IMPRESSION: RIGHT TOTAL KNEE PROSTHESIS.

XR Chest Portable 05/08/2024 15:03:11 *
Final *

IMPRESSION: NEW HAZY THE AIRSPACE DISEASE/OPACITIES ALONG THE RIGHT PERIHILAR AND INFRAHILAR REGIONS. THERE IS NO VISIBLE PLEURAL EFFUSION OR PNEUMOTHORAX. THE CARDIOMEDIASTINAL SILHOUETTE IS STABLE. NO ACUTE OSSEOUS ABNORMALITIES ARE IDENTIFIED.

IR Venacavogram Inferior * New *

IR Percutaneous Placement Of IVC Filter *
New *

US Renal 05/08/2024 17:25:22 * Final *
IMPRESSION: ECHOPIC, CYSTIC KIDNEYS CONSISTENT WITH CHRONIC RENAL DISEASE. MILD RIGHT HYDRONEPHROSIS. BLADDER DECOMRESSED BY FOLEY CATHETER.

Pathology Results

No qualifying data available.

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***Consultations*



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Consultations

DOCUMENT NAME: Spiritual Care
SERVICE DATE/TIME: 5/9/2024 10:32 PDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Junker ,Karen (5/9/2024 10:32 PDT)
SIGN INFORMATION: Junker ,Karen (5/9/2024 10:32 PDT)

Spiritual Care Entered On: 05/09/2024 10:30 PDT
Performed On: 05/09/2024 10:32 PDT by Junker , Karen

Spiritual Care

Spiritual Care D/T of Visit : 05/09/2024 10:32 PDT

Spiritual Care Visit Type : Initial Visit

SC Consult With : Patient, Spouse, Children

SC Theological Issues : Current spiritual needs & how chaplain can assist

Spiritual Needs Assessment : Anxiety, Confusion

Proposed Spiritual Care Plan : Monitor for spiritual needs, Monitor for emotional status

Spiritual Care Notes : Patient said that he just arrived and trying to "figure out how things work here." Patient expressed frustration at not being able to have some food. Patient's daughter was wiping patients eyes and wound around nose.

Visitors seemed anxious and afraid. Patient's daughter said that they have been praying a lot. Visitors thanked Chaplain for coming by and asked to be added to prayer list.

Religion Preference Smart Template : No Preference

Cultural/Spiritual Practices : prayer

Spiritual Advisor/Minister Name : Karen Junker

Spiritual Advisor/Minister Phone # : x65469

Junker , Karen - 05/09/2024 10:32 PDT



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Consultations

DOCUMENT NAME: Surgical Consultation
SERVICE DATE/TIME: 5/9/2024 12:07 PDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Shum,DPM,Karen C (5/9/2024 12:30 PDT)
SIGN INFORMATION: Shum,DPM,Karen C (5/9/2024 12:30 PDT)



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Consultations

Attachment(s):

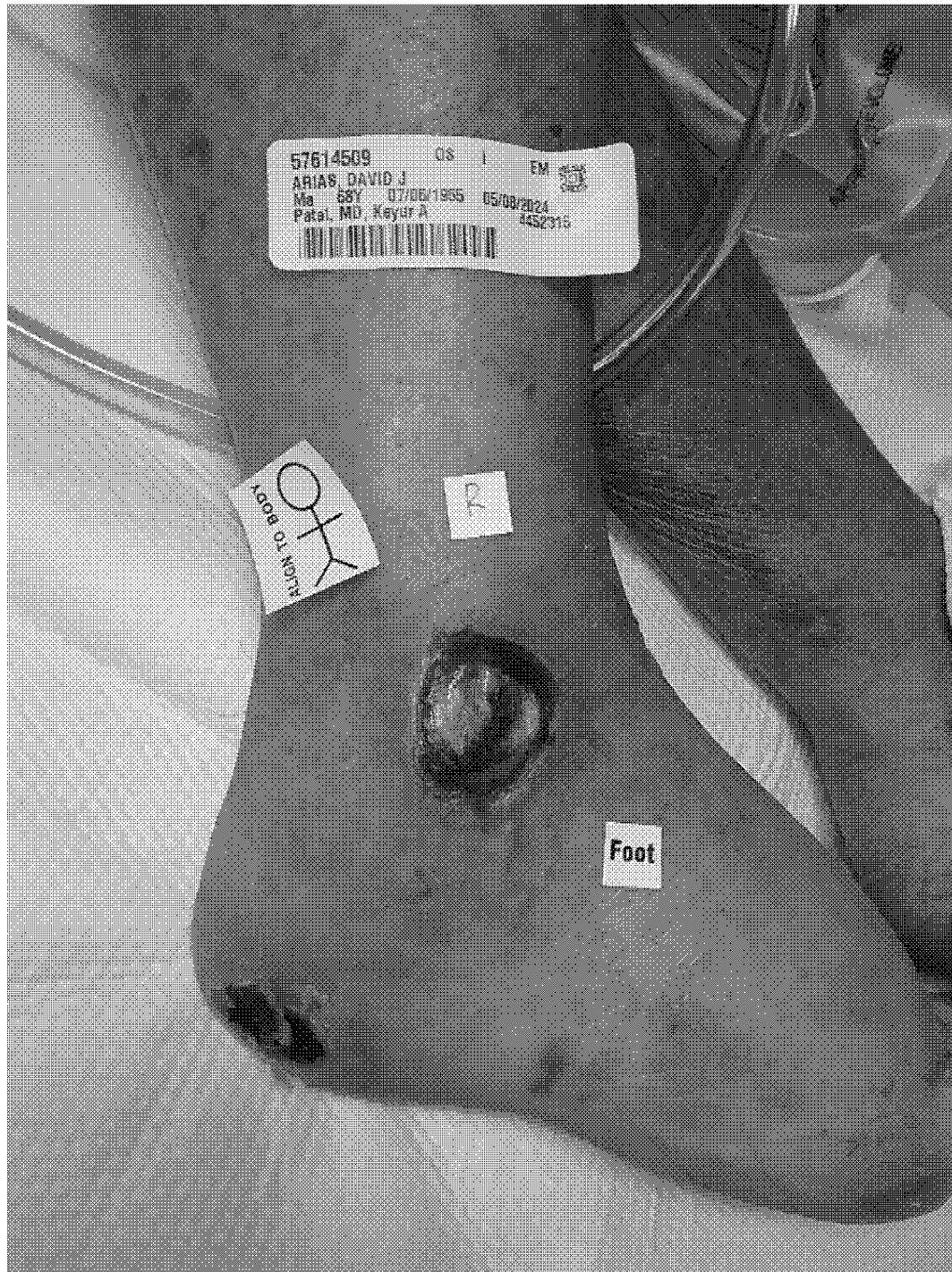
5/9/2024 12:07 PDT



Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***Consultations*

Attachment(s):

5/9/2024 12:07 PDT



Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***Consultations*

Attachment(s):

5/9/2024 12:07 PDT





Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

Attachment(s):

5/9/2024 12:07 PDT





Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

Reason for Consultation

Lower extremity wound care

Requesting Provider

Dr. Patel

Chief Complaint

weak x 3 days, c/o leg pain, recent dx dvt, on blood thinners, bloody nose last night

History of Present Illness

68-year-old male with alcohol abuse, cigarette smoker (50 pack year) now smokes 5-6 cigarettes per day, CAD, stage III CKD, COPD, history of TIA with right foot drop, hyperlipidemia, thrombocytopenia, and PAD status post right lower extremity angioplasty approximately 8 years ago by Dr. Adoumie who presents to the hospital with weakness, epistaxis, and acute renal failure. Patient was diagnosed with right soleus vein thrombus on 5/3/24 after developing leg pain, swelling and fevers. He was started on Eliquis for the clot and Keflex and Bactrim for right lower extremity cellulitis. Wound care consultation is requested. Patient has chronic right leg ulcers from arterial insufficiency and pressure. Family is assisting with wound care where MediHoney is being applied.

CT scan of chest abdomen and pelvis reveals bone lesions concerning for metastatic disease. Blood transfusion and IVC filter placement is pending.

Review of Systems

Constitutional: No fevers, chills, sweats

Eye: No recent visual problems

ENMT: No ear pain, nasal congestion, sore throat

Respiratory: No shortness of breath, cough

Cardiovascular: Right leg edema

Gastrointestinal: Low appetite

Genitourinary: No hematuria

Hema/Lymph: Negative for bruising tendency, swollen lymph glands

Endocrine: Negative for excessive thirst, excessive hunger

Musculoskeletal: Right leg pain

Integumentary: Right leg wounds

Neurologic: Alert & oriented X 4

Psychiatric: No anxiety, depression

Physical Exam**Vitals & Measurements**

T: 98.3 °F (Oral) TMIN: 97.1 °F (Oral) TMAX: 99.3 °F (Oral) HR: 91(Monitored)

RR: 20 BP: 129/89 SpO2: 97% WT: 64.3 kg

General: Awake and alert. Disheveled appearing male in no acute distress.

Head: Normocephalic and atraumatic.

Neck: At midline and without masses.

Chest: Even and unlabored breathing. Normal chest rises.

Vascular: Right and left pedal pulses are nonpalpable. Right leg 1-2+ pitting edema

Dermatological: Right lateral heel ulcer 1.9 x 2.6 x 0.1 cm eschar covered.

Right proximal anterior leg ulcer 3.5 x 3 x 0.2 cm with subcutaneous tissue exposed. Right calf ulcer 4 x 3.5 x 0.1 cm with subcutaneous tissue exposed. Right anterior leg ulcer 2.9 x 3.4 x 0.4 cm with subcutaneous tissue exposed. Right lateral ankle ulcer 2.6 x 3 x 0.4 cm with necrotic subcutaneous tissue and ligament exposed. No right lower extremity erythema or warmth

Neurological: Gross sensations are intact.

Musculoskeletal: Right lateral ankle and calf tenderness.

Problem List/Past Medical History**Ongoing**

Abrasion of right lower leg

Aftercare

Alcohol abuse

Anemia

CAD in native artery

Chronic renal insufficiency, stage III (moderate)

COPD type A

Diarrhea

Elevated transaminase level

Falls

History of heart artery stent

History of TIA (transient ischemic attack)

HTN (hypertension)

Hyponatremia

Mixed hyperlipidemia

Peripheral vascular disease

Thrombocytopenia

Tobacco use

Tobacco user

Weight loss

Historical

History of shingles

Procedure/Surgical History

- cardiac stent placement
- femoral stent placement
- L knee replacement

Medications**Inpatient**

acetaminophen tablet - 650 mg by mouth every 4 hours.

acetaminophen-hydrocodone 325 mg-5 mg oral tablet - 1 tab(s) by mouth every 4 hours.

albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution - 3 mL hand held nebulizer every 4 hours.

doxazosin - 2 mg by mouth once daily.

hydrALAZINE injection - 10 mg IVP every 6 hours.

hydrALAZINE tab - 25 mg by mouth every 6 hours.

Lipitor 80 mg oral tablet - 80 mg by mouth once daily.

mirtazapine - 15 mg by mouth at bedtime.

Nicoderm 21mg/24hr patch - 21 mg transdermally once daily.

Norvasc - 10 mg by mouth once daily.

omeprazole delayed release cap - 40 mg by mouth once daily.

ondansetron injection - 4 mg IVP every 4 hours.

pregabalin - 25 mg by mouth every 8 hours.



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

Psychiatric: Cooperative.

Assessment/Plan**Acute renal failure** (N17.9: Acute kidney failure, unspecified)**Appetite impaired** (R63.0: Anorexia)**Gastrointestinal bleed** (K92.2: Gastrointestinal hemorrhage, unspecified)**Leg wound, right** (S81.801A: Unspecified open wound, right lower leg, initial encounter)

- Chronic ulcers with underlying pressure and arterial etiology
- No acute surgical intervention indicated at this time
- Local wound care with medihibone gel for autolytic wound debridement and to maintain a clean wound bed
- Prevalon boot for pressure reduction
- Wound healing guarded in light of medical comorbidities
- Nutrition support for wound healing
- Weightbearing as tolerated when able

Lytic lesion of bone on x-ray (M89.9: Disorder of bone, unspecified)

- Heme/Onc recommends bone biopsy

Right leg DVT (I82.401: Acute embolism and thrombosis of unspecified deep veins of right lower extremity)

- IVC filter pending

Right leg pain (M79.604: Pain in right leg)

- Likely from right soleus vein thrombosis
- Pain control as needed

Weight loss (R63.4: Abnormal weight loss)

Anemia

-1 unit PRBC transfusion pending

remove patch - 1 patch(es) topically every 24 hours.

Senokot S 50 mg-8.6 mg oral tablet - 2 tab(s) by mouth once daily.

sodium bicarbonate tab - 650 mg by mouth three times a day.

traMADol - 50 mg by mouth every 6 hours.

Home

acetaminophen-hydrocodone 325 mg-10 mg oral tablet - 1 tab(s) by mouth every 4 hours as needed for as needed for pain.

aspirin 81 mg oral delayed release tablet - 81 mg by mouth once daily.

Bactrim DS 800 mg-160 mg oral tablet - 1 tab(s) by mouth twice a day.

cephalexin 500 mg oral capsule - 500 mg by mouth twice a day.

folic acid 0.8 mg oral tablet - 0.8 mg by mouth once daily.

Lipitor 80 mg oral tablet - 80 mg by mouth once daily.

mirtazapine 15 mg oral tablet - 15 mg by mouth at bedtime.

Norvasc 10 mg oral tablet - 10 mg by mouth once daily SBP>160.

pantoprazole 40 mg oral delayed release tablet - 40 mg by mouth once daily.

pregabalin 25 mg oral capsule - 25 mg by mouth every 8 hours start at bed time only. If not to sleepy after 5 days take BID for 5 days, if not sleepy can take TID.

tamsulosin 0.4 mg oral capsule - 0.4 mg by mouth once daily.

Vitamin B12 250 mcg oral tablet - 500 mcg by mouth once daily.

Vitamin C 1000 mg oral tablet - 1,000 mg by mouth once daily.

zinc (as acetate) 50 mg oral capsule - 50 mg by mouth three times a day.

Allergies

NKA

Social HistorySmoking Status - 05/19/2010

Current

Alcohol

Alcohol Use: Current. Type: Beer.

Frequency: Weekly. Amount: 1 can beer 5/7/2024., 05/08/2024

Alcohol Use: Current. Frequency: Occasionally., 02/24/2023

Substance Abuse

Drug Use: None., 05/08/2024

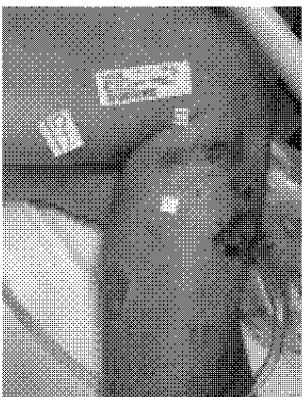
Tobacco

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509*****Consultations*****Images**

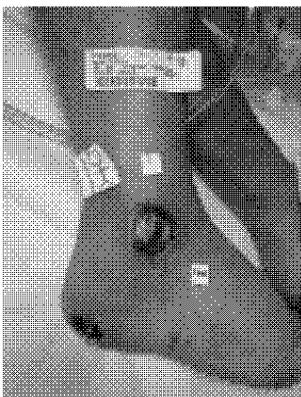
2024-05-08 20:39:28



2024-05-08 20:45:52



2024-05-08 20:48:17



2024-05-08 20:48:39

Tobacco Use: 10 or more cigarettes (1/2 pack or more)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 05/08/2024
 Tobacco Use: 4 or less cigarettes(less than 1/4 pack)/day in last 30 days. Type: Cigarettes. Did the patient use tobacco anytime during the past 12 months prior to hospital arrival? Yes., 02/24/2023

Family History

Asthma: Child.
 High blood pressure: Father.
 Joint: Child.

Lab Results**Chemistry**

Sodium: 135 mmol/L Low (05/09/24 05:43:33)
 Potassium: 4.2mmol/L (05/09/24 05:43:33)
 Chloride: 111 mmol/L High (05/09/24 05:43:33)
 CO₂: 16 mmol/L Low (05/09/24 05:43:33)
 Anion Gap: 8 (05/09/24 05:43:33)
 Glucose: 112 mg/dL High (05/09/24 05:43:33)
 BUN: 83 mg/dL High (05/09/24 05:43:33)
 Creatinine: 3.00 mg/dL High (05/09/24 05:43:33)
 eGFR: 22 (05/09/24 05:43:33)
 Calcium: 8.3 mg/dL Low (05/09/24 05:43:33)
 Magnesium: 1.7mg/dL (05/09/24 05:43:32)
 Total Protein: 5.2 gm/dL Low (05/09/24 05:43:33)
 Albumin: 2.4 gm/dL Low (05/09/24 05:43:33)
 Globulin: 2.8gm/dL (05/09/24 05:43:33)
 Bilirubin Total: 0.4mg/dL (05/09/24 05:43:33)
 Bilirubin Direct: 0.3mg/dL (05/09/24 05:43:33)
 Alkaline Phosphatase: 65units/L (05/09/24 05:43:33)
 AST: 29units/L (05/09/24 05:43:33)
 ALT: 27units/L (05/09/24 05:43:33)

Cardiovascular Assays

Troponin I High Sensitivity: 15ng/L (05/08/24 14:35:43)

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509***Consultations***Tumor Marker**Prostatic Specific Antigen (PSA):
6.80 ng/mL High (05/09/24 06:23:05)**Urine Random Chemistry**Creatinine Random Urine: 59.0mg/dL
(05/08/24 17:15:42)
Potassium Random Urine: 27.6mmol/L
(05/08/24 17:15:32)
Sodium Random Urine: 54mmol/L
(05/08/24 17:15:33)**Complete Blood Count**WBC x 10³: 7.7/CMM (05/09/24
05:25:56)
RBC x 10⁶: 2.01 /CMM Low (05/09/24
05:25:56)
Hemoglobin: 6.4 gm/dL Low (05/09/24
05:25:56)
Hematocrit: 18.9 % Low (05/09/24
05:25:56)
MCV: 93.8fL (05/09/24 05:25:56)
MCH: 31.8pg (05/09/24 05:25:56)
MCHC: 33.9gm/dL (05/09/24 05:25:56)
RDW: 17.1 % High (05/09/24 05:25:56)
Platelets x 10³: 164/CMM (05/09/24
05:25:56)
MPV: 8.7fL (05/09/24 05:25:56)**Differential Automated**Neutrophils: 84.1 % High (05/09/24
05:25:56)
Lymphocytes: 6.8 % Low (05/09/24
05:25:56)
Monocytes: 5.2% (05/09/24 05:25:56)
Eosinophils: 3.4% (05/09/24 05:25:56)
Basophils: 0.5% (05/09/24 05:25:56)
Neutrophils Absolute: 6.5x10e3/mcL
(05/09/24 05:25:56)
Lymphocytes Absolute: 0.5 x10e3/mcL
Low (05/09/24 05:25:56)
Monocytes Absolute: 0.4x10e3/mcL
(05/09/24 05:25:56)
Eosinophils Absolute: 0.3x10e3/mcL
(05/09/24 05:25:56)
Basophils Absolute: 0.0x10e3/mcL
(05/09/24 05:25:56)**Hematology other**Eosinophil Smear: None Seen (05/08/24
18:20:53)
Eosinophil Smear Source: URINE
(05/08/24 18:20:53)

Patient Name: **ARIAS, DAVID J**MRN: **4452315**FIN: **57614509****Consultations****PT & or PTT**

Prothrombin Time: 14.6 second(s) High
(05/08/24 14:17:40)
INR: 1.3 (05/08/24 14:17:40)
PTT: 38.4 second(s) High (05/08/24
14:17:39)

Macroscopic Urinalysis

Source UA: Urine Foley (05/08/24
17:22:09)
Clarity UA: Clear (05/08/24 17:22:09)
Color UA: Light-Yellow (05/08/24
17:22:09)
Specific Gravity UA: 1.013 (05/08/24
17:22:09)
pH UA: 6 (05/08/24 17:22:09)
Protein UA: 30 (1+)mg/dL (05/08/24
17:22:09)
Glucose UA: Normal (<30)mg/dL
(05/08/24 17:22:09)
Ketones UA: Negative mg/dL (05/08/24
17:22:09)
Blood UA: 0.2 (2+)mg/dL (05/08/24
17:22:09)
Nitrite UA: Negative (05/08/24 17:22:09)
Bilirubin UA: Negative (<0.5)mg/dL
(05/08/24 17:22:09)
Urobilinogen UA: Normal (<2)mg/dL
(05/08/24 17:22:09)
Leukocyte Esterase UA: 250
(2+)WBCs/microLiter (05/08/24 17:22:09)

Microscopic Urinalysis

Urine Microscopy?: Auto (05/08/24
17:22:09)
WBC/hpf: 21-50/HPF (05/08/24 17:22:09)
RBC/hpf: >20/HPF (05/08/24 17:22:09)
Bacteria: Few (1+)/HPF (05/08/24
17:22:09)
Squamous Epithelial Cells: Rare (Tr)/LPF
(05/08/24 17:22:09)
Urinalysis Culture Reflex: Indicated
(05/08/24 17:22:09)

Blood Type

ABORh: O POS (05/08/24 15:45:21)

Antibody Screen/IdentificationAntibody Screen: Negative (05/08/24
15:45:22)**Blood Products**

Crossmatch: Compatible (05/09/24
08:19:20)
of Units: 1 (05/09/24 08:19:19)



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

Point of Care - Urines

Clarity UA POC: Clear (05/08/24 16:30:20)
Color UA POC: Yellow (05/08/24 16:30:20)
Specific Gravity UA POC: 1.015 (05/08/24 16:30:20)
pH UA POC: 6.0 (05/08/24 16:30:20)
Glucose UA POC: Neg (05/08/24 16:30:20)
Ketones UA POC: Neg (05/08/24 16:30:20)
Blood UA POC: 2+ (05/08/24 16:30:20)
Protein UA POC: 1+ (05/08/24 16:30:20)
Nitrite UA POC: Neg (05/08/24 16:30:20)
Leukocyte Esterase UA POC: Trace (05/08/24 16:30:20)

Diagnostic Results**CT Brain/Head without Contrast 05/08/2024
15:01:50 * Final ***

IMPRESSION: NO SIGNIFICANT ACUTE INTRACRANIAL ABNORMALITY. MILD TO MODERATE GLOBAL PARENCHYMAL VOLUME LOSS. MILD TO MODERATE AGE-DETERMINATE SMALL VESSEL ISCHEMIC DISEASE IN THE WHITE MATTER. NONSPECIFIC RIGHT PARIETAL CALVARIAL LUENT LESIONS, POSSIBLY REPRESENTING PROMINENT ARACHNOID GRANULATIONS, WITH OTHER ETIOLOGIES INCLUDING METASTATIC DISEASE OR MYELOMA NOT ENTIRELY EXCLUDED. CORRELATION WITH PREVIOUS AVAILABLE STUDIES IS RECOMMENDED TO ASSESS FOR STABILITY. ALTERNATIVELY, BONE SCAN MAY BE PERFORMED FOR FURTHER EVALUATION.

**CT Chest without Contrast 05/09/2024
08:32:38 * Final ***

IMPRESSION: 6 X 12 X 9 MM HIGHLY IRREGULAR SPICULATED NONCALCIFIED NODULE IN THE POSTERIOR SEGMENT OF THE RIGHT UPPER LOBE BORDERING ON THE MAJOR FISSURE WITH MILD FOCAL PLEURAL THICKENING. 15 X 8 X 13 MM GROUNDDGLASS NODULE IN THE MEDIAL LUNGULA ADJACENT TO THE MEDIASTINAL PLEURA. SMALL AREAS OF PERIBRONCHIAL NODULARITY/BRONCHIAL WALL



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Consultations

THICKENING IN THE RIGHT UPPER LOBE AS WELL AS SCATTERED AREAS OF TREE-IN-BUD MICRONODULARITY IN THE RIGHT UPPER AND LOWER LOBES WITH A FEW SCATTERED SMALL SUB-4 MM PULMONARY NODULES, EXCEPT FOR A 6 MM NONCALCIFIED GROUNDGLASS NODULE IN THE POSTERIOR RIGHT LOWER LOBE SUPERIOR SEGMENT ON SERIES 3-52. IMAGING DEGRADATION NOTED DUE TO MOTION ARTIFACT. MODERATE CORONARY ARTERIAL CALCIFICATIONS. POSSIBLE ESOPHAGEAL WALL THICKENING.

CT Abd/Pelv NO IV/NO GI Contrast05/09/2024 08:58:25 * Final *

IMPRESSION: MULTIPLE SMALL SUBTLE LYtic LESIONS INCLUDING THE LEFT SUPERIOR ILIAC BONE, RIGHT POSTERIOR 11TH AND 12TH RIBS, AND LEFT L2 PEDICLE. SUGGEST CLINICAL CORRELATION TO EXCLUDE MULTIPLE MYELOMA VERSUS METASTASES. INTERVAL APPEARANCE OF MILD TO MODERATE RIGHT AND MILD LEFT HYDRONEPHROSIS AND HYDROURETER IS LIKELY DUE TO BLADDER OBSTRUCTION WITH NOW ELONGATED BUT DECOMPRESSED BLADDER CONTAINING A FOLEY BALLOON CATHETER. INTERVAL APPEARANCE OF ANASARCA. RENAL CYSTS. POSSIBLE CONSTIPATION. STATUS POST VASECTOMY.

XR Ankle Complete Right (4V) 05/08/202416:58:52 * Final *

IMPRESSION: NEGATIVE.

XR Tibia/Fibula Right 05/08/2024 16:58:22 *Final *



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Consultations

IMPRESSION: RIGHT TOTAL KNEE PROSTHESIS.

XR Chest Portable 05/08/2024 15:03:11 *
Final *

IMPRESSION: NEW HAZY THE AIRSPACE DISEASE/OPACITIES ALONG THE RIGHT PERIHILAR AND INFRAHILAR REGIONS. THERE IS NO VISIBLE PLEURAL EFFUSION OR PNEUMOTHORAX. THE CARDIOMEDIASTINAL SILHOUETTE IS STABLE. NO ACUTE OSSEOUS ABNORMALITIES ARE IDENTIFIED.

IR Venacavogram Inferior * New *

IR Percutaneous Placement Of IVC Filter *
New *

US Renal 05/08/2024 17:25:22 * Final *
IMPRESSION: ECHOPIC, CYSTIC KIDNEYS CONSISTENT WITH CHRONIC RENAL DISEASE. MILD RIGHT HYDRONEPHROSIS. BLADDER DECOMRESSED BY FOLEY CATHETER.



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Consultations

Electronically Signed On: 05/09/2024 12:30 PDT
By: Shum, DPM, Karen C

Miscellaneous Transcriptions

DOCUMENT NAME: Query Form
SERVICE DATE/TIME: 5/14/2024 07:24 PDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION:
SIGN INFORMATION:

PROG

RESPONSE TEXT:

Patient with Severe Protein-Calorie Malnutrition. Continue with treatment per RDN

QUERY TEXT:

TMMC Malnutrition Severity

A review of the inpatient record found further clarification of the medical record is required to accurately reflect the severity of illness and risk of mortality of your patient.

If you have any questions, please contact Carolyn Ito, RN, CCDS @ ext. 25650 or the CDI Manager @ ext. 16691, or on Mobile Heartbeat. Thank you.

Please clarify if agree with RDN evaluation.

Options to consider:

- Severe Protein-Calorie Malnutrition. Continue treatment per RDN.
- Patient does not have Severe Protein-Calorie Malnutrition
- Other
- Unable to determine

The patient's Clinical Indicators include:

68 yr old male who presents to the emergency room due to weakness/confusion as well as nose bleed.

05/10/24: RDN assessment: Malnutrition Diagnosis: Chronic Disease Related with Severe Protein-Calorie Malnutrition. Pressure Ulcer, Present on Admission, Left heel, Stage Suspected Deep Tissue Injury

Nutrition Diagnosis

1) Predicted suboptimal intake R/T cognitive dysfunction/confusion as evidenced by report of poor po intake PTA, wt loss (36 lbs?), moderate to severe muscle wasting & SQ fat loss - meets criteria for severe protein-Calorie malnutrition

2) Increased kcal/protein needs R/T increased physiological demands with metastatic disease as evidenced by conditions associated with a DX or Tx; also, pressure injury as above plus other non-pressure wounds on LE

Options provided:

- Severe Protein-Calorie Malnutrition. Continue treatment per RDN



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Miscellaneous Transcriptions

-- Patient does not have Severe Protein-Calorie Malnutrition

Query created by: Ito, Carolyn on 5/13/2024 9:27 AM

Electronically signed by: MD Keyur A Patel 5/14/2024 7:24 AM

Cardiology Report

DOCUMENT NAME:	Card EKG
SERVICE DATE/TIME:	5/8/2024 15:32 PDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Matchison,MD,James C (5/8/2024 15:32 PDT)
SIGN INFORMATION:	



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Cardiology Report

Attachment(s):

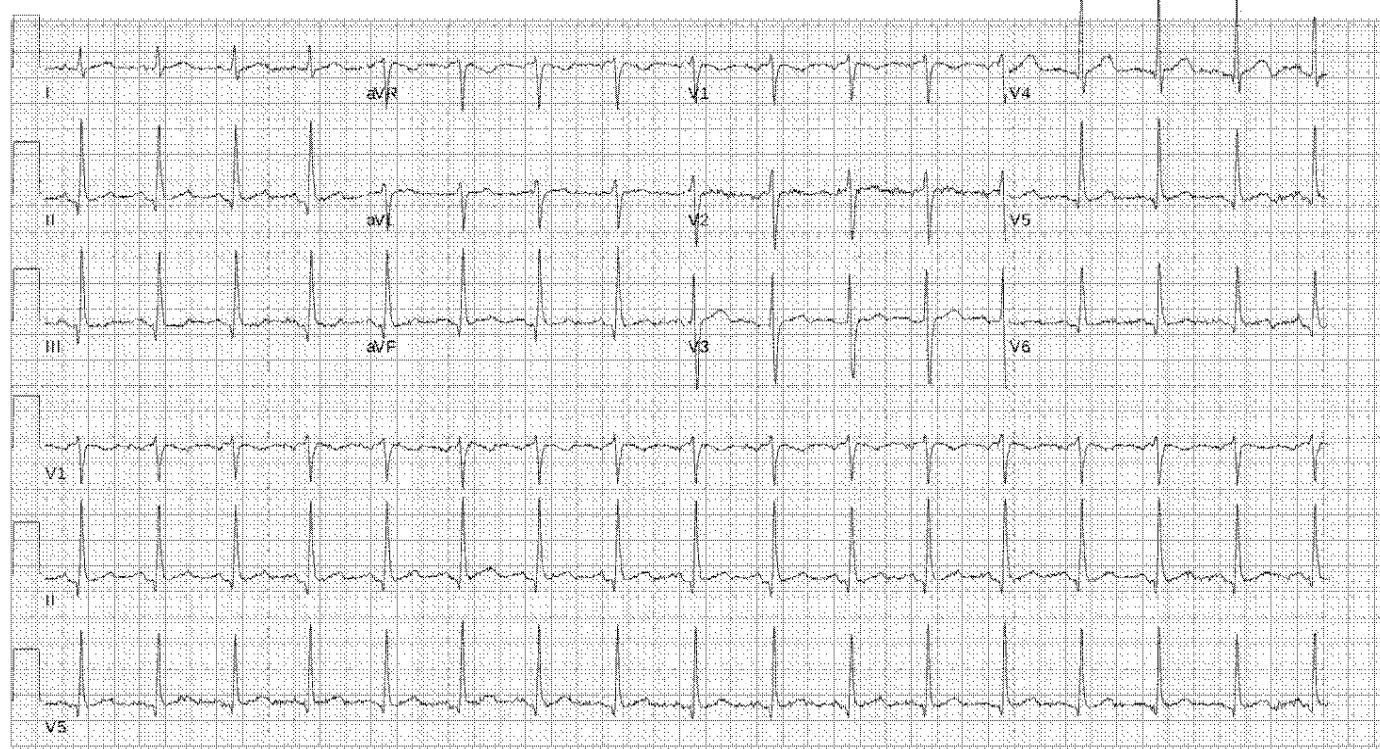
[5/8/2024 15:32 PDT 57614509_7400010_Card_EKG.pdf](#)

ARIAS, DAVID	ID:004452315	08-May-2024 13:44:23	TORRANCE MEMORIAL MEDICAL CENTER-ER ROUTINE RECORD
06-Jul-1955 (68 yr) Male White	Vent. rate: 100 BPM PR interval: 152 ms QRS duration: 90 ms QT/QTcB: 346/446 ms P-R-T axes: 72 79 50	Normal sinus rhythm Normal ECG	Confirmed by MATCHISON, M.D., JAMES (1059) on 5/8/2024 3:32:48 PM
Room: AMBU Loc: 1			

Technician: BN
Test Ind: WEAKNESS

Referred by: Richard Bracken

Confirmed By: JAMES MATCHISON, M.D.



25mm/s 100mV/mV 100Hz 10.2.3 125L 241 CID: 1 SID: OS EID: 1059 EDT: 15:32 09-May-2024 ORDER: 240027501 ACCOUNT: 57614509

Page 1 of 1

7400010

Please click on link to see image.

7400010

Test Reason : WEAKNESS

Blood Pressure : */* mmHG

Vent. Rate : 100 BPM Atrial Rate : 100 BPM

P-R Int : 152 ms QRS Dur : 90 ms

QT Int : 346 ms P-R-T Axes : 72 79 50 degrees

QTcB Int : 446 ms



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Cardiology Report

Normal sinus rhythm

Normal ECG

Confirmed by MATCHISON, M.D., JAMES (1059) on 5/8/2024 3:32:48 PM

Referred By: Richard Bracken

Confirmed By: JAMES MATCHISON, M.D.

* Auth (Verified) *

ARIAS, DAVID 4452315

Patient Name: ARIAS, DAVID J

MRN: 4452315

Study #: 57614509

Initial MD: So, George,MD

Date of Birth: 7/6/1955

Study Date: 5/9/2024

Medication

Medication

Medication Total Dose (Bolus/Oral)

<i>Medication</i>	<i>Total Dosage/Unit</i>
FENTANYL	25 mcg
LIDOCAINE	10 mL
VERSED	0.5 mg

Medications (Bolus/Oral)

<i>Medication</i>	<i>Time Given</i>	<i>Dosage/Unit</i>	<i>Administered By</i>	<i>Reason</i>
<u>FENTANYL</u>	5/9/2024 17:55:35	25 mcg	Roj sirivat, Rocky	
25 mcg FENTANYL given in lab by Rojsirivat, Rocky in Left Antecubital via Peripheral IV. Ordered by So, George, MD.				
<u>VERSED</u>	5/9/2024 17:55:55	0.5 mg	Roj sirivat, Rocky	
0.5 mg VERSED given in lab by Rojsirivat, Rocky via Peripheral IV. Ordered by So, George, MD.				
<u>LIDOCAINE</u>	5/9/2024 18:02:30	10 mL	Roj sirivat, Rocky	
10 mL LIDOCAINE given in lab by Rojsirivat, Rocky in Right Groin via Subcutaneous. Ordered by So, George, MD.				

Cyber

Medication (Drip)

<i>Medication</i>	<i>Time Given</i>	<i>Dosage/Unit</i>	<i>Concentration/Unit</i>	<i>Diluent (ml)</i>	<i>Solution</i>
<u>IV SOLUTIONS</u>	5/9/2024 17:22:21	ml, (IV)		500	NS
IV SOLUTIONS given in lab by Rojsirivat, Rocky in Right Antecubital via Peripheral IV. Pump/Drip Flow using NS. Ordered by So, George, MD.					

5/17/2024 12:42

#13103259110

Torrance Memorial Medical Cent

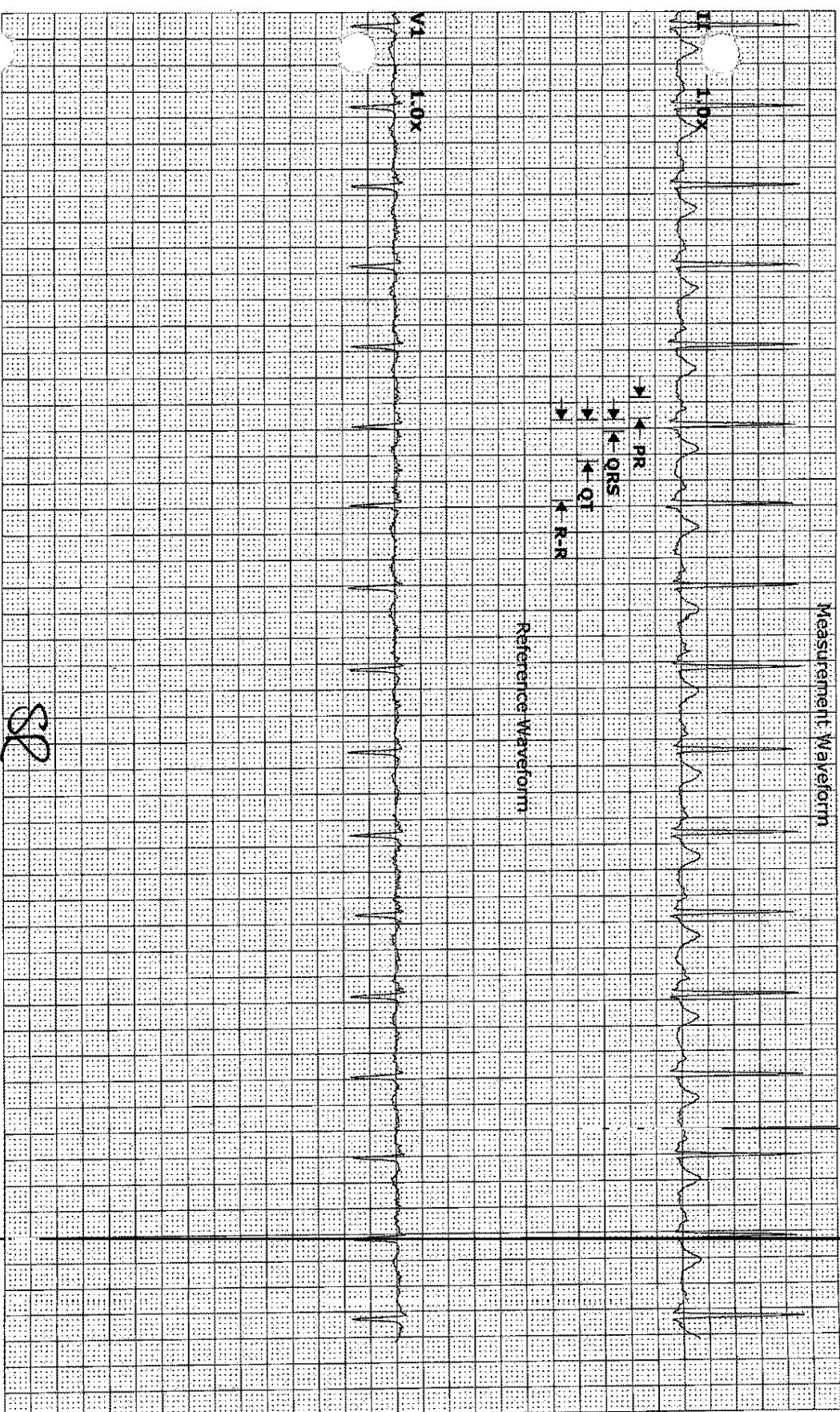
RRD→16573482482

054/103

ARIAS,DAVID 57614509
10-May-2024 03:17:45 - 10-May-2024 03:17:55

Caliper Measurements

SE-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.169 sec	QT	= 0.328 sec
QRS	= 0.099 sec	R-R	= 0.623 sec
RTC	= 0.416 sec	Rate	= 96 /min

CARESCAPE Central Station (7.1.8),
Friday, May 10, 2024 3:18:40 AM

57614509 OS I EM

ARIAS, DAVID J Ma 68Y 07/06/1955 05/08/2024 Patel, MD, Kayur A 4452315

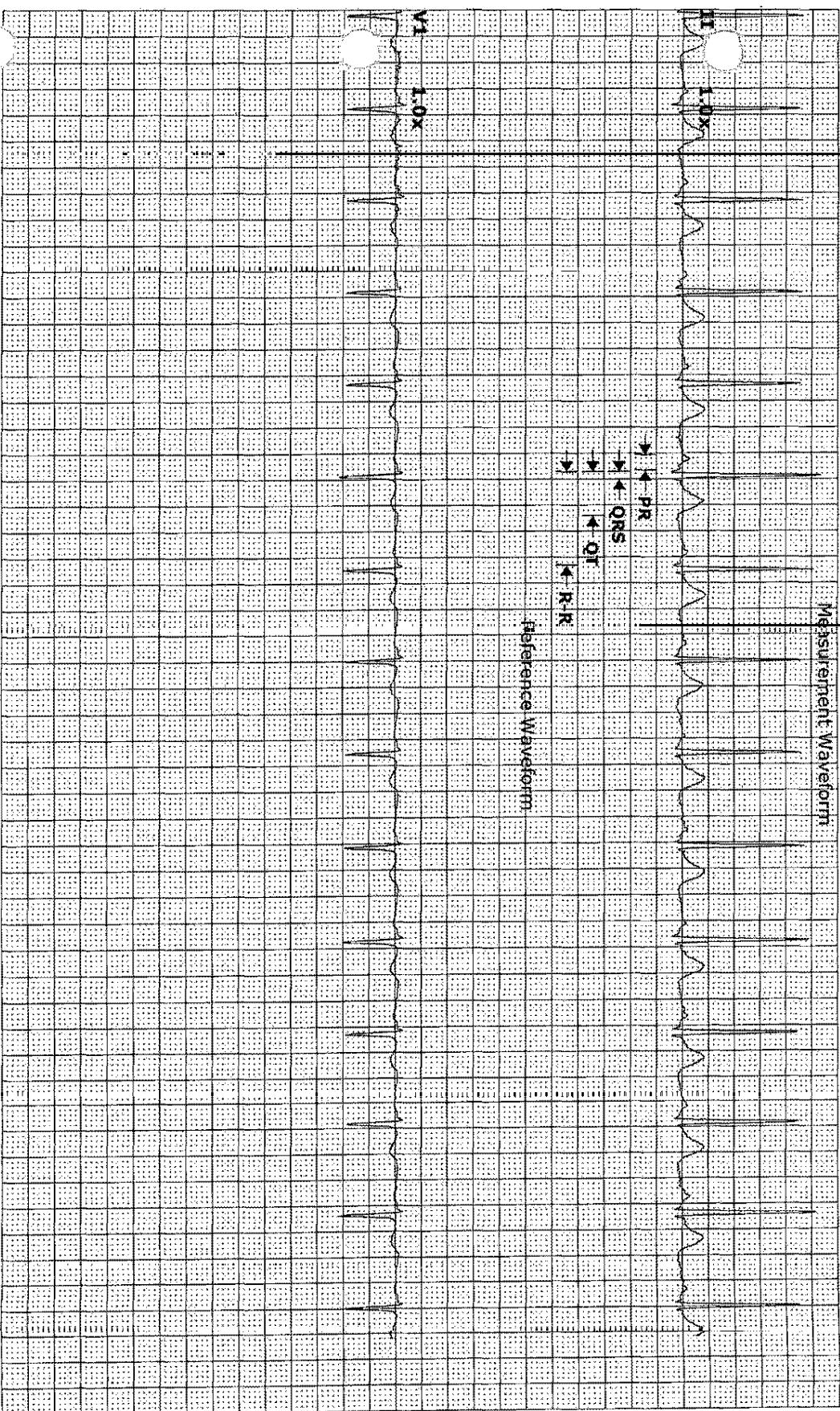
mm/s

Page 1
END OF REPORT

ARIAS,DAVID **57614509**
 09-May-2024 23:21:06 - 09-May-2024 23:21:16

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.129 sec	QT	= 0.343 sec
QRS	= 0.069 sec	R-R	= 0.723 sec
RTC	= 0.403 sec	Rate	= 83 /min

SR

57614509 08 1 EM

ARIAS, DAVID J

Ma 68Y

07/06/1955

05/08/2024

Patel, MD, Keyuna A

4452315



; mm/s

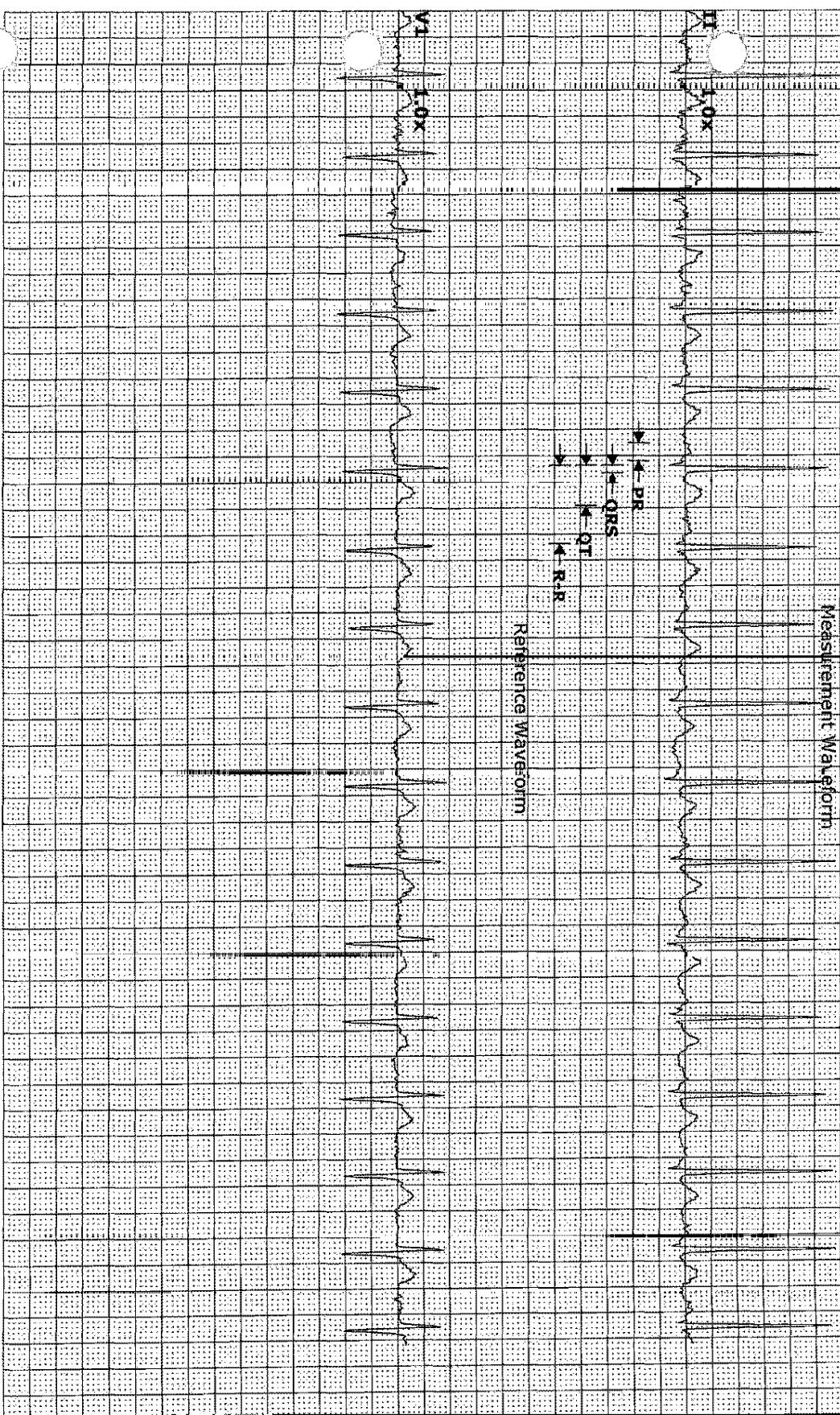
Page 1

ARIAS, DAVID 4452315

Auth Verified

ARIAS,DAVID**57614509****Caliper Measurements****5E-PCU|5135**

09-May-2024 20:07:14 - 09-May-2024 20:07:24



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.149 sec	QT	= 0.314 sec
QRS	= 0.064 sec	R-R	= 0.603 sec
RTC	= 0.404 sec	Rate	= 100 /min

SR**57614509**

ARIAS, DAVID J
Ma 68Y 07/05/1955 05/18/2024
Patel, MD Keyur A 4452315



15 mm/s

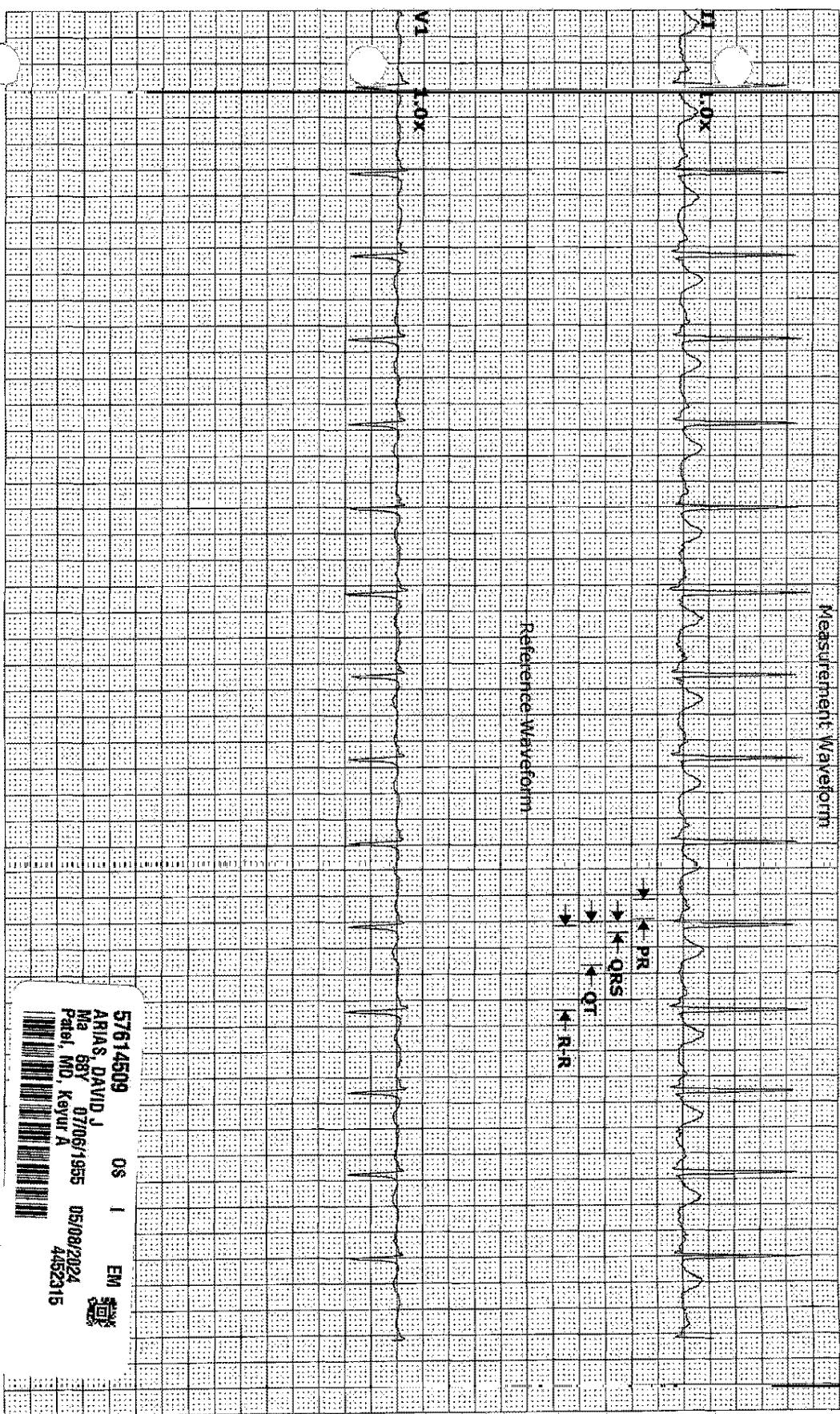
Page 1

CARESCAPE Central Station (7.1.8),
Thursday, May 09, 2024 8:19:51 PM

END OF REPORT

ARIAS, DAVID 44523315

* Auth (Verified) *

ARIAS, DAVID **57614509**
 10-May-2024 11:19:49 - 10-May-2024 11:19:59
Caliper Measurements**5E-PCU|5135**

Values displayed reflect measurements acquired against the measured waveform only.

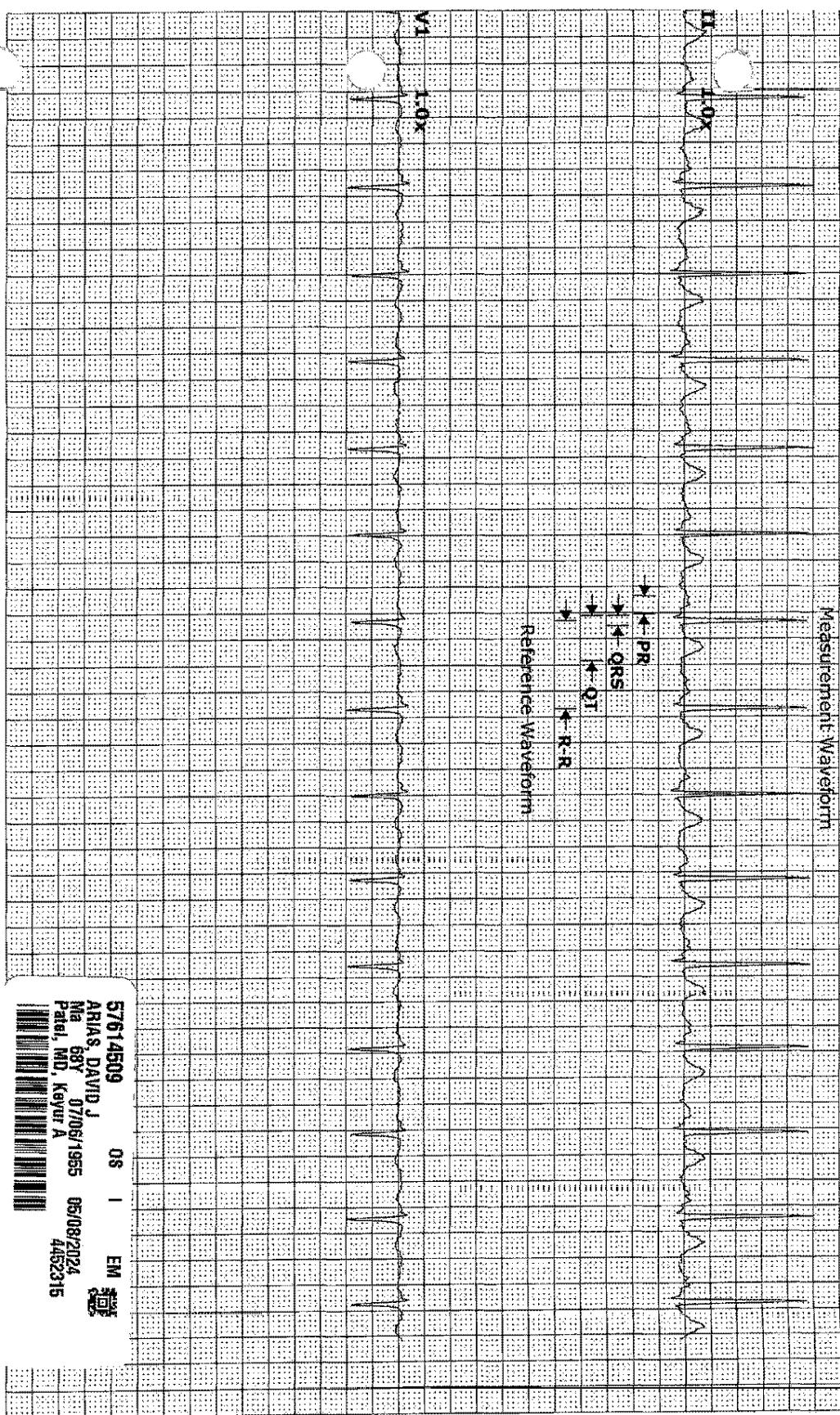
PR	= 0.150 sec	QT	= 0.329 sec
QRS	= 0.080 sec	R-R	= 0.649 sec
Rate	= 93 sec	/min	

SR

MD

ARIAS,DAVID**57614509****Caliper Measurements****5E-PCU|5135**

10-May-2024 08:03:04 - 10-May-2024 08:03:14



5/17/2024 12:42

#13103259110

Torrance Memorial Medical Cent

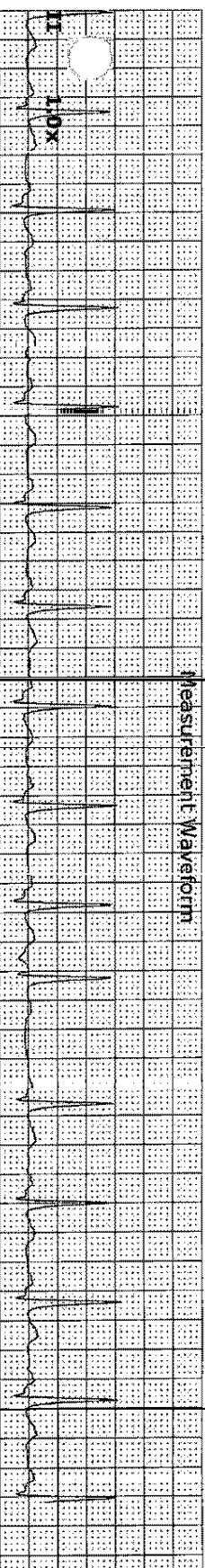
RRD→16573482482

060/103

ARIAS, DAVID 57614509
09-May-2024 07:32:03 - 09-May-2024 07:32:13

Caliper Measurements

5E-PCU|5135



Reference Waveform

Values displayed reflect measurements acquired against the measured waveform only.

PR = 0.179 sec QT = 0.328 sec
QRS = 0.099 sec R-R = 0.678 sec
QTC = 0.398 sec Rate = 89 /min

S.K. Patel

57614509 OS I EM **STOP**
ARIAS, DAVID J 05/08/2024
Ma 68Y 07/06/1955
Patel, MD, Ketur A

25 mm/s

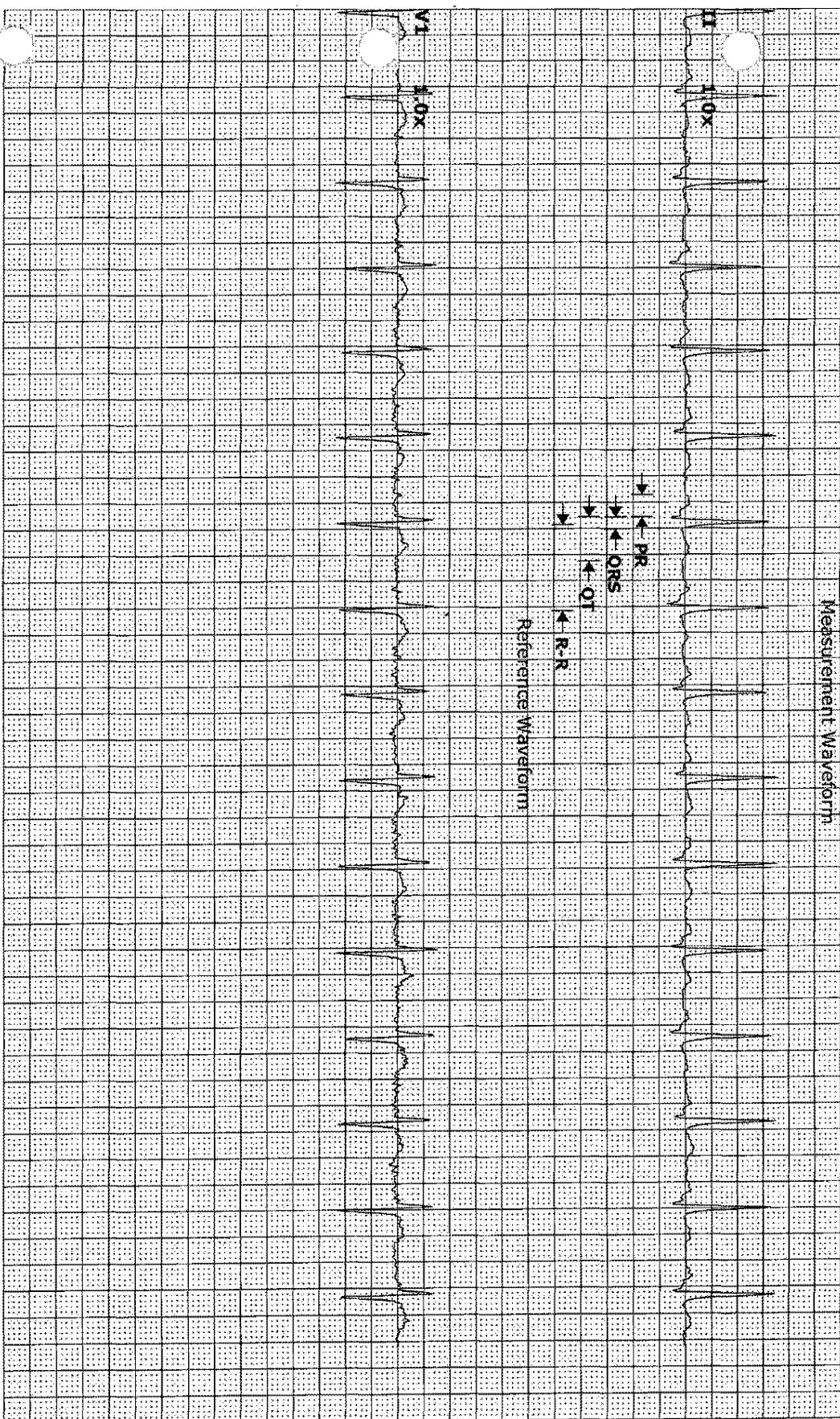
Page 1
END OF REPORT

CARESCAPE Central Station (7.1.8),
Thursday, May 9, 2024 7:35:42 AM

ARIAS,DAVID 57614509
09-May-2024 11:30:40 - 09-May-2024 11:30:50

Caliper Measurements

5E-PCU|5135



CARESCAPE Central Station (7.1.8),
Thursday, May 09, 2024 11:40:40 AM



57614509 OS I EM

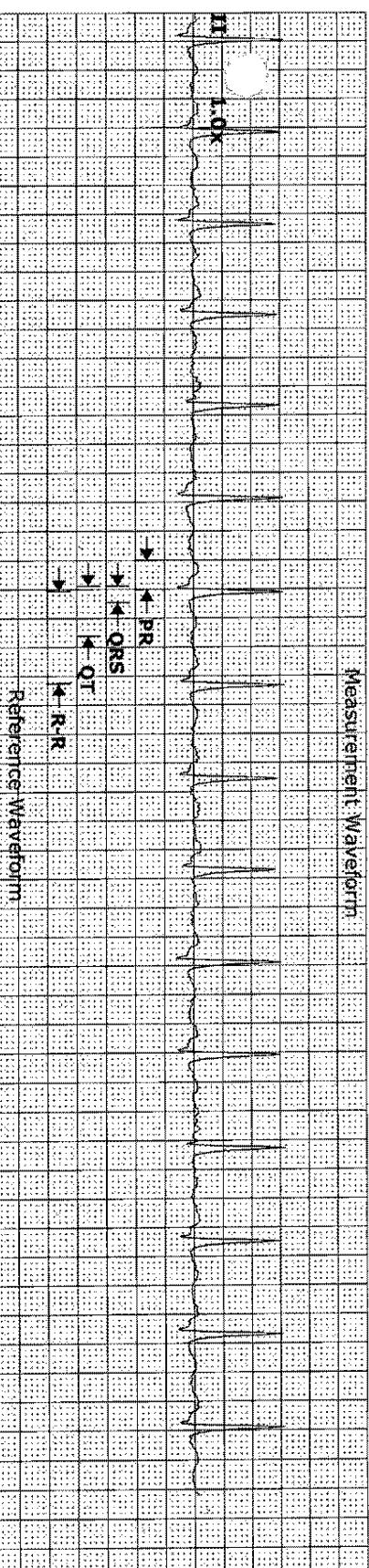
ARIAS, DAVID J
Ma 68Y 07061955 05/08/2024
Patel, MD, Ketura 4452315

25 mm/s
Page 1

ARIAS,DAVID **57614509**
 09-May-2024 15:39:08 - 09-May-2024 15:39:18

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.204 sec	QT	= 0.348 sec
QRS	= 0.124 sec	R-R	= 0.648 sec
QTc	= 0.432 sec	Rate	= 93 /min

SR

MD

57614509 OS I EM
 ARIAS, DAVID J Ma 68y 07/06/1955 05/08/2024
 Patel, MD, Kevur A 4452315



5/17/2024 12:42

#13103259110

Torrance Memorial Medical Cent

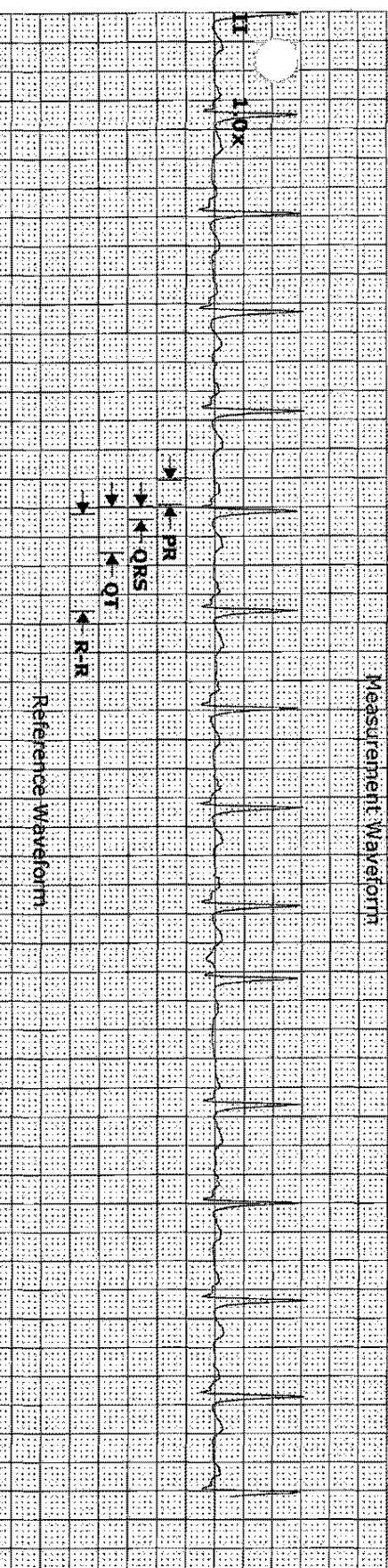
RRD→16573482482

064/103

ARIAS,DAVID **57614509** 09-May-2024 07:32:03 - 09-May-2024 07:32:13

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.179 sec	QT	= 0.328 sec
QRS	= 0.099 sec	R-R	= 0.678 sec
OTC	= 0.398 sec	Rate	= 89 /min

SK & Page

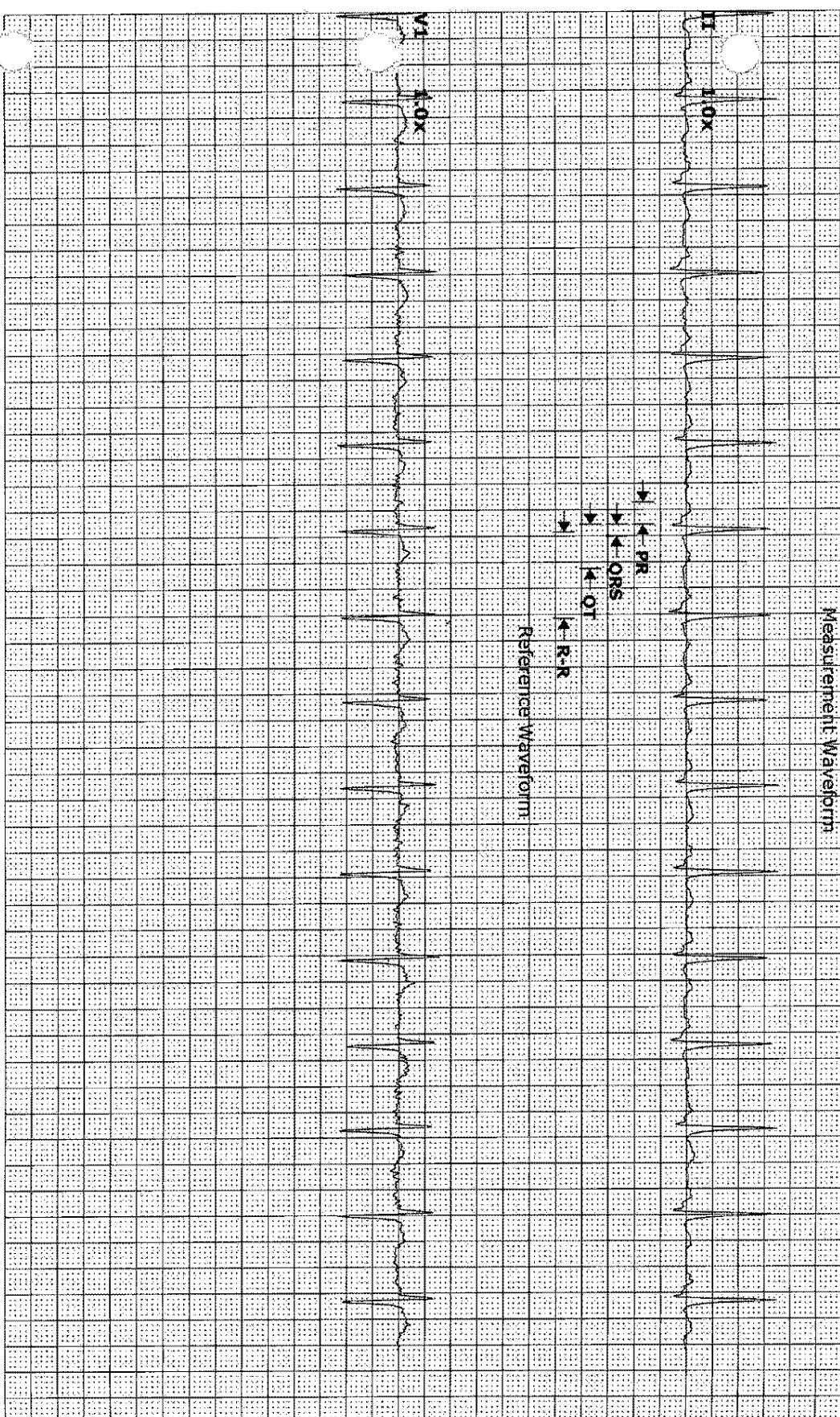
57614509 05 1 EM
ARIAS, DAVID J 07/06/1955 05/08/2024
Ma 68Y Patel, MD, Kevur A
CARESCAPE Central Station (7.1.8)
Thursday, May 09, 2024 7:35:42 AM

25 mm/s

Page 1
END OF REPORT

ARIAS,DAVID**57614509****Caliper Measurements****5E-PCU|5135**

09-May-2024 11:30:40 - 09-May-2024 11:30:50



Values displayed reflect measurements acquired against the measured waveform only.

PR	=	0.174	sec	QT	=	0.343	sec
QRS	=	0.099	sec	R-R	=	0.663	sec
QTc	=	0.421	sec			91	/min

57614509 08 1 EM 
 ARIAS, DAVID J
 Ma 68Y
 07/06/1965 05/08/2024
 Patel, MD, Keyur A
 4452315



25 mm/s

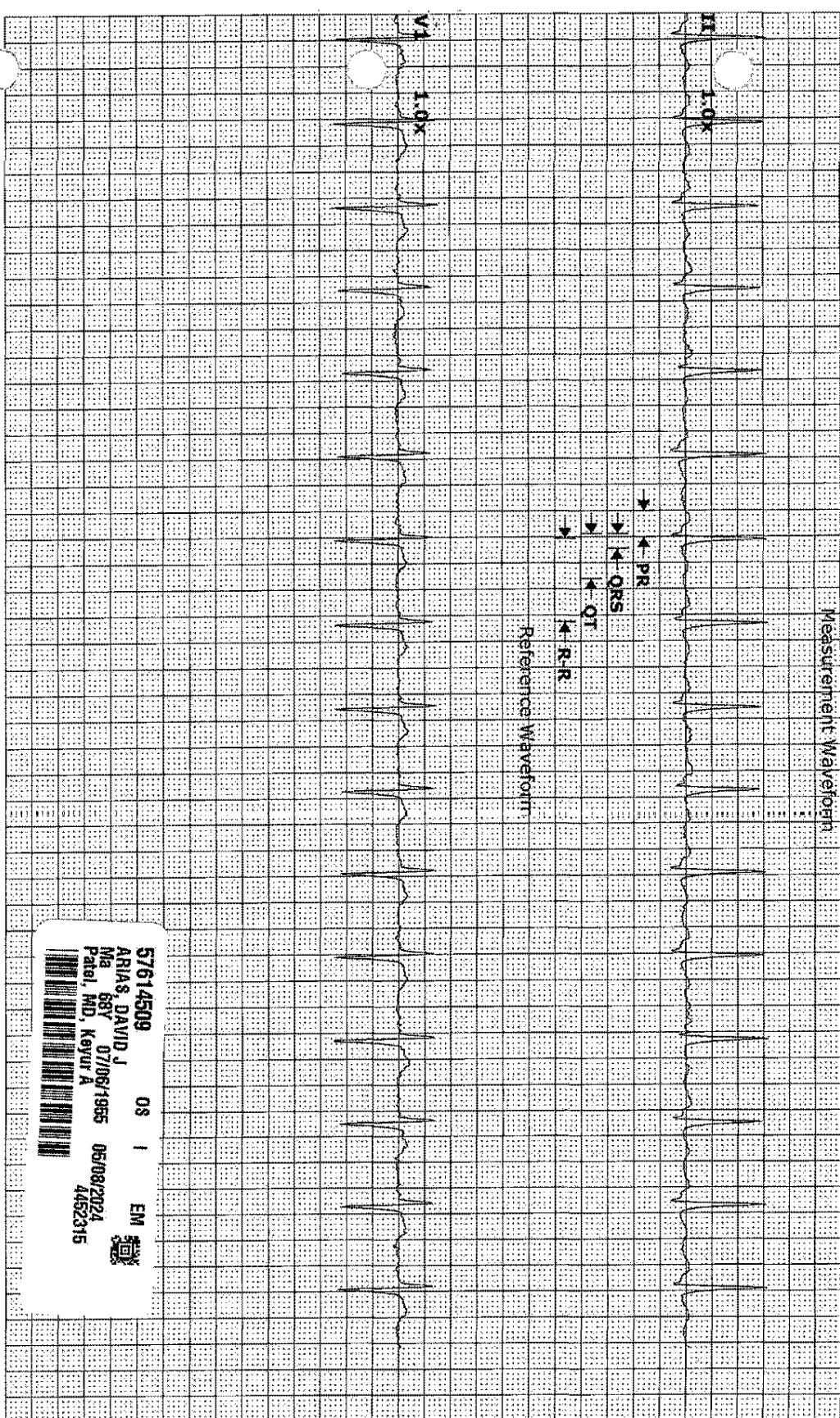
Page 1

CORESCAPE Central Station (7.1.B),
 Thursday, May 09, 2024 11:40:40 AM

END OF REPORT

ARIAS,DAVID**57614509****Caliper Measurements****5E-PCU|5135**

09-May-2024 15:39:08 - 09-May-2024 15:39:18



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.204 sec	QT	= 0.348 sec
QRS	= 0.124 sec	R-R	= 0.648 sec
QTC	= 0.432 sec	Rate	= 93 /min

CARESCAPE Central Station (7.1.8),
Thursday, May 09, 2024 3:40:51 PM

SR

WD

5/17/2024 12:42

#13103259110

Torrance Memorial Medical Cent

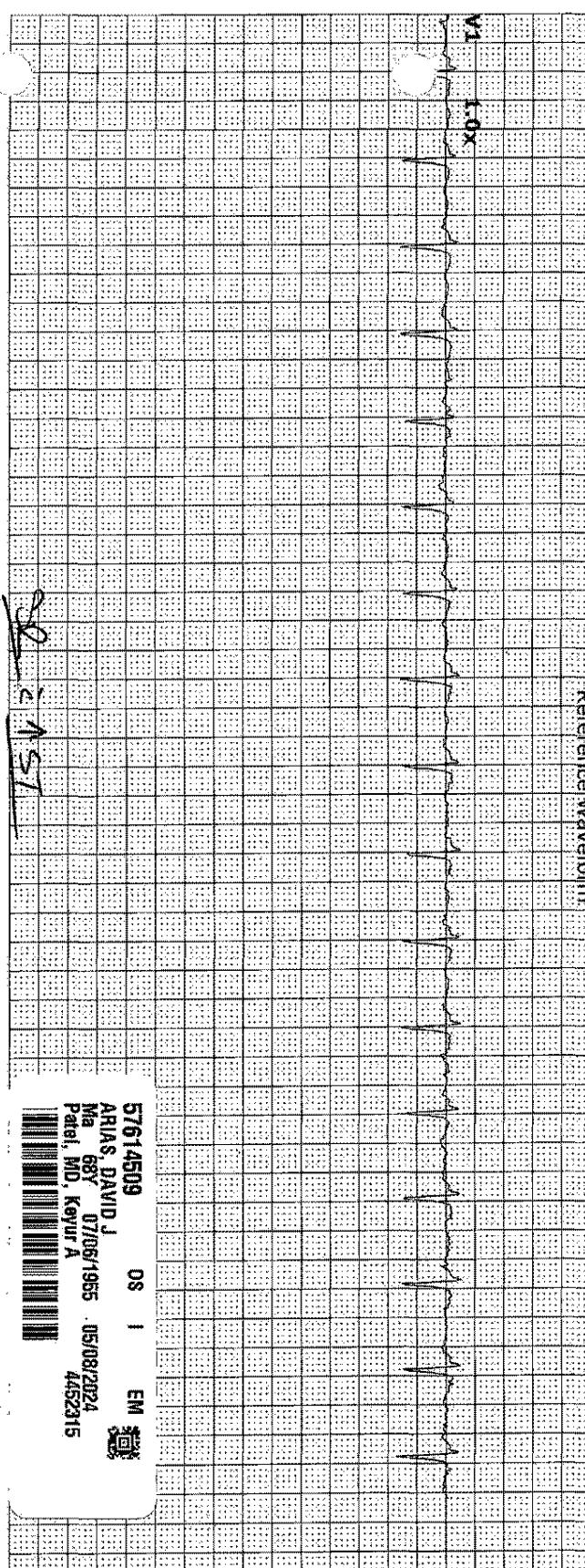
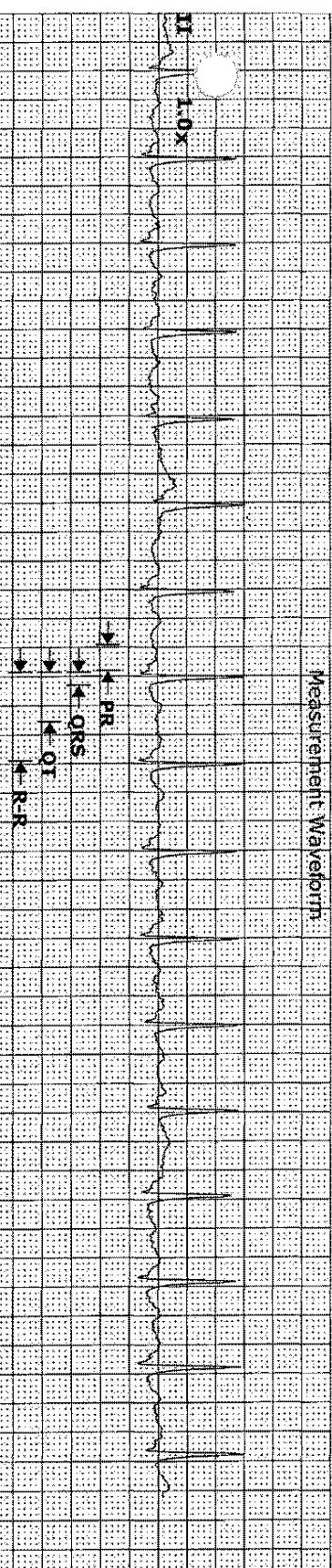
RRD→16573482482

068/103

ARIAS,DAVID **57614509**
 08-May-2024 19:26:17 - 08-May-2024 19:26:27

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.189 sec	QT	= 0.343 sec
QRS	= 0.094 sec	R-R	= 0.618 sec
QTc	= 0.436 sec	Rate	= 97 /min

CARESCAPE Central Station (7.1.8),
 Wednesday, May 08, 2024 7:27:02 PM

25 mm/s
 Page 1
 END OF REPORT

57614509 08 | EM
 ARIAS, DAVID J
 Ma 68Y 07/06/1955 05/08/2024
 Patel, MD, Keyur A 4452315

5/17/2024 12:42

#13103259110

Torrance Memorial Medical Cent

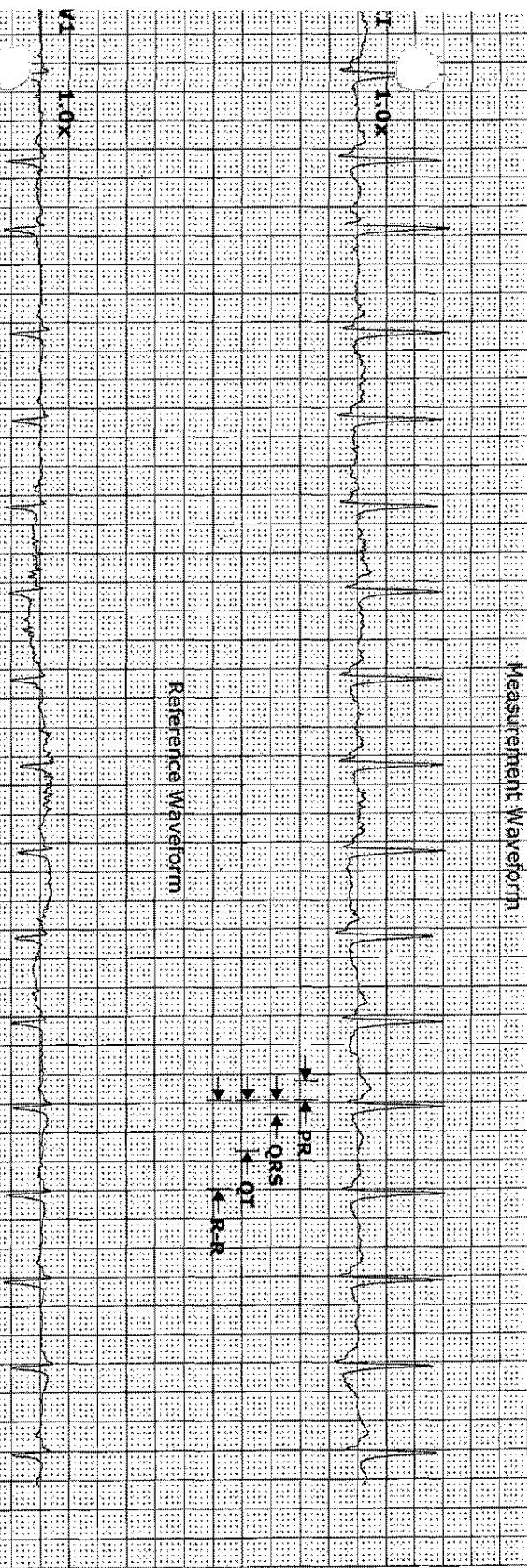
RRD→16573482482

070/103

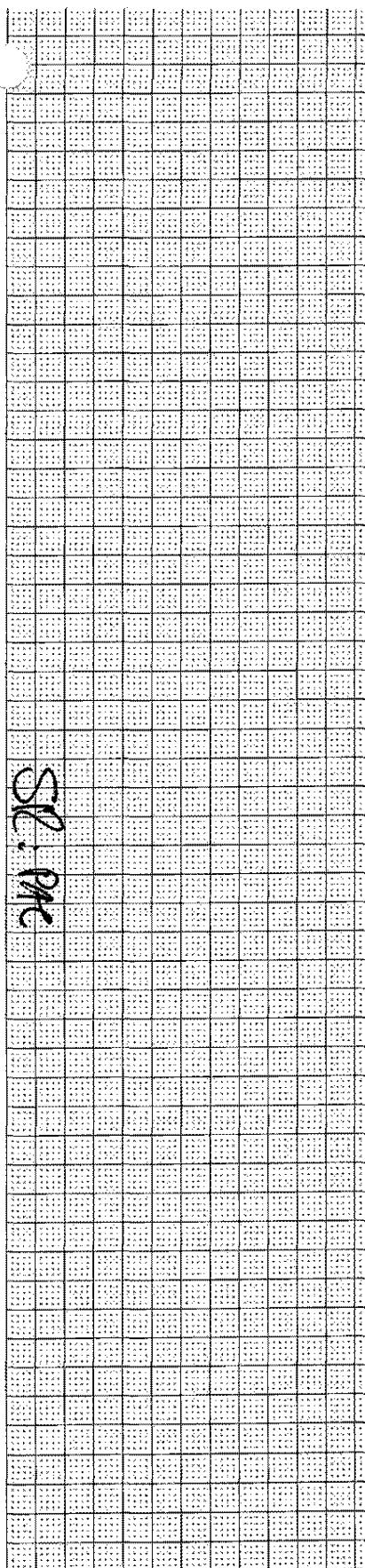
ARIAS,DAVID**57614509****Caliper Measurements****SE-PCU|5135**

18-May-2024 23:38:35 - 08-May-2024 23:38:45

Measurement Waveform



Reference Waveform

**SL. PTC**

Values displayed reflect measurements acquired against the measured waveform only.

PR	=	0.139 sec	QT	=	0.358 sec
QRS	=	0.109 sec	R-R	=	0.618 sec
QTc	=	0.455 sec	Rate	=	97 /min

57614509 OS I EM **EM**
 ARIAS, DAVID J 07061985 05082024
 Ma 68y Patel, MD, Kavur A 4452315



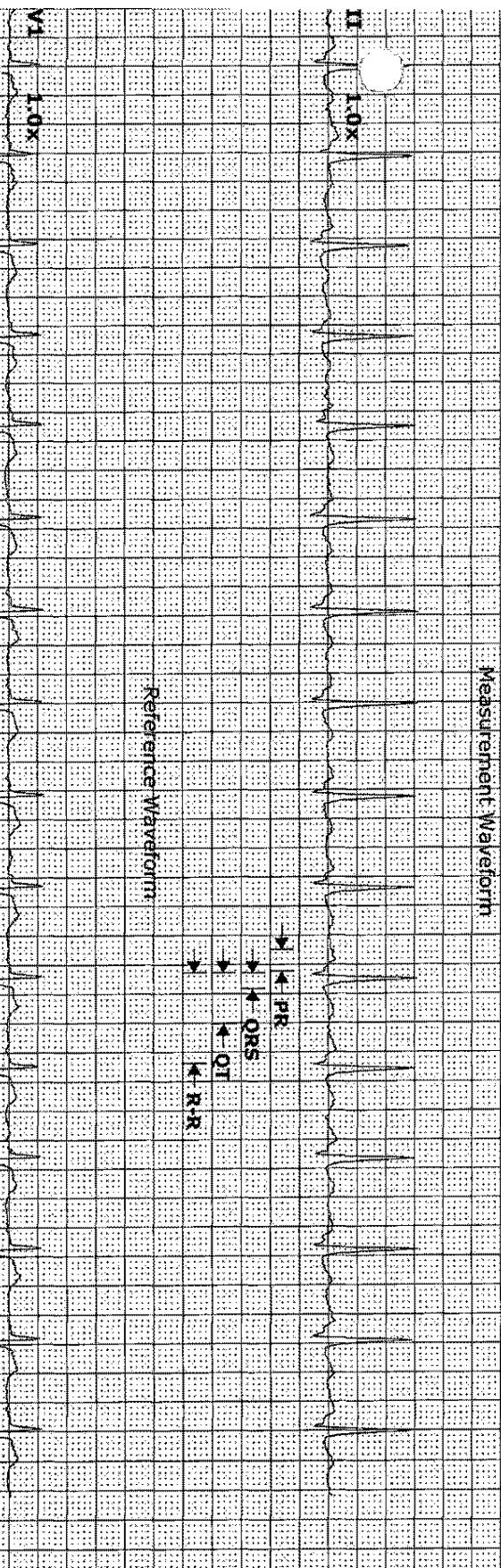
mm/s

Page 1

ARIAS,DAVID 57614509
39-May-2024 03:13:06 - 09-May-2024 03:13:16

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.154 sec	QT	= 0.353 sec
QRS	= 0.114 sec	R-R	= 0.623 sec
RTC	= 0.447 sec	Rate	= 96 /min



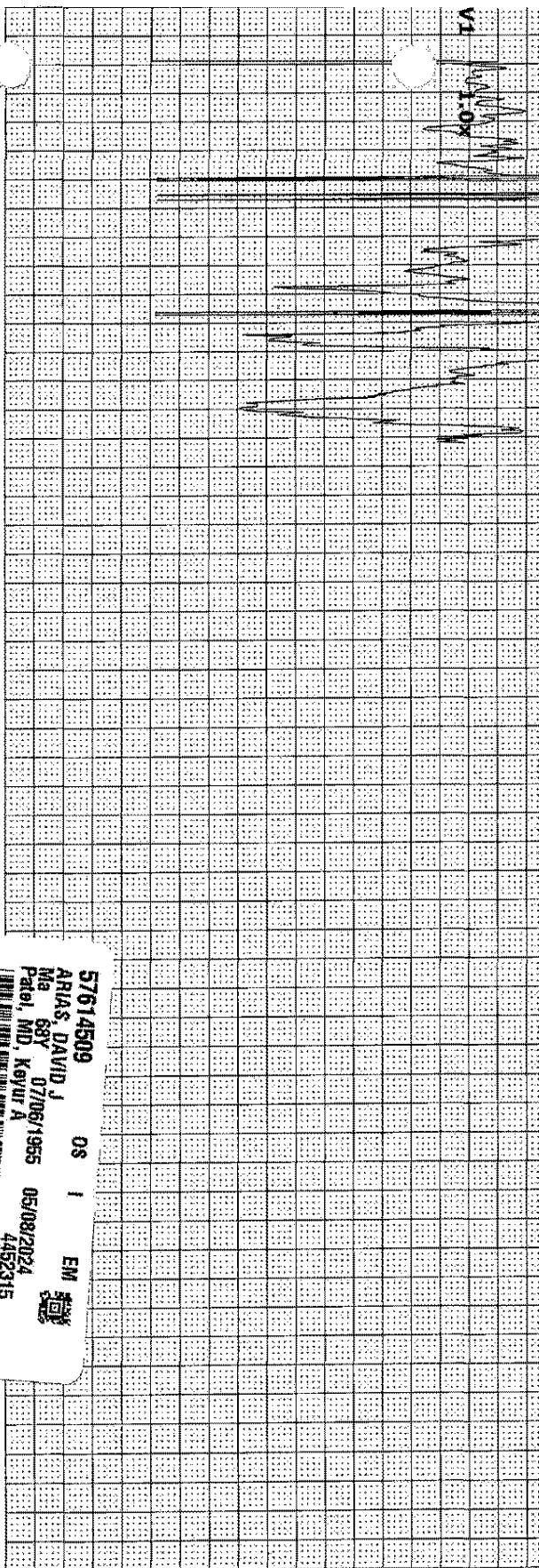
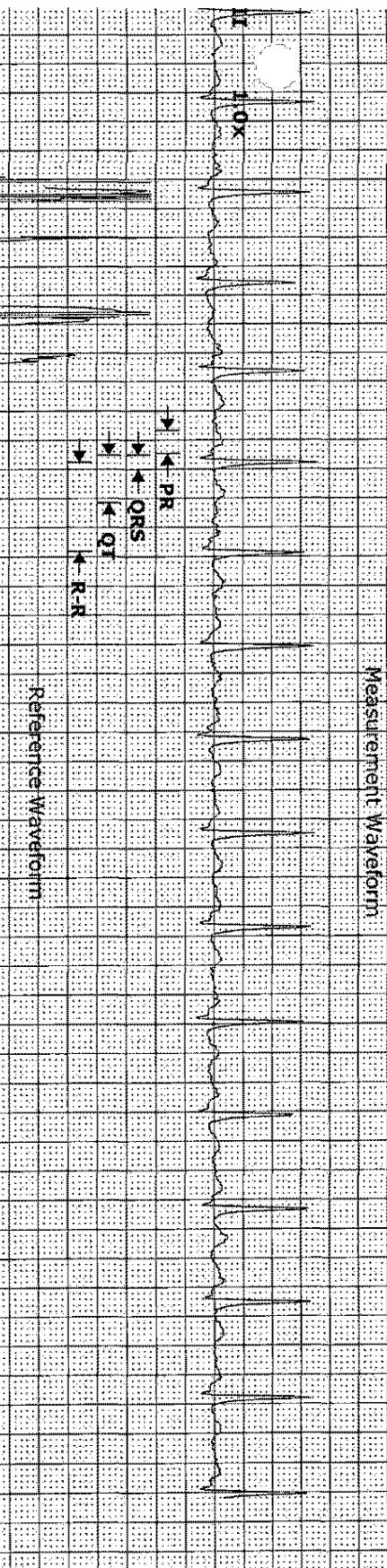
57614509 08 1 EM

ARIAS, DAVID J
Ma 68Y 07/06/1955 05/08/2024
Paul, MD, Kayur A 4452315

ARIAS,DAVID 57614509
08-May-2024 17:18:23 - 08-May-2024 17:18:33

Caliper Measurements

5E-PCU|5135



Values displayed reflect measurements acquired against the measured waveform only.

PR	=	0.164 sec	QT	=	0.338 sec
QRS	=	0.109 sec	R-R	=	0.618 sec
QTC	=	0.430 sec	Rate	=	97 /min



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Procedure Report

DOCUMENT NAME: Radiology Procedure Note
SERVICE DATE/TIME: 5/13/2024 15:14 PDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: So,MD,George J (5/13/2024 15:16 PDT)
SIGN INFORMATION: So,MD,George J (5/13/2024 15:16 PDT)

Biopsy by Radiology

Diagnosis: Left iliac bone small lytic lesion

Procedure: Biopsy with imaging guidance

Anesthesia: Local - Lidocaine 1%

Findings: Appropriate needle position, s/p core bx left iliac bone small lytic lesion, total of 5 core bx performed with 11G 10 cm Madison needle

Specimens: Core biopsies

Drain(s): None

Estimated Blood Loss: Minimal

Complications: None

Condition: Patient re-assessed, with no change from immediate pre-procedure condition.

Additional Notes: Please see full detailed report to follow.

Electronically Signed On: 05/13/2024 15:16 PDT

By: So, MD, George J

DOCUMENT NAME: Radiology Procedure Note
SERVICE DATE/TIME: 5/9/2024 18:11 PDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: So,MD,George J (5/9/2024 18:12 PDT)
SIGN INFORMATION: So,MD,George J (5/9/2024 18:12 PDT)

Pre-procedure Sedation Documentation

05/09/24 17:37:00

History and Physical Update : Patient was examined, H&P reviewed & there are no changes in condition since dictated/documentated H&P report

Allergies Reviewed : NKA

Airway Assessment : No obvious abnormalities; Dentures and removable oral appliances removed, when applicable; No loose teeth; No foreign objects in mouth

ASA Classification : ASA 2: patient with mild system disease

Sedation Level : Moderate Sedation

Sedation Route : IV

Sedation Approval : Patient determined to be an appropriate candidate for anesthesia/sedation

Sedation Explained : Risks, benefits and alternatives of procedure and sedation have been explained to and understood by the



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Procedure Report

patient/agent

Pre-sedation Assessment Date/Time : 05/09/2024 17:37 PDT

So, MD, George J - 05/09/2024 17:37 PDT

Pre-induction Assessment

05/09/24 17:37:00

Pre-procedure assessment reviewed; vital signs reviewed; will proceed as planned

Pre-induction Assessment Date/Time : 05/09/2024 17:37 PDT

So, MD, George J - 05/09/2024 17:37 PDT

Retrievable IVC Filter Placement by Radiology

Diagnosis: Contraindication to anticoagulation.

Procedure: Retrievable IVC filter placement.

Anesthesia: Local

Findings: Infrarenal placement of retrievable IVC filter via right common femoral vein.

Specimens: None.

Drain(s): None

Estimated Blood Loss: Minimal

Complications: None

Condition: Patient re-assessed, with no change from immediate pre-procedure condition.

Additional Notes: Please see full detailed report to follow.

Electronically Signed On: 05/09/2024 18:12 PDT

By: So, MD, George J

Microbiology

PROCEDURE:	Respiratory PCR Panel ^{***}	ACCESSION:	24-133-2491
SOURCE:	NP Swab	BODY SITE:	
COLLECTED DATE/TIME:	5/12/2024 17:41 PDT	RECEIVED DATE/TIME:	5/12/2024 18:00 PDT
START DATE/TIME:	5/12/2024 18:00 PDT	FREE TEXT SOURCE:	

FINAL REPORTS

Final Report

Verified Date/Time/Personnel: 5/12/2024 19:02 PDT Kuizon , MaryAnn T

None Detected by a culture independent diagnostic test (PCR)



Patient Name: **ARIAS, DAVID J**
MRN: **4452315**
FIN: **57614509**

Microbiology

Interpretive Data

^1: Respiratory PCR Panel

This is a culture independent diagnostic test (multiplexed individual PCR assays). The panel simultaneously detects SARS-CoV-2 (COVID-19), Adenovirus, Coronavirus 229E, Coronavirus HKU1, Coronavirus NL63, Coronavirus OC43, Human Metapneumovirus, Human Rhinovirus/Enterovirus, Influenza A, Influenza B, Parainfluenza Viruses 1-4, Respiratory Syncytial Virus, Bordetella pertussis, Bordetella parapertussis, Chlamydophila pneumoniae and Mycoplasma pneumoniae.

This test does not differentiate viable from non-viable/non-infectious microorganisms. Recent administration of nasal influenza vaccines (e.g. FluMist) prior to specimen collection could lead to accurate detection of the viruses contained in the vaccine but would not represent infection.

Negative results do not exclude target nucleic acids which are present in the specimen but below the limit of detection for each assay. In addition, optimum specimen type and timing for peak viral levels during infection caused by SARS-CoV-2 has not been determined. The possibility of a false negative result should be considered if the patient's recent exposure or clinical presentation suggests COVID-19 and diagnostic tests for other causes of respiratory illness are not detected. All results should be correlated with patient's clinical history and symptoms.

PROCEDURE:	Blood Culture ^{^1}	ACCESSION:	24-133-1332
SOURCE:	Blood	BODY SITE:	
COLLECTED DATE/TIME:	5/12/2024 09:29 PDT	RECEIVED DATE/TIME:	5/12/2024 10:09 PDT
START DATE/TIME:	5/12/2024 10:09 PDT	FREE TEXT SOURCE:	

PRELIMINARY REPORTS

Preliminary Report

Verified Date/Time/Personnel: 5/13/2024 08:00 PDT ANG Process Server

No growth to date

PROCEDURE:	Blood Culture ^{^1}	ACCESSION:	24-133-1333
SOURCE:	Blood	BODY SITE:	
COLLECTED DATE/TIME:	5/12/2024 09:27 PDT	RECEIVED DATE/TIME:	5/12/2024 10:09 PDT
START DATE/TIME:	5/12/2024 10:09 PDT	FREE TEXT SOURCE:	

PRELIMINARY REPORTS

Preliminary Report

Verified Date/Time/Personnel: 5/13/2024 08:00 PDT ANG Process Server

No growth to date



Patient Name: ARIAS, DAVID J
 MRN: 4452315
 FIN: 57614509

Microbiology

PROCEDURE: Urine Culture *1
 SOURCE: Urine
 COLLECTED DATE/TIME: 5/8/2024 16:21 PDT
 START DATE/TIME: 5/8/2024 17:55 PDT

ACCESSION: 24-129-4841
 BODY SITE:
 RECEIVED DATE/TIME: 5/8/2024 17:55 PDT
 FREE TEXT SOURCE:

FINAL REPORTS

Final Report

Verified Date/Time/Personnel: 5/10/2024 10:39 PDT Drew ,Nichole M

NO GROWTH AT 2 DAYS

PRELIMINARY REPORTS

Preliminary Report

Verified Date/Time/Personnel: 5/9/2024 11:15 PDT Drew ,Nichole M

NO GROWTH AT 1 DAY

Chemistry

Procedure	Collected Date 5/8/2024	Collected Time 13:56 PDT	5/8/2024 16:21 PDT	Units	Ref Range
Clarity UA POC	-		Clear 01*1		Clear
Color UA POC	-		Yellow 01*1		Yellow
Specific Gravity UA POC	-		1.015 01*1		1.005-1.030
pH UA POC	-		6.0 01*1		5.0-7.5
Ketones UA POC	-		Neg 01*1		Neg
Blood UA POC	-		2+ @ 01*1		Neg
Protein UA POC	-		1+ @ 01*1		Neg
Nitrite UA POC	-		Neg 01*1		Neg
Leukocyte Esterase UA POC	-		Trace 01*1		Neg
Glucose UA POC	-		Neg 01*1		Neg
Sodium	134 L*1	-		mmol/L	136-145
Potassium	5.6 H*1	-		mmol/L	3.5-5.1
Chloride	107 *1	-		mmol/L	98-107
CO2	17 L*1	-		mmol/L	22-29
Anion Gap	10 *1	-			3-11
Glucose	105 H*2 *1	-		mg/dL	70-99
BUN	105 H*1	-		mg/dL	8-26
Creatinine	4.44 H*1	-		mg/dL	0.73-1.18
eGFR	14 *3 *1	-			
Calcium	8.9 ^4 *1	-		mg/dL	8.7-10.5
Total Protein	6.5 *1	-		gm/dL	6.4-8.3
Albumin	3.0 L*1	-		gm/dL	3.5-5.2
Globulin	3.5 *1	-		gm/dL	1.0-5.0
Bilirubin Total	0.4 *1	-		mg/dL	0.2-1.2
Bilirubin Direct	0.3 *1	-		mg/dL	0.0-0.5
Alkaline Phosphatase	79 *1	-		units/L	40-150



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Chemistry

	Collected Date	5/8/2024	5/8/2024	
	Collected Time	13:56 PDT	16:21 PDT	
Procedure				Units
AST		34 *1	-	units/L
ALT		32 *1	-	units/L
Troponin I High Sensitivity		15 ^5 *1	-	ng/L
Creatinine Random Urine		-	59.0 *9 *1	mg/dL
Potassium Random Urine		-	27.6 ^10 *1	mmol/L
Sodium Random Urine		-	54 ^11 *1	mmol/L

	Collected Date	5/8/2024		
	Collected Time	16:23 PDT		
Procedure				Units
Protein Electrophor.Rnd Urine-Albumin		22.7 *2		mg/dL
Alpha 1-Globulin PEP Rnd Urn		1.3 *2		mg/dL
Alpha 2-Globulin PEP Rnd Urn		5.0 *2		mg/dL
Beta-Globulin PEP Rnd Urn		5.0 *2		mg/dL
Gamma Globulin PEP Rnd Urn		8.0 *2		mg/dL
A/G Ratio PEP Rnd Urn		1.17 *2		
M spike PEP Rnd Urn		NA *2		
M spike2 PEP Rnd Urn		NA *2		
Impression PEP Rnd Urn		SEE COMMENTS R3 *2		
Protein,Total -PEP Rnd Urn		42 *2		mg/dL
Creatinine,PEP Rnd Urn		61 *2		mg/dL
Protein/Creatinine Ratio,PEP Rnd Urn		0.69 H R4 *2		<0.18
M-protein Isotype MS,Rnd Urn		See Comment R5 *2		
Flag M-protein Isotype MS,Rnd Urn		Negative *2		Negative

Result Comments

R3: Impression PEP Rnd Urn
Small abnormality in gamma fraction.

See Isotype.

-----ADDITIONAL INFORMATION-----

This test has been modified from the manufacturer's instructions. Its performance characteristics were determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

R4: Protein/Creatinine Ratio, PEP Rnd Urn

Test Performed by:
Mayo Clinic Laboratories - Rochester Superior Drive
3050 Superior Drive NW, Rochester, MN 55905
Lab Director: William G. Morice M.D. Ph.D.; CLIA# 24D1040592

Test Performed by:



Patient Name: ARIAS, DAVID J
MRN: 4452315
FIN: 57614509

Chemistry

Result Comments

- R4: Protein/Creatinine Ratio, PEP Rnd Urn
Mayo Clinic Laboratories - Rochester Main Campus
200 First Street SW, Rochester, MN 55905
Lab Director: William G. Morice M.D. Ph.D.; CLIA# 24D0404292
- R5: M-protein Isotype MS, Rnd Urn
RESULT: No monoclonal protein detected.

-----ADDITIONAL INFORMATION-----

The submitted sample was assayed by five separate immunopurifications for IgG, IgA, IgM, kappa and lambda. The result reflects the findings of either no monoclonal protein detected or those monoclonal immunoglobulins that were detected.

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

Procedure	Collected Date Collected Time	5/9/2024 05:07 PDT	5/10/2024 05:24 PDT	Units	Ref Range
Sodium		135 ^{L+1}	142 ^{L+1}	mmol/L	136-145
Potassium		4.2 ⁺¹	3.9 ⁺¹	mmol/L	3.5-5.1
Chloride		111 ^{H+1}	115 ^{H+1}	mmol/L	98-107
CO2		16 ^{L+1}	21 ^{L+1}	mmol/L	22-29
Anion Gap		8 ⁺¹	6 ⁺¹		3-11
Glucose		112 ^{H+2+1}	115 ^{H+2+1}	mg/dL	70-99
BUN		83 ^{H+1}	52 ^{H+1}	mg/dL	8-26
Creatinine		3.00 ^{H+1}	1.62 ^{H+1}	mg/dL	0.73-1.18
eGFR		22 ³⁺¹	46 ³⁺¹		
Calcium		8.3 ^{L+4+1}	8.5 ^{L+4+1}	mg/dL	8.7-10.5
Magnesium		1.7 ⁺¹	-	mg/dL	1.6-2.6
Total Protein		5.2 ^{L+1}	5.3 ^{L+1}	gm/dL	6.4-8.3
Albumin		2.4 ^{L+1}	2.4 ^{L+1}	gm/dL	3.5-5.2
Globulin		2.8 ⁺¹	2.9 ⁺¹	gm/dL	1.0-5.0
Bilirubin Total		0.4 ⁺¹	0.5 ⁺¹	mg/dL	0.2-1.2
Bilirubin Direct		0.3 ⁺¹	-	mg/dL	0.0-0.5
Alkaline Phosphatase		65 ⁺¹	60 ⁺¹	units/L	40-150
AST		29 ⁺¹	33 ⁺¹	units/L	5-34
ALT		27 ⁺¹	31 ⁺¹	units/L	0-55
Iron		-	23 ^{L+1}	mcg/dL	65-175
Iron % Saturation		-	16 ⁺¹	%	11-46
UIBC (Unsaturated Iron Binding Capacity)		-	123 ⁺¹	mcg/dL	69-240
Ferritin		-	342.8 ^{H+1}	ng/mL	22.0-275.0
Immunoglobulin A (IgA)		-	245 ⁺¹	mg/dL	101-645
Immunoglobulin A (IgA)		255 ⁻²	-	mg/dL	61-356
Immunoglobulin G (IgG)		-	1161 ⁻⁶⁺¹	mg/dL	540-1822



Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Chemistry

Procedure	Collected Date Collected Time	5/9/2024 05:07 PDT	5/10/2024 05:24 PDT	Units	Ref Range
Immunoglobulin G (IgG)		1010 *2	-	mg/dL	767 -1590
Immunoglobulin M (IgM)		-	70 *1	mg/dL	22-240
Immunoglobulin M (IgM)		59 *2	-	mg/dL	37 -286
Free Light Chains -Kappa Light Chain		12.1 H *2	-	mg/dL	0.3300-1.94
Lambda Light Chain		5.86 H *2	-	mg/dL	0.5700-2.63
Kappa/Lambda Ratio		2.06 H R1 *2	-		0.2600-1.65
M-protein GK		0.030 H *2	-	gm/dL	
M-protein GL		NA *2	-		
M-protein AK		NA *2	-		
M-protein AL		NA *2	-		
M-protein MK		NA *2	-		
M-protein ML		NA *2	-		
Flag,M-protein Isotype		Positive @ *2	-		Negative
QMPTS Interpretation		SEE COMMENTS R2 *2	-		
Glycosylation		NA *2	-		
CEA		-	12.3 H *7 *1	ng/mL	<=5.0
Prostatic Specific Antigen (PSA)		6.80 H *8 *1	-	ng/mL	0.10-4.00

Result Comments

R1: Kappa/Lambda Ratio

Elevated free light chain ratios between 1.66 and 3.00 may occur due to polyclonal hypergammaglobulinemia or impaired renal clearance. An isolated increased free light chain ratio in this range should be interpreted with caution, and clinical correlation is recommended.

Test Performed by:

Mayo Clinic Laboratories - Rochester Superior Drive
3050 Superior Drive NW, Rochester, MN 55905
Lab Director: William G. Morice M.D. Ph.D.; CLIA# 24D1040592

R2: QMPTS Interpretation

IgG kappa <0.010 g/dL
IgG kappa 0.025 g/dL C/W Elotuzumab.

If the patient is not on Elotuzumab (Empliciti) or REGN5458/5459, the monoclonal IgG kappa is indicative of a monoclonal gammopathy.

-----ADDITIONAL INFORMATION-----

The submitted sample was assayed by five separate immunopurifications for IgG, IgA, IgM, kappa and lambda. The result reflects the findings of either no monoclonal protein detected or those monoclonal immunoglobulins that were detected.

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA



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Chemistry**Result Comments**

R2: QMPTS Interpretation
 requirements. This test has not been cleared or approved by
 the U.S. Food and Drug Administration.

Procedure	Collected Date 5/11/2024	Collected Time 06:03 PDT	5/12/2024 09:27 PDT	5/13/2024 06:02 PDT	Units	Ref Range
Sodium	143 ^{**}		139 ^{**}	137 ^{**}	mmol/L	136-145
Potassium	3.7 ^{**}		4.2 ^{**}	4.6 ^{**}	mmol/L	3.5-5.1
Chloride	115 ^{H**}		111 ^{H**}	109 ^{H**}	mmol/L	98-107
CO2	21 ^{L**}		22 ^{**}	22 ^{**}	mmol/L	22-29
Anion Gap	7 ^{**}		6 ^{**}	6 ^{**}		3-11
Glucose	111 ^{H^2**}		97 ^{H^2**}	99 ^{H^2**}	mg/dL	70-99
BUN	28 ^{H**}		24 ^{**}	25 ^{**}	mg/dL	8-26
Creatinine	1.04 ^{**}		1.11 ^{**}	1.34 ^{H**}	mg/dL	0.73-1.18
eGFR	78 ^{A^3**}		72 ^{A^3**}	58 ^{A^3**}		
Calcium	8.4 ^{L^4**}		7.7 ^{L^4**}	7.4 ^{L^4**}	mg/dL	8.7-10.5
Total Protein	5.5 ^{L**}		5.1 ^{L**}	5.0 ^{L**}	gm/dL	6.4-8.3
Albumin	2.5 ^{L**}		2.3 ^{L**}	2.1 ^{L**}	gm/dL	3.5-5.2
Globulin	3.0 ^{**}		2.8 ^{**}	2.9 ^{**}	gm/dL	1.0-5.0
Bilirubin Total	0.4 ^{**}		0.3 ^{**}	0.3 ^{**}	mg/dL	0.2-1.2
Alkaline Phosphatase	59 ^{**}		51 ^{**}	47 ^{**}	units/L	40-150
AST	35 ^{H**}		50 ^{H**}	39 ^{H**}	units/L	5-34
ALT	34 ^{**}		48 ^{**}	42 ^{**}	units/L	0-55
CRP Non-Cardiac	-		-	5.96 ^{H**}	mg/dL	<=0.49

Order Comments

O1: POCT Urine Dip Accn
 POCT Urine Dip order placed.

Interpretive Data

^{**}2: Glucose

Interpretive Guidelines:

Fasting: 70 - 99 mg/dL

Non-fasting: <140 mg/dL - 2 hours after eating

^{A^3}: eGFR

Estimated GFR units are reported in ml/min/1.73 sq. meter.

eGFR 2021 CKD EPI equation adopted 02/01/2022

The CKD-EPI equation has not been validated in children (age < 18 years), pregnant women, or in some racial or ethnic subgroups, such as Hispanics. The equation will also be less accurate in patients with differences in nutritional status or muscle mass.

Classification of Stages of Chronic Kidney Disease

Stage 1: eGFR >90: Consistent with normal GFR unless evidence of kidney damage exists.

Stage 2: eGFR 60 - 89: Consistent with mild kidney disease.

Stage 3: eGFR 30 - 59: Consistent with moderate chronic renal disease.



Patient Name: **ARIAS, DAVID J**
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 FIN: **57614509**

Chemistry

Interpretive Data

^3: eGFR

Stage 4: eGFR 15 - 29: Consistent with severe chronic kidney disease.
 Stage 5: eGFR <15: Consistent with kidney failure.

^4: Calcium

New reference range effective 4/2/2024

^5: Troponin I High Sensitivity

Interpretive Guidelines: Abbott Troponin I High Sensitivity

A reference range study was conducted based on guidance from CLSI EP28-A3c. Specimens were collected from 1531 apparently healthy individuals in a US population with normal levels of cardiac B-type natriuretic peptide (BNP) and HbA1c, and glomerular filtration rate (GFR) values \geq 60 mL/min.

The 99th percentiles for Abbott Alinity High Sensitivity Troponin I assay are:

Female: \leq 14 ng/L

Male: \leq 35 ng/L

^6: Immunoglobulin G (IgG)

Reference Range(s)

	Male	Female
0-1 month	397-1765 mg/dL	391-1737 mg/dL
>1 month - 1 Year	205-948 mg/dL	203-934 mg/dL
>1-2 Years	475-1210 mg/dL	483-1226 mg/dL
>2-80 Years	540-1822 mg/dL	552-1631 mg/dL
>80 Years	Not established	Not established

^7: CEA

Reference Range for CEA (ng/mL)

Smokers: $<$ 5.0

Non-smokers: $<$ 2.5

Results were generated using the Siemens Advia Centaur Immunoassay system. Values obtained from different assay methods cannot be used interchangeably. The results of this assay should not be used as absolute evidence of the presence or absence of malignant disease. Results should be used in conjunction with other diagnostic procedures.

^8: Prostatic Specific Antigen (PSA)

Results were generated using the **Abbott Alinity** Immunoassay system. Values obtained from different assay methods cannot be used interchangeably. The results of this assay should not be used as absolute evidence of the presence or absence of malignant disease. Results should be used in conjunction with other diagnostic procedures.

Effective date June 22, 2021

^9: Creatinine Random Urine

Interpretive Guidelines: Random Urine Creatinine



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Chemistry

Interpretive Data**^9: Creatinine Random Urine**

Creatinine in a random sample is highly variable and must be interpreted with the knowledge of a number of factors including the patient's age, weight, diet, exercise routine, and infection status. Results may be useful in correlation with other tests.

Reference ranges are not established for Random Urine Creatinine.

^10: Potassium Random Urine

Interpretive Guidelines: Potassium Random Urine

Interpretation requires clinical correlation. In the hypokalemic patient, a spot urinary potassium greater than 20 mmol/L suggests that the kidney may be the source of potassium loss or that the loss may be acute. Random excretion is variable and must be correlated with the patient's diet, acid-base balance and state of hydration. Significant diurnal variation (output greater at night) can exist. Results may be useful in conjunction with other tests.

There are no established reference ranges for Random Urine Potassium.

^11: Sodium Random Urine

Interpretive Guidelines: Sodium Random Urine

Sodium excretion in a random specimen is highly variable and must be correlated with the patient's diet and state of hydration. Interpretation requires clinical correlation. Significant diurnal variation (output lower at night) can exist. Results may be useful in conjunction with other tests.

There are no established reference ranges for Random Urine Sodium.

Hematology

Procedure	Collected Date	5/8/2024	5/8/2024	5/8/2024	Units	Ref Range
	Collected Time	13:56 PDT	14:51 PDT	16:21 PDT		
WBC x 10 ³		11.2 ^H 1	-	-	/CMM	3.6-11.2
RBC x 10 ⁶		2.38 ^L 1	-	-	/CMM	4.70-6.10
Hemoglobin		7.5 ^L 1	-	-	gm/dL	14.0-18.0
Hematocrit		22.5 ^L 1	-	-	%	42.0-52.0
MCV		94.6 ^H 1	-	-	fL	80.0-99.0
MCH		31.7 ^H 1	-	-	pg	26.0-34.0
MCHC		33.5 ^H 1	-	-	gm/dL	31.0-36.5
RDW		17.5 ^H 1	-	-	%	11.0-15.5
Platelets x 10 ³		190 ^H 1	-	-	/CMM	140-440
MPV		8.6 ^H 1	-	-	fL	5.1-10.0
Neutrophils		88.1 ^H 1	-	-	%	50.0-75.0
Lymphocytes		3.9 ^L 1	-	-	%	20.0-45.0
Monocytes		5.1 ^H 1	-	-	%	2.0-10.0
Eosinophils		2.5 ^H 1	-	-	%	0.0-6.0
Basophils		0.4 ^H 1	-	-	%	0.0-2.0
Neutrophils Absolute		9.9 ^H 1	-	-	x10e3/mcL	1.8-8.4
Lymphocytes Absolute		0.4 ^L 1	-	-	x10e3/mcL	0.7-5.0
Monocytes Absolute		0.6 ^H 1	-	-	x10e3/mcL	0.1-1.1



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Hematology

	Collected Date Collected Time	5/8/2024 13:56 PDT	5/8/2024 14:51 PDT	5/8/2024 16:21 PDT	Units	Ref Range
Procedure						
Eosinophils Absolute		0.3 *1	-	-	x10e3/mcL	0.0-0.7
Basophils Absolute		0.0 *1	-	-	x10e3/mcL	0.0-0.2
Eosinophil Smear		-	-	None Seen *1		None Seen
Eosinophil Smear Source		-	-	URINE *1		
ABORh		-	O POS *2 *1	-		
Antibody Screen		-	Negative *1	-		
Prothrombin Time		14.6 H *1	-	-	second(s)	10.2-12.9
PTT		38.4 H *1	-	-	second(s)	25.0-38.0
INR		1.3 *13 *1	-	-		

	Collected Date Collected Time	5/9/2024 05:07 PDT	5/9/2024 16:29 PDT	5/10/2024 05:24 PDT	Units	Ref Range
Procedure						
WBC x 10 ³		7.7 *1	6.7 *1	-	/CMM	3.6-11.2
RBC x 10 ⁶		2.01 L *1	2.25 L *1	-	/CMM	4.70-6.10
Hemoglobin		6.4 L *1	7.1 L *1	-	gm/dL	14.0-18.0
Hematocrit		18.9 L *1	20.8 L *1	-	%	42.0-52.0
MCV		93.8 *1	92.2 *1	-	fL	80.0-99.0
MCH		31.8 *1	31.6 *1	-	pg	26.0-34.0
MCHC		33.9 *1	34.3 *1	-	gm/dL	31.0-36.5
RDW		17.1 H *1	16.7 H *1	-	%	11.0-15.5
Platelets x 10 ³		164 *1	159 *1	-	/CMM	140-440
MPV		8.7 *1	8.2 *1	-	fL	5.1-10.0
Neutrophils		84.1 H *1	-	-	%	50.0-75.0
Lymphocytes		6.8 L *1	-	-	%	20.0-45.0
Monocytes		5.2 *1	-	-	%	2.0-10.0
Eosinophils		3.4 *1	-	-	%	0.0-6.0
Basophils		0.5 *1	-	-	%	0.0-2.0
Neutrophils Absolute		6.5 *1	-	-	x10e3/mcL	1.8-8.4
Lymphocytes Absolute		0.5 L *1	-	-	x10e3/mcL	0.7-5.0
Monocytes Absolute		0.4 *1	-	-	x10e3/mcL	0.1-1.1
Eosinophils Absolute		0.3 *1	-	-	x10e3/mcL	0.0-0.7
Basophils Absolute		0.0 *1	-	-	x10e3/mcL	0.0-0.2
Neutrophils Manl		-	-	88 H *1	%	50-75
Bands Manl		-	-	1 *1	%	0-7
Lymphocytes Manl		-	-	4 L *1	%	20-45
Monocytes Manl		-	-	4 *1	%	2-10
Eosinophils Manl		-	-	2 *1	%	0-6
Basophil Man		-	-	1 *1	%	0-2
Nucleated RBCs Manl		-	-	0 *1	/100WBC	0-0
Neutrophils Manl Absolute		-	-	5.5 *1	x10e3/mcL	1.8-8.4
Lymphocytes Manl Absolute		-	-	0.2 L *1	x10e3/mcL	0.7-5.0
Monocytes Manl Absolute		-	-	0.2 *1	x10e3/mcL	0.1-1.1



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	Collected Date Collected Time	5/9/2024 05:07 PDT	5/9/2024 16:29 PDT	5/10/2024 05:24 PDT	Units	Ref Range
Procedure						
Eosinophils ManL Absolute	-	-	-	0.1 ¹¹	x10e3/mcL	0.0-0.7
Basophils ManL Absolute	-	-	-	0.0 ¹¹	x10e3/mcL	0.0-0.2
NRBC ManL Absolute	-	-	-	0.0 ¹¹	x10e3/mcL	
Segmented Neutrophils ManL Absolute	-	-	-	5.4 ¹¹	x10e3/mcL	
Sample Comment	-	-	-	See Notes ^{R6 11}		
Platelet Estimate	-	-	-	Normal ¹¹		
Poikilocytosis	-	-	-	2+ ¹¹		None
Anisocytosis	-	-	-	1+ ¹¹		None
Polychromasia	-	-	-	2+ ¹¹		None
Acanthocytes	-	-	-	1+ ¹¹		None
Reticulocyte Count	-	-	-	1.6 ¹¹	%	0.5-2.0

Result Comments

R6: Sample Comment

Slide Reviewed by KU

	Collected Date Collected Time	5/10/2024 05:24 PDT	5/11/2024 06:03 PDT	5/12/2024 09:27 PDT	Units	Ref Range
Procedure						
WBC x 10 ³		6.2 ¹¹	7.2 ¹¹	10.3 ¹¹	/CMM	3.6-11.2
RBC x 10 ⁶		2.41 ^{L 11}	2.41 ^{L 11}	2.41 ^{L 11}	/CMM	4.70-6.10
Hemoglobin		7.4 ^{L 11}	8.1 ^{L 11}	7.6 ^{L 11}	gm/dL	14.0-18.0
Hematocrit		22.1 ^{L 11}	22.2 ^{L 11}	22.4 ^{L 11}	%	42.0-52.0
MCV		91.7 ¹¹	92.3 ¹¹	93.1 ¹¹	fL	80.0-99.0
MCH		30.9 ¹¹	33.7 ¹¹	31.4 ¹¹	pg	26.0-34.0
MCHC		33.6 ¹¹	36.5 ¹¹	33.7 ¹¹	gm/dL	31.0-36.5
RDW		17.4 ^{H 11}	17.4 ^{H 11}	17.4 ^{H 11}	%	11.0-15.5
Platelets x 10 ³		185 ¹¹	187 ¹¹	177 ¹¹	/CMM	140-440
MPV		8.8 ¹¹	8.8 ¹¹	8.9 ¹¹	fL	5.1-10.0
Neutrophils		See Manual Diff ¹¹	69.4 ¹¹	88.6 ^{H 11}	%	50.0-75.0
Lymphocytes		See Manual Diff ¹¹	15.1 ^{L 11}	4.9 ^{L 11}	%	20.0-45.0
Monocytes		See Manual Diff ¹¹	12.1 ^{H 11}	3.7 ¹¹	%	2.0-10.0
Eosinophils		See Manual Diff ¹¹	2.6 ¹¹	2.7 ¹¹	%	0.0-6.0
Basophils		See Manual Diff ¹¹	0.8 ¹¹	0.1 ¹¹	%	0.0-2.0
Neutrophils Absolute		See Manual Diff ¹¹	5.0 ¹¹	9.1 ^{H 11}	x10e3/mcL	1.8-8.4
Lymphocytes Absolute		See Manual Diff ¹¹	1.1 ¹¹	0.5 ^{L 11}	x10e3/mcL	0.7-5.0
Monocytes Absolute		See Manual Diff ¹¹	0.9 ¹¹	0.4 ¹¹	x10e3/mcL	0.1-1.1
Eosinophils Absolute		See Manual Diff ¹¹	0.2 ¹¹	0.3 ¹¹	x10e3/mcL	0.0-0.7
Basophils Absolute		See Manual Diff ¹¹	0.1 ¹¹	0.0 ¹¹	x10e3/mcL	0.0-0.2
Sample Comment		See Notes ^{R6 11}	-	-		

Result Comments

R6: Sample Comment

Slide Reviewed by KU



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Hematology

Procedure	Collected Date	5/13/2024	Units	Ref Range
	Collected Time	06:02 PDT		
WBC x 10 ³	8.3 ^{*1}	/CMM	3.6-11.2	
RBC x 10 ⁶	2.31L ^{*1}	/CMM	4.70-6.10	
Hemoglobin	7.2L ^{*1}	gm/dL	14.0-18.0	
Hematocrit	21.4L ^{*1}	%	42.0-52.0	
MCV	92.6 ^{*1}	fL	80.0-99.0	
MCH	31.2 ^{*1}	pg	26.0-34.0	
MCHC	33.7 ^{*1}	gm/dL	31.0-36.5	
RDW	17.2H ^{*1}	%	11.0-15.5	
Platelets x 10 ³	154 ^{*1}	/CMM	140-440	
MPV	9.2 ^{*1}	fL	5.1-10.0	
Neutrophils	81.5 H ^{*1}	%	50.0-75.0	
Lymphocytes	8.4 L ^{*1}	%	20.0-45.0	
Monocytes	4.1 ^{*1}	%	2.0-10.0	
Eosinophils	5.7 ^{*1}	%	0.0-6.0	
Basophils	0.3 ^{*1}	%	0.0-2.0	
Neutrophils Absolute	6.7 ^{*1}	x10e3/mcL	1.8-8.4	
Lymphocytes Absolute	0.7 ^{*1}	x10e3/mcL	0.7-5.0	
Monocytes Absolute	0.3 ^{*1}	x10e3/mcL	0.1-1.1	
Eosinophils Absolute	0.5 ^{*1}	x10e3/mcL	0.0-0.7	
Basophils Absolute	0.0 ^{*1}	x10e3/mcL	0.0-0.2	
Sedimentation Rate	15 ^12 ^{*1}	mm/hr	0-20	
Prothrombin Time	14.0 H ^{*1}	second(s)	10.2-12.9	
INR	1.2 ^13 ^{*1}			

Order Comments

O2: ABORH - Blood Type

State law requires that pregnant women be informed of the results of the Rh Typing

Interpretive Data

^12: Sedimentation Rate

Sedimentation rate being performed by capillary photometry / kinetics.

^13: INR

Guidelines for Stabilized Anticoagulant Therapy *

INR Range

Surgery, most thromboembolic conditions 2.0-3.0

Recurrent venous thrombosis, recent MI, prosthetic valves 2.5-3.5

*INR values are for the evaluation of patients receiving long term stable anticoagulant therapy (achieved after two weeks of therapy).



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Urinalysis

Collected Date	5/8/2024	Ref Range	Units
Collected Time	16:21 PDT		
Procedure			
Source UA	Urine Foley *1		
Clarity UA	Clear *1	Clear	
Color UA	Light-Yellow *1	Yellow	
Specific Gravity UA	1.013 *1	1.005-1.030	
pH UA	6 *1	5-9	
Protein UA	30 (1+) @ *1	Negative (<10)	mg/dL
Glucose UA	Normal (<30) *1	Normal (<30)	mg/dL
Ketones UA	Negative *1	Negative	mg/dL
Blood UA	0.2 (2+) @ *1	None (<0.03)	mg/dL
Nitrite UA	Negative *1	Negative	
Bilirubin UA	Negative (<0.5) *1	Negative (<0.5)	mg/dL
Urobilinogen UA	Normal (<2) *1	Normal (<2)	mg/dL
Leukocyte Esterase UA	250 (2+) @ *1		WBCs/microLiter
Urine Microscopy?	Auto *1		
WBC/hpf	21-50 @ *1	0-5	/HPF
RBC/hpf	>20 @ *1	0-2	/HPF
Bacteria	Few (1+) @ *14 *1	None	/HPF
Squamous Epithelial Cells	Rare (Tr) @ *1	None	/LPF
Urinalysis Culture Reflex	Indicated *1		

Interpretive Data***14: Bacteria**

A negative nitrite test in the presence of bacteruria is possible and may be caused by:

- Non-nitrite producing bacteria
- Low nitrate diet
- Antibiotic therapy
- Strong diuresis
- Insufficient urinary retention time in the bladder
- The amount of bacteria
- Presence of ascorbic acid

Radiology Documentation

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
CT-24-0030343	5/8/2024 14:08 PDT	CT Brain/Head without Contrast	Bracken,DO,Richard H	Auth (Verified)

Reason For Exam

(CT Brain/Head without Contrast) Confusion

Report

CLINICAL HISTORY: Weakness and confusion.

COMPARISON: None available



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Radiology Documentation

Report

TECHNIQUE: Contiguous axial images were obtained from the vertex to the base of the skull without IV contrast. Multiplanar reconstructions were performed.

For studies that include multiple body parts, this dose information includes all areas that were scanned:
Radiation dose:

Scan 1 CTDIvol (mGy): 44.45 DLP (mGy-cm): 849

FINDINGS:

Mild to moderate ventricular and sulcal prominence compatible with volume loss without hydrocephalus. No acute intracranial hemorrhage. No CT evidence of acute large vascular territory infarction. Mild to moderate subcortical and periventricular white matter hypodensity, nonspecific, but often seen in the setting of age-indeterminate small vessel ischemic disease in this age group. No mass or mass effect. The midline structures are normally aligned, and the basal cisterns are patent.

The globes and orbits are unremarkable. The paranasal sinuses and mastoid air cells are clear. No scalp soft tissue swelling or acute fracture. Nonspecific right parietal calvarial lucent lesions measuring up to 1 cm, possibly representing prominent arachnoid granulations, with other etiologies including metastatic disease or myeloma not entirely excluded.

IMPRESSION:

No significant acute intracranial abnormality.

Mild to moderate global parenchymal volume loss.

Mild to moderate age-indeterminate small vessel ischemic disease in the white matter.

Nonspecific right parietal calvarial lucent lesions, possibly representing prominent arachnoid granulations, with other etiologies including metastatic disease or myeloma not entirely excluded. Correlation with previous available studies is recommended to assess for stability. Alternatively, bone scan may be performed for further evaluation.

****Final Report****

Signed: Chaudhary, MD, Saadia R

Signed Date/Time: 08-MAY-2024 14:57 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
RA-24-0042901	5/8/2024 14:51 PDT	XR Chest Portable	Bracken,DO,Richard H	Auth (Verified)

Reason For Exam

(XR Chest Portable) Chest Pain;Chest Pain

Report

CLINICAL HISTORY: provided as " Chest Pain"

COMPARISON: 03/10/2024



Patient Name: ARIAS, DAVID J
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Radiology Documentation

Report

FINDINGS/IMPRESSION:

New hazy the airspace disease/opacities along the right perihilar and infrahilar regions.

There is no visible pleural effusion or pneumothorax.

The cardiomediastinal silhouette is stable.

No acute osseous abnormalities are identified.

****Final Report****

Signed: Lee, MD, Kim M

Signed Date/Time: 08-MAY-2024 14:59 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
RA-24-0042961	5/8/2024 16:50 PDT	XR Tibia/Fibula Right	Bracken,DO,Richard H	Auth (Verified)

Reason For Exam

(XR Tibia/Fibula Right) Pain;Osteomyelitis

Report

COMPARISON: None

FINDINGS:

There is a right total knee prosthesis. No fractures are seen. Ankle mortise appears intact.

IMPRESSION:

Right total knee prosthesis.

****Final Report****

Signed: Joyce, MD, Peter W

Signed Date/Time: 08-MAY-2024 16:54 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
RA-24-0042960	5/8/2024 16:50 PDT	XR Ankle Complete Right (4V)	Bracken,DO,Richard H	Auth (Verified)

Reason For Exam

(XR Ankle Complete Right (4V)) Pain;Osteomyelitis

Report



Patient Name: ARIAS, DAVID J
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Radiology Documentation

Report

COMPARISON: None

FINDINGS:

Alignment is normal. There is no significant bone, joint, or soft tissue abnormality.

IMPRESSION:

Negative.

****Final Report****

Signed: Joyce, MD, Peter W

Signed Date/Time: 08-MAY-2024 16:54 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
US-24-0019278	5/8/2024 16:57 PDT	US Renal	Patel,MD,Keyur A	Auth (Verified)

Reason For Exam

(US Renal) Elevated BUN/Creatinine

Report

CLINICAL HISTORY: Elevated BUN and/or creatinine

COMPARISON: None

SONOGRAPHIC VISUALIZATION AND STUDY ADEQUACY: Satisfactory

FINDINGS:

Right Kidney: 11.1 x 5.2 x 7.3 cm, volume 222 cc

Left Kidney: 11.4 x 4.4 x 5.1 cm, volume 133 cc

Echogenicity: There is increased parenchymal echogenicity consistent with medical renal disease.

Cysts: Small benign cortical and parapelvic cysts bilaterally.

Calculi: None.

Hydronephrosis: Mild right hydronephrosis.

Mass: None.

Bladder: Decompressed by Foley catheter.

Other: None.

IMPRESSION:



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Radiology Documentation

Report

Echogenic, cystic kidneys consistent with chronic renal disease.

Mild right hydronephrosis.

Bladder decompressed by Foley catheter.

****Final Report****

Signed: Hoffman, MD, Heidi

Signed Date/Time: 08-MAY-2024 17:21 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
CT-24-0030397	5/8/2024 17:46 PDT	CT Chest without Contrast	Patel,MD,Keyur A	Auth (Verified)

Reason For Exam

(CT Chest without Contrast) Malignant Neoplasm

Report

CLINICAL HISTORY: Provided as: "Malignant Neoplasm" calvarial lesions noted on CT head

COMPARISON: None

TECHNIQUE: No IV contrast

For studies that include multiple body parts, this dose information includes all areas that were scanned:

Radiation dose:

Scan 1 CTDIvol (mGy): 14.29 DLP (mGy·cm): 994.7

FINDINGS:

Hilum and Mediastinum: Moderate coronary arterial calcifications. Possible esophageal wall thickening.

Lungs: 6 x 12 x 9 mm highly irregular spiculated noncalcified nodule in the posterior segment of the right upper lobe bordering on the major fissure with mild focal pleural thickening.

15 x 8 x 13 mm groundglass nodule in the medial lingula adjacent to the mediastinal pleura.

Small areas of peribronchial nodularity/bronchial wall thickening in the right upper lobe as well as scattered areas of tree-in-bud micronodularity in the right upper and lower lobes with a few scattered small sub-4 mm pulmonary nodules, except for a 6 mm noncalcified groundglass nodule in the posterior right lower lobe superior segment on series 3-52.

Imaging degradation noted due to motion artifact.

Pleura: There are no significant pleural abnormalities.

Bones: Degenerative changes of spine with suture anchors in the right humeral head. No suspicious bony lesions..



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Radiology Documentation

Report

Small area of sclerosis in the right anterior sixth rib near the costochondral cartilage likely posttraumatic.

Upper Abdomen: See separate CT abdomen report of the same day.

Other: No other significant abnormalities.

IMPRESSION:

6 x 12 x 9 mm highly irregular spiculated noncalcified nodule in the posterior segment of the right upper lobe bordering on the major fissure with mild focal pleural thickening.

15 x 8 x 13 mm groundglass nodule in the medial lingula adjacent to the mediastinal pleura.

Small areas of peribronchial nodularity/bronchial wall thickening in the right upper lobe as well as scattered areas of tree-in-bud micronodularity in the right upper and lower lobes with a few scattered small sub-4 mm pulmonary nodules, except for a 6 mm noncalcified groundglass nodule in the posterior right lower lobe superior segment on series 3-52.

Imaging degradation noted due to motion artifact.

Moderate coronary arterial calcifications.

Possible esophageal wall thickening.

****Final Report****

Signed: Krauthamer, MD, Richard E

Signed Date/Time: 09-MAY-2024 08:28 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
CT-24-0030398	5/8/2024 17:46 PDT	CT Abd/Pelv NO IV/NO GI Contrast	Patel,MD,Keyur A	Auth (Verified)

Reason For Exam

(CT Abd/Pelv NO IV/NO GI Contrast) Mets/Lung CA

Report

CLINICAL HISTORY: Provided as: "Mets/Lung CA" calvarial lesions noted on CT head

COMPARISON: CT abdomen 03/11/2024.

TECHNIQUE: Noncontrast CT of the abdomen and pelvis

For studies that include multiple body parts, this dose information includes all areas that were scanned:
Radiation dose:

Scan 1 CTDlvol (mGy): 14.29 DLP (mGy-cm): 994.7

FINDINGS:



Patient Name: ARIAS, DAVID J
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Radiology Documentation

Report

Lower Chest: See separate report for CT scan of the chest.

Liver: Normal, except for possible tiny capsular punctate calcification on series 2-114 at the medial inferior right lower lobe..

Spleen: Normal.

Pancreas: Normal, without pancreatic dilatation.

Adrenal Glands: Normal.

Kidneys: Interval appearance of mild to moderate right and mild left hydronephrosis and hydroureters likely due to bladder abnormality. See comments under bladder. Unchanged renal cortical hypodensities measuring up to slightly over 2 cm in the posterior left upper pole cortex consistent with cysts.

Gallbladder: Normal.

Bile Ducts. Normal.

Bowel: High attenuation material within nondilated colon with increased fecal material suggestive of constipation. No evidence of intestinal dilatation. Normal air-filled appendix.

Bladder/Pelvic Organs: Foley balloon catheter in place with collapsed elongated bladder extending almost to the umbilicus normal-size prostate gland. Reidentified vasectomy clips in the bilateral scrotum

Lymph Nodes: None significant by size criteria.

Aorta: Severe aortoiliac calcific plaquing without aneurysm.

Bones: Small subtle lytic lesion in the endosteal left superior iliac bone with cortical thinning on series 2-142 and series 2-143. Focal lytic expansile lesion of the right posterior 12th rib on series 2-113 and additional possible subtle endosteal lytic lesion in the posterior right 11th rib on series 2-93. Possible subtle lytic lesions at the base of the left L2 pedicle on series 2-114. Suggest clinical correlation to exclude multiple myeloma versus metastases.

End degenerative cysts in both femoral heads.

Other: Interval appearance of body wall edema consistent with anasarca.

IMPRESSION:

Multiple small subtle lytic lesions including the left superior iliac bone, right posterior 11th and 12th ribs, and left L2 pedicle. Suggest clinical correlation to exclude multiple myeloma versus metastases.

Interval appearance of mild to moderate right and mild left hydronephrosis and hydroureter is likely due to bladder obstruction with now elongated but decompressed bladder containing a Foley balloon catheter.

Interval appearance of anasarca.

Renal cysts.



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Radiology Documentation

Report

Possible constipation.

Status post vasectomy.

****Final Report****

Signed: Krauthamer, MD, Richard E
Signed Date/Time: 09-MAY-2024 08:54 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
IR-24-0003558	5/9/2024 18:26 PDT	IR Conscious Sedation	So,MD,George J	Auth (Verified)

Reason For Exam

(IR Conscious Sedation) Pain; sedation needed for IR Procedure

Report

MODERATE SEDATION: Under physician supervision, analgesics and/or anxiolytics were administered intravenously for moderate sedation. Pulse oximetry, heart rate, and BP were continuously monitored by the circulating RN present. The physician spent 30 minutes of face-to-face sedation time with the patient.

****Final Report****

Signed: So, MD, George J
Signed Date/Time: 10-MAY-2024 14:17 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROVIDER	STATUS
IR-24-0003529	5/9/2024 18:26 PDT	IR Percutaneous Placement Of IVC Filter	Patel,MD,Keyur A	Auth (Verified)

Reason For Exam

(IR Percutaneous Placement Of IVC Filter) Thrombosis

Report

INDICATION: Deep venous thrombosis, anticoagulation contraindicated. Renal insufficiency.

PROCEDURES PERFORMED:

1. Ultrasound-guided right common femoral vein access
2. Fluoroscopically guided retrievable IVC filter placement
3. Radiologic supervision and interpretation for above

INFORMED CONSENT: After the plan, procedure, risks, benefits, alternatives, and aftercare were discussed with the patient, patient's wife and all questions were answered, written informed consent was obtained. Discussed risks included, but were not limited to, bleeding, infection, organ injury, filter migration and fracturing, and IVC thrombosis. The decreasing probability of successful filter retrieval with increasing filter dwell times was also discussed.

TECHNIQUE AND IMAGING FINDINGS:



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Radiology Documentation

Report

The patient was prepped and draped in the usual sterile fashion.

Real-time ultrasound imaging was performed. The right common femoral vein was compressible and patent.

1.0% lidocaine was used for local anesthesia. Using real-time ultrasound guidance, the right common femoral vein was accessed with a micropuncture set.

Using previous CT examination for imaging guidance and using fluoroscopic guidance, the retrievable IVC filter was advanced and deployed in an infrarenal location.

The sheath was removed, and hemostasis was achieved by manual compression. The patient tolerated the procedure well without immediate complication.

IMPRESSION:

Status post placement of Celect retrievable-type infrarenal inferior vena cava filter.

Note that the probability of successful filter retrieval diminishes with increasing filter dwell times greater than 6 months. If a longer duration of filter protection is required and retrievability is to be maintained, the filter can be removed and replaced at a future session.

****Final Report****

Signed: So, MD, George J

Signed Date/Time: 09-MAY-2024 18:25 PDT

ACCESSION	EXAM DATE/TIME	PROCEDURE	ORDERING PROV/INFR	STATUS
CT-24-0031190	5/13/2024 15:18 PDT	CT Biopsy	Patel,MD,Keyur A	Auth (Verified)

Reason For Exam

(CT Biopsy) Bone Mets

Report

CLINICAL HISTORY: Provided as: "Bone Mets", multiple small lytic bone lesions

COMPARISON: CT examination 05/08/2024

INFORMED CONSENT: After the plan, procedure, risks, benefits, alternatives, and aftercare were discussed with the patient and all questions were answered, written informed consent was obtained. Discussed risks included, but were not limited to, bleeding, infection, and organ/vascular injury. Alternative treatments were also discussed.

FINDINGS:

The procedure, its risks, and alternatives were discussed with the patient, and the patient's questions were answered. Written informed consent was obtained.

The small lytic bone lesion that measures about 6 mm in size in the left iliac wing was localized under CT guidance.

The patient was prepped and draped in the usual sterile fashion. The skin and subcutaneous tissues were anesthetized



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Radiology Documentation

Report

with 1% lidocaine.

Under CT guidance, an 11-gauge Madison needle was advanced into the lesion and position confirmed with CT imaging. Using the core biopsy needle, five core biopsy samples were obtained and placed in formalin. The needle was removed.

The patient tolerated the procedure with no immediate complication. The patient will be observed prior to discharge.

IMPRESSION:

CT-guided core biopsies of the small left iliac wing bone lytic lesion.

****Final Report****

Signed: So, MD, George J

Signed Date/Time: 13-MAY-2024 17:12 PDT

Transcribed by: AMC

Transcribed Date/Time: 13-MAY-2024 15:49 PDT

Rehab Documentation

DOCUMENT NAME:

PT Inpatient Evaluation Txt

SERVICE DATE/TIME:

5/9/2024 11:19 PDT

RESULT STATUS:

Auth (Verified)

PERFORM INFORMATION:

Alicna,PT,Randy N (5/9/2024 15:39 PDT)

SIGN INFORMATION:

Alicna,PT,Randy N (5/9/2024 15:39 PDT)

PT Inpatient Evaluation Entered On: 05/09/2024 11:20 PDT
Performed On: 05/09/2024 11:19 PDT by Alicna, PT, Randy N

General Information

Precautions RTF : Fall Precautions

Orientation : Oriented x 3

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Affect/Behavior : Appropriate

Arousal : Alert

Basic Command Following : Intact

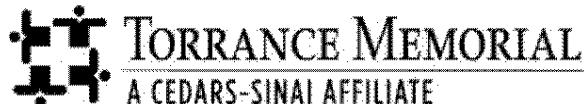
Safety/Judgment : Intact

Alicna, PT, Randy N - 05/09/2024 11:19 PDT

Additional Information

Additional Information PT : HPI: 68-year-old male with a history of alcohol abuse, TIA, coronary artery disease status post PCI many years ago, hypertension, COPD not on home oxygen who presents to the emergency room due to weakness/confusion as well as nose bleed.

PLOF: Per patient and wife; Patient lives with wife in a SLH with 3 outside steps and a bilateral rail. Per wife patient has been more bed bound /wheelchair bound during the past month and transfers via pivot transfer; From the previous admission 3/10/2024 -3/15/2024. Patient was on Physical therapy caseload and patient was able to get in and out of bed with complete independence and was able to ambulate 120 feet with FWW with Modified independence. Patient has a FWW and w/c at home.



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Rehab Documentation

CLOF: Patient was received in supine and was agreeable to participate. Patient is Max A of 2 person with bed mobility using chuck. Patient needs manual and verbal cues to maintain static sitting. Patient L ankle demonstrate plantar flexion contracture or tightness. Endled therapy with patient back in bed with all needs within reach and bed alarm set and direct hand off care to RN. Patient will be having blood transfusion today.

Anticipated d/c: SNF

Updated RN

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Home Environment

Stairs

	Outside Stairs
Number of Stairs :	3
Rail :	Bilateral
	Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Home Setup

Primary Bedroom : 1st floor

Primary Bathroom : 1st floor

Kitchen : 1st floor

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Living Situation : Home with Family

Alicna, PT, Randy N - 05/09/2024 11:19 PDT

Home Environment II

Devices/Equipment : Front Wheeled Walker, Manual wheelchair

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Prior Functional Status

Bed Mobility : Assist needed

Gait/locomotion assessment : Assist needed, Dependent, hasn't ambulated for a month per wife.

Transfer : Assist needed

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

LE ROM/Strength

LE Overall ROM Grid

Left Lower Extremity Active Range : Within functional limits, tightness of plantarflexion/ contracture of plantar fl contracture

Left Lower Extremity Passive Range : Within functional limits, tightness of /plantrar flexion contracture

Right Lower Extremity Active Range : Within functional limits

Right Lower Extremity Passive Range : Within functional limits

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Sitting Balance

Static Sitting Balance

Sits Without UE Support : Rehab Maximal assistance

Sits With One UE Support : Rehab Moderate assistance

Sits With Two UE Support : Rehab Moderate assistance

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Mobility

Mobility Grid



Patient Name: ARIAS, DAVID J
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Rehab Documentation

Roll Left : Rehab Maximal assistance
Roll Right : Rehab Maximal assistance
Roll Supine : Rehab Maximal assistance
Supine to Sit : Rehab Total assistance
Sit to Supine : Rehab Maximal assistance
Scooting : Rehab Total assistance

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Assessment

PT Impairments or Limitations : Bed mobility deficits, Transfer deficits, Ambulation deficits, Balance deficits, Strength deficits, Endurance deficits, Abnormal tone

Barriers to Safe Discharge PT : Limited family support, Medical diagnosis

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

DME/Discharge

PT Recommended Discharge Disposition : SNF

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Short Term Goals

Bed Mobility Goal Grid

	Goal #1
<i>Descriptors</i> :	Bed mobility
<i>Level</i> :	CGA
<i>Status</i> :	Initial
	Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Transfers Goal Grid

	Goal #1
<i>Descriptors</i> :	Sit to stand
<i>Level</i> :	CGA
<i>Device</i> :	Front Wheeled Walker
<i>Status</i> :	Initial
	Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Ambulation Goal Grid

	Goal #1	Goal #2
<i>Descriptors</i> :	Ambulate	Stairs
<i>Level</i> :	Minimal assistance	Moderate assistance
<i>Distance/# of Steps</i> :	50 feet	3
<i>Device</i> :	Front Wheeled Walker	Bilateral rails
<i>Status</i> :	Initial	Initial



Patient Name: ARIAS, DAVID J
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Rehab Documentation

	Alicna, PT, Randy N - 05/09/2024 15:39 PDT	Alicna, PT, Randy N - 05/09/2024 15:39 PDT
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Plan

PT Anticipated Treatments, Needs : Bed mobility training, Transfer training, Gait training, Stair training, Therapeutic exercises, Caregiver/Family Training, DME/DCP Recommendations, Equipment training, Patient education, Balance training, Neuromuscular reeducation

PT Plan/Goals Established w Pt/Caregiver : No

Other PT Treatment Provided : Patient was seen for PT eval and treatment. patient performed bed mobility and balance and ROM and positioning.

Physical Therapy Evaluation : PT Eval low

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

Time Spent With Patient

PT Therapeutic Activity Units : 2

PT Total Treatment Time Rehab : 30 minute(s)

Pre-Morbid MRS Score : N/A

MRS Score : N/A

Alicna, PT, Randy N - 05/09/2024 15:39 PDT

DOCUMENT NAME:

PT Inpatient Daily Documentation Txt

SERVICE DATE/TIME:

5/13/2024 14:03 PDT

RESULT STATUS:

Auth (Verified)

PERFORM INFORMATION:

Todd,PT,Rebecca S (5/13/2024 14:03 PDT)

SIGN INFORMATION:

Todd,PT,Rebecca S (5/13/2024 14:03 PDT)

PT Inpatient Daily Documentation Entered On: 05/13/2024 14:04 PDT

Performed On: 05/13/2024 14:03 PDT by Todd, PT, Rebecca S

Review/Treatments Provided

Precautions RTF : Fall Precautions

Todd, PT, Rebecca S - 05/13/2024 14:03 PDT

Time Spent With Patient

Pre-Morbid MRS Score : N/A

MRS Score : N/A

Todd, PT, Rebecca S - 05/13/2024 14:03 PDT

Additional Information

Additional Information PT : Follow up for physical therapy treatment, pt. currently off the floor for bone biopsy. Plan for home on hospice after biopsy.

Todd, PT, Rebecca S - 05/13/2024 14:03 PDT



Patient Name: ARIAS, DAVID J
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 FIN: 57614509

Rehab Documentation

DOCUMENT NAME: OT Inpatient Evaluation Txt
 SERVICE DATE/TIME: 5/9/2024 17:11 PDT
 RESULT STATUS: Auth (Verified)
 PERFORM INFORMATION: Delrosario,OT,Erica (5/9/2024 17:11 PDT)
 SIGN INFORMATION: Delrosario,OT,Erica (5/9/2024 17:11 PDT)

OT Inpatient Evaluation Entered On: 05/09/2024 17:19 PDT
Performed On: 05/09/2024 17:11 PDT by Delrosario, OT, Erica

General Information

Precautions RTF : Fall Precautions

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Additional Information

Additional Information OT : 68-year-old male with a history of alcohol abuse, TIA, coronary artery disease status post PCI many years ago, hypertension, COPD not on home oxygen who presents to the emergency room due to weakness/confusion as well as nose bleed.

RN cleared pt for OT, pt's wife at bedside. Pt known to me from previous admission where pt was ambulating and able to perform his own ADLs. Per wife, pt has been bedbound and assisted/dependent on ADLs, and pivots into w/c. Pt overall looked weak and somewhat disheveled in appearance, but cooperative. Pt w/ pain to RLE d/t recent DVT (pending IVC filter). Pt required max A x 2 to sit EOB and min A to maintain sitting balance. Pt w/ L foot plantar flexion contracture, pt's family educated on positioning and gentle stretching. Pt max/total A for ADLs at this time. Recommending short term rehab. Pt endorsed directly to RN, all needs met, NAD.

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Home Environment II

Devices/Equipment at Home : Front Wheeled Walker, Manual wheelchair

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Prior Functional Status Grid

Upper Body Dressing : Assist needed

Lower Body Dressing : Assist needed

Feeding : Independent

Mobility : Assist needed

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Home Living Additional Information : Per patient and wife; Patient lives with wife in a SLH with 3 outside steps and a bilateral rail. Per wife patient has been more bed bound /wheelchair bound during the past month and transfers via pivot transfer; From the previous admission 3/10/2024 -3/15/2024

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Basic ADL

Basic ADL Grid

Feeding : Did not occur, npo

Grooming : Rehab Maximal assistance

UE Dressing : Rehab Maximal assistance

LE Dressing : Rehab Total assistance

Toileting : Rehab Total assistance

Bed Mobility : Rehab Total assistance, Rehab Maximal assistance

Limiting Factors : Endurance, Pain, Weakness

Delrosario, OT, Erica - 05/09/2024 17:11 PDT



Patient Name: ARIAS, DAVID J
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Rehab Documentation

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Sitting Balance Assessment

Static Sitting Balance Grid

Sits Without UE Support : Does not occur

Sits With One UE Support : Does not occur

Sits With Two UE Support : Rehab Minimal assistance, Rehab Moderate assistance

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Dynamic Sitting, Outside Base Grid

Anterior Shift : Unable

Posterior Shift : Unable

Lateral to the Left Shift : Unable

Lateral to the Right Shift : Unable

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Cognition

Cognition : Impaired

Memory : Impaired

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

UE ROM/Strength

Upper Extremity Overall ROM Grid

Left Upper Extremity Active Range : Within functional limits

Left Upper Extremity Passive Range : Within functional limits

Right Upper Extremity Active Range : Within functional limits

Right Upper Extremity Passive Range : Within functional limits

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

DME/Discharge OT

OT Recommended DC Disposition : SNF

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Education

Home Caregiver Present for Session : Yes

Barriers To Learning : Difficulty concentrating

Teaching Method : Demonstration, Explanation

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Occupational Therapy Education Grid

ADL's : Needs practice/supervision, Needs further teaching

OT Plan of Care : Verbalizes understanding

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Short Term Goals

Upper Body Dressing Short Term Goal Grid

	Goal #1
<i>Activity</i> :	Upper extremity dressing
<i>Assist</i> :	Minimal assistance
<i>Status</i> :	Initial
	Delrosario, OT, Erica - 05/09/2024 17:11 PDT



Patient Name: ARIAS, DAVID J
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Rehab Documentation

Lower Body Dressing Grid

	Goal #1
Activity :	Lower extremity dressing
Assist :	Moderate assistance
	Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Functional Transfer Grid

	OT Short Term Goal	Goal #2
Activity :	Bed mobility	3 in 1 Commode Transfer, Chair Transfers, Wheelchair Transfer
Descriptor :		Sit and Pivot, Stand pivot, Transfer with DME
Assist :	Minimal assistance	Moderate assistance
Status :	Initial	Initial
	Delrosario, OT, Erica - 05/09/2024 17:11 PDT	Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Plan

Frequency : MTuWThF

Planned Treatments : Balance training, Basic Activities of Daily Living, Caregiver training, Energy conservation training, Home Safety, Joint protection, Mobility training, Pain management, Patient education, Safety education, Therapeutic exercises

Treatment Plan/Goals Established With Patient/Caregiver : Yes

Occupational Therapy Evaluation : OT Eval low

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Time Spent With Patient

Self Care/Home Management (97535) (ref) : 1

Therapeutic Activity (97530) (ref) : 1

*Total Treatment Time : 30 minute(s)

Pre-Morbid MRS Score : N/A

MRS Score : N/A

Delrosario, OT, Erica - 05/09/2024 17:11 PDT

Vaccine: influenza virus vaccine,inactivated	Date Given: 9/17/2020	Age: 65 years
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Patient Name: ARIAS, DAVID J

MRN: 4452315

FIN: 57614509

Vaccine: influenza virus vaccine,inactivated	Date Given: 9/25/2018	Age: 63 years
Vaccine: influenza virus vaccine,inactivated	Date Given: 1/18/2018	Age: 62 years
Vaccine: pneumococcal 23-valent vaccine	Date Given: 9/17/2020	Age: 65 years
Vaccine: SARS-CoV-2 (COVID-19) Ad26 vacc, recomb	Date Given: 4/9/2021	Age: 65 years
Vaccine: tetanus/diphtheria/pertussis,acel (Tdap	Date Given: 10/7/2016	Age: 61 years

Performing Locations

*1: This test was performed at:

Torrance Memorial Medical Center Lab, 3330 Lomita Blvd, Torrance, CA, 90505-, US

*2: This test was performed at:

Lab