**A4665 Token count 143**

1. **HISTORY OF PRESENT ILLNESS: , The patient is an 85-year-old gentleman who has a history of sick sinus syndrome for which he has St. Jude permanent pacemaker. Pacemaker battery has reached end of life and the patient is dependent on his pacemaker with 100% pacing in the right ventricle. He also has a fairly advanced degree of Alzheimer's dementia and is living in an assisted care facility. The patient is unable to make his own health care decision and his daughter ABC has medical power of attorney. The patient's dementia has resulted in the patient's having sufficient and chronic anger and his daughter that he refuses to speak with her, refuses to be in a same room with her. For this reason the Casa Grande Regional Medical Center would obtain surgical and anesthesia consent from the patient's daughter in the fashion keeps the patient and daughter separated. Furthermore it is important to note that his degree of dementia has disabled the patient to adequately self monitor his status following surgery for significant changes and to seek appropriate medical care, hence he will be admitted after the pacemaker exchange.,PAST MEDICAL HISTORY:,1. Sick sinus syndrome, pacemaker dependence with 100% with right ventricular pacing.,2. Dementia of Alzheimer's disease.,3. Gastroesophageal reflux disease.,4. Multiple pacemaker implantation and exchanges.,FAMILY HISTORY: , Unobtainable.,SOCIAL HISTORY: , The patient resides full time at ABC supervised living facility. He is nonsmoker, nondrinker. He uses wheelchair and moves himself about with his feet. He is independent of activities of daily living and dependent on independent activities of daily living.,ALLERGIES TO MEDICATIONS: , No known drug allergies.,MEDICATIONS: ,Omeprazole 20 mg p.o. daily, furosemide 20 mg p.o. daily, citalopram 20 mg p.o. daily, loratadine 10 mg p.o. p.r.n.,REVIEW OF SYSTEMS: , A 10 systems review negative for chest pain, pressure, shortness of breath, paroxysmal nocturnal dyspnea, orthopnea, syncope, near-syncopal episodes. Negative for recent falls. Positive for significant memory loss. All other review of systems is negative.,PHYSICAL EXAMINATION:,GENERAL: The patient is an 85-year-old gentleman in no acute distress, sitting in the wheelchair.,VITAL SIGNS: Blood pressure is 118/68, pulse is 80 and regular, respirations 16, weight is 200 pounds, oxygen saturation is 90% on room air.,HEENT: Head atraumatic and normocephalic. Eyes, pupils are equal and reactive to light and accommodate bilaterally, free from focal lesions. Ears, nose, mouth, and throat.,NECK: Supple. No lymphadenopathy, thyromegaly, or thyroid masses appreciated.,CARDIOVASCULAR: No JVD or no jugular venous distention. No carotid bruits bilaterally. Pacemaker pocket right upper thorax with healed surgical incisions. S1 and S2 are normal. No S3 or S4. There are no murmurs. No heaves or thrills, gout, or gallops. Trace edema at dorsum of his feet and ankles. Femoral pulses are present without bruits, posterior tibial pulses would be palpable bilaterally.,RESPIRATORY: Breath sounds are clear but diminished throughout AP diameters expanded. The patient speaks in full sentences. No wheezing, no accessory muscles used for breathing.,GASTROINTESTINAL: Abdomen is soft and nontender. Bowel sounds are active in all 4 quadrants. No palpable pulses. No abdominal bruit is appreciated. No hepatosplenomegaly.,GENITOURINARY: Nonfocal.,MUSCULOSKELETAL: Muscle strength in lower extremities is 4/5 bilaterally. Upper extremities are 5/5 bilaterally with adequate range of motion.,SKIN: Warm and dry. No obvious rashes, lesions, or ulcerations. ,NEUROLOGIC: Alert, not oriented to place and date. His speech is clear. There are no focal motor or sensory deficits.,PSYCHIATRIC: Talkative, pleasant affect with limited impulse control, severe short-term memory loss.,LABORATORY DATA:, Blood work dated 12/15/08, white count 4.7, hemoglobin 11.9, hematocrit 33.9, and platelets 115,000. BUN 19, creatinine 1.15, glucose 94, potassium 4.5, sodium 140, and calcium 8.6.,DIAGNOSTIC DATA:, St. Jude pacemaker interrogation dated 11/10/08 shows single chamber pacemaker and VVIR mode, implant date 08/2000, 100% paced in right ventricle, battery status is ERI. A 12-lead ECG 12/15/08 shows 100% paced rhythm with rate of 80. No Q waves at the baseline of atrial fibrillation. Last measured ejection fraction 40% 12/08 with no significant decompensation.,IMPRESSION/PLAN:,1. Sick sinus syndrome.,2. Atrial fibrillation.,3. Pacemaker dependent.,4. Mild cardiomyopathy with ejection fraction 40% and no significant decompensation.,5. Pacemaker battery end of life requiring exchange.,6. Dementia of Alzheimer's disease with short and long term memory dysfunction. The dementia disables the patient from recognizing changes in his health status in knowing if he needed to seek appropriate health care. Dementia also renders the patient incapable informed consent, schedule the patient for pacemaker. I explain the patient and reimplantation with any device in the surgical suite. He will require anesthesia assistance for adequate sedation as the patient possesses behavioral risk secondary to his advanced dementia.,7. Admit the patient after surgery for postoperative care and monitoring.**

**A4747 Token count 130**

1. **PREOPERATIVE DIAGNOSIS:, Right middle lobe lung cancer.,POSTOPERATIVE DIAGNOSIS: , Right middle lobe lung cancer.,PROCEDURES PERFORMED:,1. VATS right middle lobectomy.,2. Fiberoptic bronchoscopy thus before and after the procedure.,3. Mediastinal lymph node sampling including levels 4R and 7.,4. Tube thoracostomy x2 including a 19-French Blake and a 32-French chest tube.,5. Multiple chest wall biopsies and excision of margin on anterior chest wall adjacent to adherent tumor.,ANESTHESIA: ,General endotracheal anesthesia with double-lumen endotracheal tube.,DISPOSITION OF SPECIMENS: , To pathology both for frozen and permanent analysis.,FINDINGS:, The right middle lobe tumor was adherent to the anterior chest wall. The adhesion was taken down, and the entire pleural surface along the edge of the adhesion was sent for pathologic analysis. The final frozen pathology on this entire area returned as negative for tumor. Additional chest wall abnormalities were biopsied and sent for pathologic analysis, and these all returned separately as negative for tumor and only fibrotic tissue. Several other biopsies were taken and sent for permanent analysis of the chest wall. All of the biopsy sites were additionally marked with Hemoclips. The right middle lobe lesion was accompanied with distal pneumonitis and otherwise no direct involvement of the right upper lobe or right lower lobe.,ESTIMATED BLOOD LOSS: , Less than 100 mL.,CONDITION OF THE PATIENT AFTER SURGERY: , Stable.,HISTORY OF PROCEDURE:, This patient is well known to our service. He was admitted the night before surgery and given hemodialysis and had close blood sugar monitoring in control. The patient was subsequently taken to the operating room on April 4, 2007, was given general anesthesia and was endotracheally intubated without incident. Although, he had markedly difficult airway, the patient had fiberoptic bronchoscopy performed all the way down to the level of the subsegmental bronchi. No abnormalities were noted in the entire tracheobronchial tree, and based on this, the decision was made to proceed with the surgery. The patient was kept in the supine position, and the single-lumen endotracheal tube was removed and a double-lumen tube was placed. Following this, the patient was placed into the left lateral decubitus position with the right side up and all pressure points were padded. Sterile DuraPrep preparation on the right chest was placed. A sterile drape around that was also placed. The table was flexed to open up the intercostal spaces. A second bronchoscopy was performed to confirm placement of the double-lumen endotracheal tube. Marcaine was infused into all incision areas prior to making an incision. The incisions for the VATS right middle lobectomy included a small 1-cm incision for the auscultatory incision approximately 4 cm inferior to the inferior tip of the scapula. The camera port was in the posterior axillary line in the eighth intercostal space through which a 5-mm 30-degree scope was used. Third incision was an anterior port, which was approximately 2 cm inferior to the inframammary crease and the midclavicular line in the anterior sixth intercostal space, and the third incision was a utility port, which was a 4 cm long incision, which was approximately one rib space below the superior pulmonary vein. All of these incisions were eventually created during the procedure. The initial incision was the camera port through which, under direct visualization, an additional small 5-mm port was created just inferior to the anterior port. These two ports were used to identify the chest wall lesions, which were initially thought to be metastatic lesions. Multiple biopsies of the chest wall lesions were taken, and the decision was made to also insert the auscultatory incision port. Through these three incisions, the initial working of the diagnostic portion of the chest wall lesion was performed. Multiple biopsies were taken of the entire chest wall offers and specimens came back as negative. The right middle lobe was noted to be adherent to the anterior chest wall. This area was taken down and the entire pleural surface along this area was taken down and sent for frozen pathologic analysis. This also returned as negative with only fibrotic tissue and a few lymphocytes within the fibrotic tissue, but no tumor cells. Based on this, the decision was made to not proceed with chest wall resection and continue with right middle lobectomy. Following this, the anterior port was increased in size and the utility port was made and meticulous dissection from an anterior to posterior direction was performed. The middle lobe branch of the right superior pulmonary vein was initially dissected and stapled with vascular load 45-mm EndoGIA stapler. Following division of the right superior pulmonary vein, the right middle lobe bronchus was easily identified. Initially, this was thought to be the main right middle lobe bronchus, but in fact it was the medial branch of the right middle lobe bronchus. This was encircled and divided with a blue load stapler with a 45-mm EndoGIA. Following division of this, the pulmonary artery was easily identified. Two branches of the pulmonary artery were noted to be going into the right middle lobe. These were individually divided with a vascular load after encircling with a right angle clamp. The vascular staple load completely divided these arterial branches successfully from the main pulmonary artery trunk, and following this, an additional branch of the bronchus was noted to be going to the right middle lobe. A fiberoptic bronchoscopy was performed intraoperatively and confirmed that this was in fact the lateral branch of the right middle lobe bronchus. This was divided with a blue load stapler 45 mm EndoGIA. Following division of this, the minor and major fissures were completed along the edges of the right middle lobe separating the right upper lobe from the right middle lobe as well as the right middle lobe from the right lower lobe. Following complete division of the fissure, the lobe was put into an EndoGIA bag and taken out through the utility port. Following removal of the right middle lobe, a meticulous lymph node dissection sampling was performed excising the lymph node package in the 4R area as well as the 7 lymph node package. Node station 8 or 9 nodes were easily identified, therefore none were taken. The patient was allowed to ventilate under water on the right lung with no obvious air leaking noted. A 19-French Blake was placed into the posterior apical position and a 32-French chest tube was placed in the anteroapical position. Following this, the patient's lung was allowed to reexpand fully, and the patient was checked for air leaking once again. Following this, all the ports were closed with 2-0 Vicryl suture used for the deeper tissue, and 3-0 Vicryl suture was used to reapproximate the subcutaneous tissue and 4-0 Monocryl suture was used to close the skin in a running subcuticular fashion. The patient tolerated the procedure well, was extubated in the operating room and taken to the recovery room in stable condition.**

**Token count 125**

1. **REASON FOR CONSULT: , I was asked to see this patient with metastatic non-small-cell lung cancer, on hospice with inferior ST-elevation MI.,HISTORY OF PRESENT ILLNESS: , The patient from prior strokes has expressive aphasia, is not able to express herself in a clear meaningful fashion. Her daughter who accompanies her is very attentive whom I had met previously during drainage of a malignant hemorrhagic pericardial effusion last month. The patient has been feeling well for the last several weeks, per the daughter, but today per the personal aide, became agitated and uncomfortable at about 2:30 p.m. At about 7 p.m., the patient began vomiting, was noted to be short of breath by her daughter with garbled speech, arms flopping, and irregular head movements. Her daughter called 911 and her symptoms seemed to improve. Then, she began vomiting. When the patient's daughter asked her if she had chest pain, the patient said yes.,She came to the emergency room, an EKG showed inferior ST-elevation MI. I was called immediately and knowing her history, especially, her hospice status with recent hemorrhagic pericardial effusion, I felt thrombolytic was contraindicated and she would not be a candidate for aggressive interventional therapy with PCI/CABG. She was begun after discussion with the oncologist, on heparin drip and has received morphine, nitro, and beta-blocker, and currently states that she is pain free. Repeat EKG shows normalization of her ST elevation in the inferior leads as well as normalization of prior reciprocal changes.,PAST MEDICAL HISTORY: , Significant for metastatic non-small-cell lung cancer. In early-to-mid December, she had an admission and was found to have a malignant pericardial effusion with tamponade requiring urgent drainage. We did repeat an echo several weeks later and that did not show any recurrence of the pericardial effusion. She is on hospice from the medical history, atrial fibrillation, hypertension, history of multiple CVA.,MEDICATIONS: , Medications as an outpatient:,1. Amiodarone 200 mg once a day.,2. Roxanol concentrate 5 mg three hours p.r.n. pain.,ALLERGIES: ,CODEINE. NO SHRIMP, SEAFOOD, OR DYE ALLERGY.,FAMILY HISTORY: , Negative for cardiac disease.,SOCIAL HISTORY: , She does not smoke cigarettes. She uses alcohol. No use of illicit drugs. She is divorced and lives with her daughter. She is a retired medical librarian from Florida.,REVIEW OF SYSTEMS: ,Unable to be obtained due to the patient's aphasia.,PHYSICAL EXAMINATION: , Height 5 feet 3, weight of 106 pounds, temperature 97.1 degrees, blood pressure ranges from 138/82 to 111/87, pulse 61, respiratory rate 22. O2 saturation 100%. On general exam, she is an elderly woman with now marked aphasia, which per her daughter waxes and wanes, was more pronounced and she nods her head up and down when she says the word, no, and conversely, she nods her head side-to-side when she uses the word yes with some discordance in her head gestures with vocalization. HEENT shows the cranium is normocephalic and atraumatic. She has dry mucosal membrane. She now has a right facial droop, which per her daughter is new. Neck veins are not distended. No carotid bruits visible. Skin: Warm, well perfused. Lungs are clear to auscultation anteriorly. No wheezes. Cardiac exam: S1, S2, regular rate. No significant murmurs. PMI is nondisplaced. Abdomen: Soft, nondistended. Extremities: Without edema, on limited exam. Neurological exam seems to show only the right facial droop.,DIAGNOSTIC/LABORATORY DATA: , EKGs as reviewed above. Her last ECG shows normalization of prior ST elevation in the inferior leads with Q waves and first-degree AV block, PR interval 280 milliseconds. Further lab shows sodium 135, potassium 4.2, chloride 98, bicarbonate 26, BUN 9, creatinine 0.8, glucose 162, troponin 0.17, INR 1.27, white blood cell count 1.3, hematocrit 31, platelet count of 179.,Chest x-ray, no significant pericardial effusion.,IMPRESSION: , The patient is a 69-year-old woman with metastatic non-small-cell lung cancer with a recent hemorrhagic pericardial effusion, now admitted with cerebrovascular accident and transient inferior myocardial infarction, which appears to be canalized. I will discuss this in detail with the patient and her daughter, and clearly, her situation is quite guarded with likely poor prognosis, which they are understanding of.,RECOMMENDATIONS:,1. I think it is reasonable to continue heparin, but clearly she would be at risk for hemorrhagic pericardial effusion recurrence.,2. Morphine is appropriate, especially for preload reduction and other comfort measures as appropriate.,3. Would avoid other blood thinners including Plavix, Integrilin, and certainly, she is not a candidate for a thrombolytic with which the patient and her daughter are in agreement with after a long discussion.,Other management as per the medical service. I have discussed the case with Dr. X of the hospitalist service who will be admitting the patient.**