

Patient: Forstatter, Alan V
MRN: 62031120118
VisitID: 122199228
49y, F

Physician Clinical Report
Some Hospital Place General
1111 Someplace Rd., Dallas, TX 75244 111-222-3333
Registration Date/Time: 10/01/2008 13:15

***This is a preliminary document and is subject to change**

Time Seen: 14:42.
Arrived- By private vehicle. Historian- patient.

HISTORY OF PRESENT ILLNESS

Chief complaint- ABDOMINAL PAIN. This started several days ago and is still present. It was gradual in onset and has been waxing/waning. It is described as "pain", cramping and diffuse and it is described as generalized in location. At its maximum, severity described as severe. When seen in the E.D., severity described as mild. Modifying factors (diahrea better w/ Immodium). Not worsened by anything. She has had severe associated nausea. It has been similar to previous symptoms. The patient has had loss of appetite. She has had vomiting (today). The vomiting has occurred twice. No diarrhea.

The patient has had similar symptoms previously. These were varying in intensity.

The patient was seen recently and hospitalized. (for AGE w/ dehydration 2 days ago; feeling ill since being home).

REVIEW OF SYSTEMS

The patient has had constipation (for 2 days). She has had difficulty with urination (c/ wusual BPH sxs). It has been similar to previous symptoms. She has had bloody stools (several days ago). She has had fever of 102 F (yesterday). The patient has had chills. She has had moderate difficulty breathing. The patient has also had dyspnea on exertion. No cough. She has had new onset of generalized weakness. All systems otherwise negative, except as recorded above.

PAST HISTORY

See nurses notes. Hypertension. Diabetes mellitus.

Irritable bowel syndrome.

Surgeries: Prior abdominal surgery: appendectomy; gall bladder surgery.

Medications: Irregular heart pill stopped 1 mo ago,

Imodium A-D Oral,

Valium Oral,

Blood Pressure small white pill,

Insulin Regular Human Injection,

Lomotil Oral,.

Allergies: PCN..

SOCIAL HISTORY

Nonsmoker. Is a local resident. The patient lives with spouse. Has good social support.

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ADDITIONAL NOTES

The nursing notes have been reviewed.

PHYSICAL EXAM

Appearance: Alert. Oriented X3. The patient appears toxic and uncomfortable and appears older than stated age.
Vital Signs: Have been reviewed and appear to be correct- hypotensive; tachycardic; tachypneic and oxygen saturation normal; febrile.
Eyes: Pale conjunctivae. No scleral icterus.
ENT: Nose normal. Dry mucous membranes present. No tonsillar exudate.
Neck: Normal inspection. Neck supple.
CVS: Tachycardia. Abnormal rhythm, which is irregular. Heart sounds normal. Pulses normal.
Respiratory: No respiratory distress. Breath sounds normal. Chest nontender.
Abdomen: Multiple scars present. Compatible with prior appendectomy and cholecystectomy. Abdominal distention with tenderness to palpation. Moderate tenderness diffusely. Abnormal bowel sounds: absent.
Back: Normal inspection.
GU: Normal genitalia. Testes descended.
Rectal: Heme-positive stool. (POC test reference range: negative).
Skin: Pallor. Cool skin. Diaphoresis.
Extremities: Extremities exhibit normal ROM. No calf tenderness. No lower extremity edema.
Neuro: Oriented X 3. No motor deficit. No sensory deficit. Reflex exam (equivocal plantar). DTRs otherwise normal.

LABS, X-RAYS, AND EKG

EKG: Rate: 112. Atrial fibrillation. Abnormal P waves. Normal QRS complex. Non-specific ST segment / T wave abnormalities. No acute ischemia. EKG unchanged when compared with prior EKG. The study has been interpreted contemporaneously by me. The EKG appears to be a good tracing. I agree with and confirm the computer reading of the EKG.
Chest X-ray: Diffuse, patchy infiltrate in the left lower lobe. Views: erect AP. The X-rays were independently viewed by me and interpreted by the radiologist.
KUB: Abnormal gas pattern (c/w ileus). Views: two-view AP. The X-rays were interpreted by the radiologist and contemporaneously by me.
Abdominal CT: Study type: abdomen and pelvis. Free fluid is present. There is evidence of diverticulitis. ischemic bowel. Abdominal CT performed with IV and oral contrast. The study was interpreted by the radiologist.

Laboratory Tests: Laboratory tests have been ordered, with results reviewed and considered in the medical decision making process. CBC WITH DIFF: (MsgRcvd 10/01/2008 13:52) Final results

Test	**Result**	**Flag**	**Units**	** (Reference) **
WHITE BLOOD COUNT	10.1		Thsd/mm3	(4.0-11.0)
RED BLOOD COUNT	3.76	L	Mill/mm3	(3.8-5.5)
HEMOGLOBIN	11.5	L	g/dL	(12.0-17.0)
HEMATOCRIT	33.2	L	%	(36.0-46.0)
MEAN CELL VOLUME	88		fL	(80-100)
MEAN CORPUSCULAR HGB	30.7		pg	(26-34)
MEAN CORPUSCULAR HGB CONC	34.8		g/dL	(31-37)
RED CELL DISTRI WIDTH	12.0		%	(11.5-14.5)
PLATELET COUNT	247		Thsd/mm3	(140-450)
MEAN PLATELET VOLUME	8.0		fL	(7.0-12.0)
LYMPH %	29.5		%	(15-50)
MONO %	8.5		%	(2-10)
NEUTR %	57.6		%	(40-75)
EOSIN %	3.7		%	(0-6)
BASO %	0.7		%	(0-2)

PTT: (MsgRcvd 10/01/2008 13:52) Final results

Test	**Result**	**Flag**	**Units**	** (Reference) **
APT	24		seconds	(24-41)

CK-MB: (MsgRcvd 10/01/2008 13:30) New Order

COMP META PANEL: (MsgRcvd 10/01/2008 13:30) New Order

EKG: (MsgRcvd 10/01/2008 13:46) Final results

Test	**Result**	**Flag**	**Units**	** (Reference) **
EKG			Normal EKG READ	

Chest XRay/: (MsgRcvd 10/01/2008 14:01) Final results

Test
CXR
Chest XRay WNL READ BY: William Decalb, MD

Microbiology: Blood culture x2 ordered.

ABG: On FIO2- simple mask. Interpretation: metabolic acidosis.

PROGRESS AND PROCEDURES

Intubation: ED physician at bedside. Intubated with 7.5 cuffed endotracheal tube. Head placed in sniffing position. Preoxygenated. Size 3 MacIntosh blade used. Intubated via orotracheal route. Administered induction agent- etomidate. Administered neuromuscular blocking agent- succinylcholine. No complications. Placement confirmed by direct visualization and ET tube CO2 detection device. Tube secured with adhesive tape and connected to ventilator. Suctioning performed. A chest x-ray was obtained: showing good tube position.

E.D. Course: Foley catheter placed by me.

Cefuroxime 1.5gm IVPB.

Evaluation after reassessment, multiple exams, observation, IV fluids and medication. Physical exam findings are unchanged. The patient's symptoms are unchanged.

Evaluation after reassessment, multiple exams, observation, results of tests back, IV fluids and medication. Physical exam findings are unchanged. Symptoms better.

Dopamine IV drip per protocol.

Evaluation after reassessment, multiple exams, observation, results of tests back, IV fluids and medication. Patient is stable. Symptoms better.

Nasogastric tube placed by RN. No difficulty with insertion..

Critical care performed (40 minutes). Time includes: direct patient care, patient reassessment, coordination of patient care, interpretation of data (laboratory data), review of patient's medical records, medical consultation, family consultation regarding treatment decisions and documentation of patient care- see progress notes. Procedures included in critical care time- see progress notes.

Discussed case with physician Dr. Smith. Reviewed test results and need for additional work-up. Agreed upon treatment plan. Physician will see patient in ED. Call placed to on-call physician. Consult obtained. ID and Surgery. Case discussed. Will see patient in the ED. Consultation performed in ED. Spouse

counseled regarding the patient's serious condition, test results, diagnosis and need for admission. Additional history sought from spouse. Old ED and inpatient records reviewed (Cxs recne admit Salmonella).

Medical Decision Making: Pertinent clinical findings include the presentation, the character of the pain, the fever and vomiting and the risk factors for heart disease. The exam revealed abnormal vital signs and heme positive stool. A serious condition is a probable cause for the patient's findings. The differential diagnosis includes, but is not limited to, perforated viscous, bowel obstruction, diverticulitis, gastroenteritis and irritable bowel syndrome. The diagnosis appears to be less serious in nature. The patient's overall risk appears to be high. The EKG is abnormal. Abnormal tests include the CT of the abdomen and pelvis. Ordered tests include a urinalysis and a white blood cell count. The patient has improved. The exam has not changed. The patient requires re-evaluation, additional studies, monitoring, hydration, medical therapy, pain control, antibiotics and specialized care. A consult has been requested. The patient is to be admitted.. Other considerations: Salmonella, septic shock.

Disposition: Admitted to ICU. Condition: stable and serious.

CLINICAL IMPRESSION

Abdominal pain.
Atrial fibrillation.
Hypotension.
Respiratory failure.
Sepsis.
Shock.
Volume depletion.
Pneumonia.
Profound anemia secondary to acute blood loss.
Leukocytosis.

Sue Holland, M.D.