UMassMemorial
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June 6, 2013

[redacted]

RE: [redacted]
UMMMC#: [redacted]

This is a 33-year-old Japanese male who we have been following here at UMass for the last 3 years while he is doing his training. He has the following problems; asymptomatic hyperuricemia, benign hypertension, cholelithiasis, chronic focal sclerosing glomerulonephritis, diabetes, fatty liver, obesity, sleep apnea, positive PPD and vitamin D deficiency. He is treated with allopurinol 300 mg 1 in the morning and a half at night, chlorthalidone 25 mg daily, diltiazem 240 mg 2 capsules daily, Diovan 160 mg 1 twice daily. For his diabetes, he is on metformin 500 mg 1 three times daily. For his fatty liver, he is on gemfibrozil 600 mg twice daily. For sleep apnea, he has CPAP with a setting of 9 cm and for vitamin D deficiency, he is on vitamin D 50,000 units. He has had chronically elevated liver function tests, with his AST hovering between 45 and 100, his ALT between 57 and 113, most recently 107. This is attributed to his fatty liver. His LDL cholesterol was 120. His last vitamin D in April was 21. He started at 10 back in 2010. So despite the 50,000 units twice a week now, his levels have remained low. His triglycerides most recently were 474. This is actually improved from 638. His glycohemoglobin was 5.7 in June 2010. Most recently, it was 8.3 in October 2012. His creatinine has remained in the normal range. His CBC has been normal. He has had negative tests for hepatitis B and hepatitis C. He has had significant protein in his urine, ranging from a low of 459 to a high of 2,466 mg, and this was attributed to his focal glomerulosclerosis. Mr. Yamada has not enjoyed significant success with weight loss since he has come to the US, although he did weigh 256 pounds in June 2010 and on his most recent visit with us, he weighed 240 pounds. His blood pressure has been very well controlled on his current medications over the past year and was 125/78 last week, but he has had diastolic pressures up to 100 in the past.

I hope this summary of his healthcare status will be helpful to his next provider.

Joseph R. DiFranza, MD
Professor
Benedict Building Family Practice
[redacted]

E-Signed By
Joseph R. DiFranza, MD 06/07/2013 13:14

D: 06/06/2013
T: 06/06/2013 4:41 P

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013634098/5813726

cc:

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May 28, 2013

Carl M. Lieberman, M.D.
61 Lincoln Street, Suite 207
Framingham, MA 01702

RE: [redacted]
UMMMC#: [redacted]
DATE OF SERVICE: 05/28/2013
DATE OF BIRTH: 12/26/1952

Dear Dr. Liebermann:

I had the pleasure of seeing your patient, Mr. [redacted], in the UMass Memorial Pancreatic Clinic along with Dr. Wassef. As you are well aware, he is a very pleasant 60-year-old male with history of stage III pancreatic adenocarcinoma which was diagnosed in November 2012, for which he underwent metal stent placement and was more recently receiving neoadjuvant treatment with gemcitabine and radiation therapy. The patient has so far finished 14 cycles of radiation therapy and over the past few weeks had been complaining of more itchiness and jaundice. Therefore, he was set up for labs which on May 23, 2013, showed bilirubin of 3.4 with direct bilirubin of 1.8, alkaline phosphatase 471, AST 44 and ALT of 101. Of note, these were elevated from the previous labs done on April 16, 2013, all of which were normal. The patient also underwent a CT scan of abdomen and pelvis on May 22, 2013, which showed new likely occlusion of the biliary stent with associated dilatation of the intrahepatic biliary ducts along with progression of pancreatic cancer with increased tumor size and persistent vascular encasement.

The patient is here today to follow up on those results. Clinically, he states he is starting to feel a little better. His itching has decreased and also his appetite is improving. He denies any fever, chills, nausea, vomiting, abdominal pain or change in bowel habits.

The patient's past medical history, social history and family history unchanged and updated in Allscripts.

ALLERGIES: Nystatin.

CURRENT MEDICATION LISTS: Consist of taking Creon, fentanyl, lactulose, lisinopril, lorazepam, Megace, oxycodone, paroxetine and prochlorpemazine.

REVIEW OF SYSTEMS: All other system were reviewed and are negative.

PHYSICAL EXAMINATION:
GENERAL: A 60-year-old male, in no apparent respiratory distress.
VITAL SIGNS: Temperature 98.2, heart rate 76, respiratory rate 18, blood pressure 97/60, height 5 feet 7 inches, weight 181 pounds, BMI of 28.
HEENT: Normocephalic, atraumatic. Mild scleral icterus.
NECK: Supple.
LUNGS: Clear to auscultation.
HEART: S1, S2 regular.
ABDOMEN: Soft, nontender, nondistended.

The patient's laboratory data and more recent CT scan have been detailed in HPI.

ASSESSMENT AND RECOMMENDATION: A 60-year-old male with stage III pancreatic adenocarcinoma, status post stent placement in November of 2012, who is currently on neoadjuvant chemo and radiation therapy, but has had worsening of liver enzymes suggesting obstructive pattern. A CT scan suggesting occlusion of the biliary stent with associated biliary ductal dilatation and progression of pancreatic cancer. At this time, we would like to proceed with ERCP for stent revision and this will be scheduled urgently this week. This was communicated with the patient who verbalized understanding and concurred the plan.

Thank you for involving us in the care of Mr. [redacted].

Sincerely,

Harbir S Sawhney, MD

Wahid Wassef, MD, FACG,MPH
Professor of Medicine
Director of Endoscopy
UMass Memorial Medical Center
[redacted]

I saw and evaluated the patient. I discussed the case with the fellow and agree with the findings and plan as documented in the fellow's note.

E-Signed By
Wahid Y. Wassef, MD,MPH 05/29/2013 07:46

D: 05/28/2013
T: 05/29/2013 12:44 A

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013606579/5796641

cc: Christine Mikule, NP

 [redacted]

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April 23, 2013

To Whom It May Concern:

RE: [redacted]
UMMMC#: [redacted]
DATE OF SERVICE: 04/23/2013
DATE OF BIRTH: 03/18/1957

I had the opportunity to see Ms. [redacted] in the Neurovascular Clinic at UMass on April 23, 2013 with Dr. Goddeau. The patient is a 56-year-old right-handed woman, who was referred to the clinic for evaluation for vertigo. The patient told us that she had been in New Jersey on a vacation when on the night of Thursday, April 18, 2013, when she went to bed at about 10 p.m., she was fine. As soon as she turned to the right side, she experienced acute onset dizziness, which she described as spinning sensation as well as a feeling as if a picture frame was quickly moving from right to left in front of her visual fields. She closed her eyes and that made her feel somewhat better. The symptoms apparently continued intermittently for about an hour and then she went to sleep. As she woke up on the morning of Friday, April 19, 2013, she experienced significant gait unsteadiness as soon as she got out of the bed. She also experienced significant spinning sensation as well. She had a feeling as if she was in a rocking boat. She also experienced significant nausea. As soon as she bent over to tie the shoelaces, the symptoms became significantly worse. She denied having any other associated neurological symptoms such as double vision, slurring of speech, swallowing difficulty, focal weakness, numbness, or paresthesias. Although she did have gait unsteadiness, she did not necessarily would be falling to one particular side or the other. She also reported that over the last several months, she had been having some hearing problem, although she was uncertain as to whether it affected either one of the ears or both together. She had longstanding history of allergies and she said that her allergic symptoms were somewhat worse over the last several months as she was in the process of moving from Lexington to Northboro as she started working as a pathologist here at UMass in Worcester. A few weeks prior to her onset of symptoms on April 18th, she had been having fullness and feeling of congestion of the right ear and she had used Mucinex drops for 2-3 days and that had led to some improvement in the ear symptoms. She denied having any preceding history of viral illness prior to the onset of symptoms on April 18th. On April 19th, she called her sister, who happened to be a physician in the New York area and the patient was prescribed meclizine in a dose of 25 t.i.d. The patient took first dose of 25 mg, but as she continued to take 25 mg doses, she started feeling significantly drowsy and she cut down the dose to 12.5 mg b.i.d. Her symptoms gradually started getting better. She has told us that over the last 3-4 days, she had been feeling better, although her symptoms had been more prominent earlier in the day than towards the latter part of the day. She continued to have some postural and positional component to her symptoms and she told us that she would prefer to keep her head still and if she would move her head to one side or the other, that would trigger the symptoms. If she would keep her head still again, symptoms would go away. She returned from her vacations and resumed work on April 22, 2013. Apparently, her symptoms got worse on April 23, 2013, which led to this clinic appointment. She was unsure as to why the symptoms had gotten worse. She had been using the same dose of meclizine. She, however, reported that the feeling of congestion in the right ear had returned and she had also been having some buzzing and ringing in the right ear as well. She, however, had not had any nausea since April 19, 2013.

PAST MEDICAL HISTORY: Her past medical history was significant for autoimmune thyroiditis, asthma, and celiac disease. She also had history of migraine headaches in the past, but had not had any headache for the last 20 years or so.

DRUG HISTORY: The patient had been taking Singulair and Advair on a regular basis and albuterol and Allegra on p.r.n. basis.

ALLERGIES: The patient was reportedly allergic to NSAID, which would cause angioedema.

FAMILY HISTORY: Her father had history of diabetes and hypertension and her mother had history of vertigo. She denied any history of stroke or heart disease at a young age in the family or any history of clotting disorders or hypercoagulability.

SOCIAL HISTORY: The patient had been working as a pathologist at the UMass in Worcester where she joined in February 2013. Prior to that, she had been working at the Quest Diagnostics. She denied any history of smoking or drug abuse. She would socially drink alcohol. She had no children. She had been living at home with her husband. She was peri/postmenopausal as she had her last menstrual period in December 2012.

REVIEW OF SYSTEMS: Unremarkable except as mentioned in the history of present illness. Please also refer to the scanned form in Allscripts.

PHYSICAL EXAMINATION:
GENERAL: The patient was a young woman, sitting in the chair, in no acute distress.
VITAL SIGNS: Her height was 5 feet and weight was 124 pounds. Postural vitals were checked. In the lying position, her heart rate was 75 per minute and blood pressure was 115/76. In the sitting position, her heart rate was 76 per minute and blood pressure was 122/84. In the standing position, her heart rate was 85 per minute and blood pressure was 123/84.
CHEST: Clear to auscultation.
CVS: S1 plus S2.
ABDOMEN: Soft.
NEUROLOGICAL: The patient was awake, alert, and oriented to time, place and person. Her language and speech functions were normal and memory was intact. On cranial nerve examination, pupils were equal and reactive to light. Funduscopic examination was normal. Extraocular movements were full. There was no field cut. There was no nystagmus. Sensations were normal to fine touch bilaterally on the face. There was no facial weakness. Palatal elevation was symmetric. Uvula was central. Tongue was central and strong. On motor system examination, bulk and tone were normal. Strength was 5/5 in all muscle groups in all 4 extremities. Reflexes were +2 to +3 and symmetrical and toes were bilaterally downgoing. There was no finger-to-nose or heel-to-shin dysmetria. Sensory examination was normal except for a very little if at all decreased vibration distally at the toes bilaterally. Gait was normal including tandem gait, heel walking, and toe walking. Dix-Hallpike maneuver did not trigger any vertigo and there was no elicitable nystagmus either. Ear examination was normal. There was no sinus tenderness.

ASSESSMENT AND PLAN: The patient is a 56-year-old right-handed woman with past medical history of autoimmune thyroiditis, asthma, celiac disease, and migraine headaches, who had acute onset vertigo on April 18, 2013, with subsequent gradual improvement in her symptoms with meclizine with some worsening of symptoms again on April 23, 2013. The worsening of the symptoms with change in head position, associated symptoms of right ear congestion, and buzzing and ringing in the ears and lack of associated neurological symptoms and unremarkable neurological exam suggest that the clinical picture is more likely suggestive of peripheral vestibulopathy. The findings are not entirely consistent with benign paroxysmal positional vertigo and vestibular neuronitis remains a possibility. It is unclear why the symptoms have gotten worse on April 23, 2013, although she also has worsening of peripheral symptoms of congestion of the right ear and buzzing and ringing in the ears as well. We shall obtain an MRI of the brain with gadolinium to rule out the possibility of any structural abnormality along with thin cuts in the region of the vestibular nerves to look for any significant nerve enhancement. As the overall clinical picture is less likely to be suggestive of stroke and her neurological exam is easily assuring, we do not intend to recommend admission at this time. We also are not going to pursue any vascular imaging of the head

and neck currently and we shall wait for the MRI brain results. We initially talked about recommending aspirin until the MRI results become available, but because of her sensitivity to NSAIDs and possibly salicylates, with history of severe reaction in the form of severe angioedema, we deferred that plan. We also intend to refer her to ENT for evaluation because of associated symptoms of decreased hearing, congestion of the ear, and tinnitus. We suggested that she might consider increasing the dose of meclizine somewhat for improved symptomatic control, particularly the night time dose. She may consider increasing the dose from 12.5 mg b.i.d. to 12.5 mg q.a.m. and 25 mg p.o. q.p.m. She may consider taking the nighttime dose somewhat earlier to avoid being groggy in the morning. We shall see her in followup in the clinic in a couple of weeks.

Bilal Hameed, MD

Richard Goddeau, MD

I saw and evaluated the patient. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note.

Reviewed
Bilal Hameed, MD 06/08/2013 13:42

E-Signed By
Richard P Goddeau, MD 06/10/2013 08:26

D: 04/23/2013
T: 04/24/2013 4:03 A

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