Summary of Comments on TLD-NTS Digital Sample 045_Redacted.pdf

Page: 1

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 2:19:19 PM
9 Protocol failure Incorrect CC format

ES #2702205

Date of Service: 01/14/2016

This is a very pleasant lady who underwent a left modified radical neck dissection as well as a thyroidectomy for a papillary thyroid cancer by Dr. Jim Freije. She then underwent radioiodine scan prior to her ablation study, which showed a large amount of retained tissue and/or lymphatic papillary thyroid cancer _____ lymph node metastases of papillary thyroid cancer in the left central compartment. I reviewed the scan, which does indeed show a very large uptake in that region. I had a long talk with her about the risks, benefits, and alternatives. After risks, benefits and alternatives were explained, informed consent was obtained, the patient was posted for a left revision central compartment lymph node dissection.

#2702205

Signature Line
Electronic Signature on File
CC: Mark Tulchinsky, MD, FACNM
Radiology
500 University Drive
Hershey, PA 17033

CC: ESCRIPTION01 CONTRIBUTOR_SYSTEM

Electronically Reviewed/Signed by: David Goldenberg, MD
Professor of Surgery and Oncology
Director, Head and Neck Surgery
Penn State Milton S. Hershey Medical Center
PO Box 850, H091, Hershey, PA 17033
(717) 531-8945

DG /NTS DD: 01/16/16 DT: 01/17/16 04:22

Result Type:	.Outpt Note
Date of Service:	January 14, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Goldenberg, MD, David on January 16, 2016 10:15

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 2:20:32 PM
2 upgraded protocol failure Incorrect addressee format. Chose from HMC database.

ES #2729994

Date of Service: 02/01/2016

Frank Guillard
1700 Old Gatesburg Road
Suite 310
State College, PA 16803

Dear Dr. Guillard:

It was my pleasure to see your patient, [redacted] in the neurosurgery clinic today. As you know, he is a 68-year-old male who over the last several years has been struggling with short-term memory loss. According to his wife, he will forget what day it is or would not remember to take his medications. They have been following with neurology who says this is likely a vascular dementia versus a mixed picture dementia. He has also been generally losing interest in things and developing a slower gait. He has had a handful of falls over the last several years, but he and his wife both deny a dramatic change in his gait. He is stable if he has a single-point cane according to the patient. He denies any bowel or bladder dysfunction. He was previously worked up for NPH, which included a lumbar puncture 1 year ago. [redacted] and his wife both deny any dramatic change in his symptoms following that lumbar puncture.

Past medical history is significant for heart disease, high blood pressure and kidney stones. He is status post bilateral knee replacements, stenting and kidney stone extraction.

Medications were reviewed and updated in PowerChart.

HE HAS ALLERGIES TO RUBBING ALCOHOL AND TAPE.

[redacted] retired in 2011. He lives with his wife who accompanies him to today's appointment. He denies any tobacco, alcohol or recreational drug use.

Family History: Significant for heart disease and high blood pressure.

Review of systems is significant for difficulty sleeping, heart attack, shortness of breath on stairs, heart problems, high blood pressure, irregular heartbeat, black stools, stroke, head injury, temporary weakness and numbness, headaches, kidney stones, kidney and bladder problems, occasional diarrhea, rash, hormone replacement, back pain, neck pain, pain in legs with exercise, joint and muscle pain. Otherwise, 11 point review of systems is negative.

[redacted] is a pleasant 68-year-old male resting in no apparent distress in the examination chair. Speech is clear and coherent, no facial asymmetry, mood and affect are appropriate. Blood pressure is 153/81, pulse is 82. He rates his pain today as 0/10. Extraocular movements are full. Tongue is midline. Shoulder shrug intact. He moves his bilateral upper and lower extremities with equal force. Gait is _____ difficulty with turning. He rises from a chair easily.

The patient was seen and examined by Dr. Iantosca. He reviewed [redacted] recent imaging. His last MRI revealed significant vascular changes with slightly progressive ventriculomegaly as noted over the past several years. We did discuss repeating [redacted] lumbar puncture with pre and post-PT testing to evaluate for any improvement. However, after my discussion with [redacted] and his wife, they are really not interested in having a shunt placed, which would be the ultimate treatment should a diagnosis for NPH be made. At this point, they wish to defer on the lumbar puncture. We would be

This page contains no comments

#2729994

happy to see them back at any time to pursue this further. They have our contact information and knows to contact with any questions or concerns.

Thank you for allowing us to participate in the care of your patient. Please do not hesitate to contact us with any questions or concerns regarding his care.

#2729994

Signature Line
Electronic Signature on File

Sincerely,

Elizabeth G Rakszawski, PA

Electronically Reviewed/Signed by: Mark R Iantosca, MD
Associate Professor of Neurosurgery
Penn State Milton S. Hershey Medical Center
500 University Drive, PO Box 850, MC H110
Hershey, PA 17033
Tel:(717)531-8807 Fax:(717)531-3858

EGR /NTS DD: 02/01/16 DT: 02/02/16 07:25

Result Type:	.Outpt Ltr
Date of Service:	February 01, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Rakszawski, PA, Elizabeth G on February 01, 2016 16:55

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 2:20:42 PM
2 upgraded protocol failure Incorrect addressee format. Choose from HMC database.

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 2:21:43 PM
11 s/b kidney, so

ES #2729223

Date of Service: 02/01/2016

Allison Ray M.D.
2025 Technology Parkway
Suite 108
Mechanicsburg, PA 17050

Dear Allison:

[redacted] came in today for a postoperative visit. She had undergone as you may recall a left-sided nephroureterectomy. She had an upper pole ureterocele, which we incised and lower pole reflux. She had very poor function from the kidneys or her kidney and a large portion of her ureters were excised.

She has subsequently been doing well.

There has been nothing to suggest problems with infections.

Her followup ultrasound, which was performed today, showed that her right kidney showed minimal hydronephrosis and measured about 8 cm.

She just started to do potty training. She is now voiding on the potty, but she is not really a defecating on the potty as yet.

We will simply observe her expectantly. We will plan to see her back for a followup ultrasound in about 1 year.

#2729223

Signature Line
Electronic Signature on File

Sincerely,

Ross M Decter, MD

RMD /NTS DD: 02/01/16 DT: 02/02/16 04:13

Result Type:	.Outpt Ltr
Date of Service:	February 01, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Decter, MD, Ross M on February 01, 2016 13:32

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:09:29 PM
11 misspelled name

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:11:12 PM
11 s/b I

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:11:40 PM
11 s/b I

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 9:47:26 AM
11 s/b A81.2

ES #2736859

Date of Service: 02/04/2016

Lisa Dewees CRNP
605 South George Street
Suite 200
York, PA 17401

Dear Ms. Dewees:

I had the pleasure seeing [redacted] in the outpatient physical medicine clinic of the Penn State Spine Center. [redacted] was accompanied by her friend, [redacted] Briefly, [redacted] is a 54-year-old African-American woman with progressive multifocal leukoencephalopathy. She developed right-sided hemiparesis involving the hand and limb in 2003 that has left her with poor stability and the need to use a cane. She wears a molded ankle-foot orthosis in the right lower extremity. She has been followed by Dr. Thyagarajan Subramanian in the movement disorder clinic with the most recent Botox injections performed in 2013 to the right quadriceps and gastrocnemius muscle. There have been no further injections since 2013. Now [redacted] is having difficulty with walking and when I saw her in October, it was for the purpose of considering Botox injections. Somehow, the plans asize made Dr. Subramanian aware of the plans. [redacted] was scheduled for an appointment in July, but did not attend and so this appointment was arranged and now she wishes to proceed with Botox injections. After received a note from her therapist, Andrew Strittmatter, DPT and he wrote a note based on his assessment of [redacted]. He felt [redacted] would potentially benefit from Botox injections to the right quadriceps to decrease spasticity and improve gait mechanics. I was able to reach Mr. Strittmatter by phone during this appointment and confirmed that he would be able to see [redacted] if we made arrangements for the Botox injections.

On today's visit, [redacted] vital signs are blood pressure 114/67, heart rate 72. [redacted] right leg is notable for Ashworth 2/3 tone. She is unable to flex her knee. Her reflexes are 2+ in the patellar tendons. She has weakness with sit-to-stand in both legs. She has a tendency to lose her balance during examination, no falls occured. Ambulating with a cane and displays an ataxic gait pattern with dependence on a cane for balance.

IMPRESSION:
1. Progressive multifocal leukoencephalopathy, 881.2.
2. Monoplegia, right leg quadriceps area, G83.11.
3. Unsteady Gait, R26.81.

MEDICAL DECISION MAKING: [redacted] may benefit from the injections to the quadriceps muscles. A 100 units _____ suggested to allow for reduction in tone without losing strengths. Mr. Strittmatter will be able to see [redacted] in a followup visit after the injections and follow her progress, keeping me informed by correspondence or by phone call.

PLAN: Botulinum toxin type A, dispense 1 vial of 100 units for injections to the right quadriceps for tone reduction and stabilization of her balance.

Arranged for procedure to be performed at Penn State Hershey Rehabilitation Hospital in the outpatient physical medicine rehabilitation clinic. [redacted] and her friend [redacted] had no further questions and voiced appreciation for today's visit.

Thank you very much for your attention to this note and feel free to call with any questions.

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 2:48:32 PM
2 upgraded protocol failure Incorrect CC format.

#2736859

Signature Line
Electronic Signature on File

CC: ESCRIPTION01 CONTRIBUTOR_SYSTEM

CC: Lisa R Dewees, CRNP
605 South George Street
Suite 200
York, PA 17401

*

Sincerely,

Everett C Hills, MD

ECH /NTS DD: 02/04/16 DT: 02/04/16 19:35

Result Type:	.Outpt Ltr
Date of Service:	February 04, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Hills, MD, Everett C on February 04, 2016 13:08

ES #2735044

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:18:15 PM
3 incorrect patient

Date of Service: 02/03/2016

Mark Folk DO
Route 501 North
PO Box 455
Schaefferstown, PA 17088

Dear Dr. Folk:

I met with _____ and his mother today. His mother was desirous of neonatal circumcision. _____ is a little bit of a big boy who is now about 6 weeks of age. We were, however, able do a circumcision on him by Gomco technique. I supported this for some stitches; however, because his phallus is rather large.

He had a little bit of minimal bleeding after the procedure, but then things settled down well.

We are going to be seeing him back for a followup in about a week and we will let you know how he is doing at that time.

#2735044

Signature Line
Electronic Signature on File

CC: Mark E Folk, DO
Route 501 North
PO Box 455
Schaefferstown, PA 17088

*

Sincerely,

Ross M Decter, MD

RMD /NTS DD: 02/03/16 DT: 02/04/16 05:06

Result Type:	.Outpt Ltr
Date of Service:	February 03, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Decter, MD, Ross M on February 03, 2016 16:03

ES #2740347

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:23:08 PM
2 upgraded protocol failure submitted incomplete document

Date of Service: 02/05/2016

SUBJECTIVE: [redacted] is a 59-year-old gentleman who presents today stating that he wants to follow up on test results ordered by his rheumatologist, Dr. Albano. He states that he called her office, but has not received any information back about his blood tests or x-rays that were done on 01/07/16. He states that he has been taking the meloxicam.

#2740347

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Debra Q Miller, MD

DQM /NTS DD: 02/05/16 DT: 02/06/16 22:54

Result Type:	.Outpt Note
Date of Service:	February 05, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Hope Drive Note
Author or Import Date:	Miller, MD, Debra Q on February 05, 2016 17:54

Author: tdijohnson Subject: Comment on Text Date: 2/22/2016 3:41:58 PM
2 upgraded protocol failure Added addressee in recipient box instead of cc box

ES #2741634

Date of Service: 02/08/2016

Addressee Forwardto

,

[redacted]
14 Country Drive
Apartment 8
Leola, PA 17540

Dear Ms. [redacted]:

I finally had the opportunity to review your imaging from your MRI that was done 12/14/15 in Lancaster. I looked _____ at our liver tumor conference. Unfortunately, we felt that the quality of the scan was not very good because there was a lot of motion artifact in it. We did continue to see these three lesions with no change in any size. It is our recommendation that you consider a repeat MRI, which we would be happy to arrange here at Hershey Medical Center for you or even a triple-phase CAT scan just of the liver which is _____ a shorter visit in the machine. Either way, we are happy to arrange those here at Hershey or Dr. Gibas could arrange for another one closer to home in Lancaster. Again, I just want to reiterate that we did not feel that the quality of the scan gave us a lot of good information to be able to determine what exactly these lesions are.

If you have any questions, please call us at 717-531-4510.

#2741634

Signature Line
Electronic Signature on File

CC: Alexandra L Gibas, MD
2104 Harrisburg Pike
Suite 300
PO Box 3200
Lancaster, PA 17604-3200

*

CC: Forward to Addressee:

Sincerely,

Karen L Krok, MD
Assoc Prof Gastroenterology & Hepatology
Medical Director Live Donor Liver Transplantation
Hershey Medical Center PO Box 850, Hershey, PA 17033
Ph:717-531-1017 Nurse:717-531-4510 Fax:717-531-0061

This page contains no comments

#2741634

KLK /NTS DD: 02/08/16 DT: 02/08/16 22:20

Result Type:	.Outpt Ltr
Date of Service:	February 08, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Krok, MD, Karen L on February 08, 2016 10:21

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 9:51:50 AM
2 upgraded protocol failure added addressee in recipient box instead of CC box

ES #2745662

Date of Service: 02/09/2016

Addressee Forwardto

,

Holly Metzgar, D.O.
1040 Reed Avenue, Wyomissing, PA 19610

Dear Dr. Metzgar:

Thank you for the opportunity to see [redacted] in followup consultation. As you know, [redacted] is a 31-year-old G2, P1-0-0-1 at 26 weeks 2 days, dated by LMP consistent with first trimester ultrasound for an estimated due date of 05/15/16. [redacted] presents to maternal fetal medicine for followup consultation after initial consultation, which was performed after the discovery of a fetal pericardial effusion at the time of patient's anatomic survey in December. Today, the patient reports good fetal movement. She denies loss of fluid, vaginal bleeding or contractions.

Ultrasound performed today demonstrated a fetal heart rate of 130 beats per minute, cephalic presentation with an anterior placenta. The maximum vertical pocket was 3.5 cm. The pericardial fluid collection measured 4.4 mm. There was no evidence of hydrops.

The patient's past medical, surgical, family history was briefly reviewed and remains unchanged from previous consult.

MEDICATIONS: The patient continues to take folic acid and a multivitamin daily.

ALLERGIES: The patient has no known drug allergies.

ASSESSMENT AND PLAN: A 31-year-old G2, P1-0-0-1 at 26 weeks 2 days with fetal pericardial effusion.

Discussed today with patient the results of her recent lab tests. The patient had undergone testing for parvovirus, explained that the results show that patient may previously had been exposed to parvovirus as her IgG antibody is positive; however, her IgM antibody for parvovirus is negative, which supports that patient was not exposed to parvovirus during pregnancy. Discussed again that patient's cell free DNA results were within normal limits, but that this is a screening test and not a diagnostic test. The patient continues to decline amniocentesis. Discussed with patient that her repeat antibody screen for her blood type in the setting of Rh negative blood type continued to have a negative antibody screen, which is reassuring that she has not undergone Rh alloimmunization. The patient has a fetal echo scheduled for February 22nd.

At this time, with no evidence of fetal hydrops, recommend that patient have repeat ultrasound in 1 month. If possible ultrasound should be scheduled with Dr. William Curtin at the Reading office in order to more easily facilitate patient's access.

The patient will continue her routine obstetric care with your office. She reports that she has an appointment on February 19th.

If any further issues arise, please do not hesitate to contact us with any questions or concerns.

This page contains no comments

#2745662

Signature Line
Electronic Signature on File
CC: Forward to Addressee:

Electronically Reviewed/Signed by: Emily R Smith, MD

Electronically Reviewed/Signed by: Anthony Ambrose, MD, FACOG
Maternal-Fetal Medicine

ERS /NTS DD: 02/09/16 DT: 02/09/16 18:20

Result Type:	.Consult
Date of Service:	February 09, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Consult Ltr
Author or Import Date:	Smith, MD, Emily R on February 09, 2016 17:29

ES #2744103

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 10:18:19 AM
2 upgraded protocol failure for submitting incomplete document
(corrected)

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 10:15:14 AM
11 s/b that

Date of Service: 02/09/2016

NAME OF PROCEDURE: Left shoulder revision, pectoralis major transfer with diagnostic arthroscopy.

DATE OF PROCEDURE: 08/28/15.

INTERIM HISTORY: [redacted] returns today ____ than anticipated. He had communicated with our service on January 21st stating that he had a sudden increase in left shoulder pain without incident. He notes that he had been doing his strengthening program with his physical therapist, using 3-pound weights. However, his pain was quite significant and he puts physical therapy on hold because of it. He also had initial inflammatory markers drawn and reviewed, which were normal at that time. These results are dated 01/25/15 in our PowerChart system. He continues Xarelto for a left upper extremity DVT, which was from a PICC line. At this point, he denies any fevers, chills, shortness of breath. Does complain of anterior superior left shoulder pain, worse with activity, but constant at rest. Does wake him up at night. Does have some radiation into the anterior chest wall on the left side, also ____ to his left hand is achy at night.

Physical examination of his left shoulder, he has a well-healed surgical incision. There is no evidence of infection. He has active forward elevation of 50 degrees, passively 160 with significant pain. Has external rotation at the side of 85 degrees and internal rotation to the side belt level. With strength testing, he has 5-/5 strength with both external rotation, scapular plane abduction, primarily limited due to pain.

Strongly positive Neer's and Hawkins on the left. He does have an equivocal belly off test. He has no AC joint, bicipital groove or greater tuberosity tenderness. He has an intact neurovascular exam in the left upper extremity, has +2 radial pulse palpable distally.

STUDIES: Left shoulder MRI was reviewed today from 02/03/16. These images show intact pectoralis major tendon transfer. There was noted to be a high-grade undersurface tear of the posterior supraspinatus and anterior infraspinatus and postoperative changes of biceps tenodesis.

ASSESSMENT: Status post left shoulder revision, pectoralis major transfer. He has symptoms today concerning for a rotator cuff tendinitis.

PLAN: We had a lengthy discussion with [redacted] today that based on his physical examination and most recent MRI study, it seems that his pain may be more related to rotator cuff tendinitis. He also is quite limited with internal rotation, which was a change for him. We have recommended both diagnostic and therapeutic subacromial injection today and after discussing the risks and benefits of the injection, he wished to proceed.

PROCEDURE: Left shoulder was identified as the correct side. His medication allergies were verified and reviewed. His left shoulder was draped and prepped in sterile fashion. The skin was cleansed with iodine. 8 mL of 1% lidocaine with epinephrine combined with 2 mL of 40 mg per mL of Kenalog were injected into the left shoulder subacromial space. The patient's skin was then cleansed with alcohol and dried and a Band-Aid was applied.

After 5 minutes, the patient was reassessed. He reported no change in the anterior superior shoulder pain. At this point, we will give him a prescription for Norco 5/325, take 1 tablet by mouth at bedtime, dispensed 30 tablets without refill. In addition, he will continue to monitor his symptoms and possible benefits from the injection for the next 4 days and contact our office on Friday if his symptoms do not improve.

This page contains no comments

#2744103

Signature Line
Electronic Signature on File
CC: Richard E Taggart, Jr, MD
Building 400 Avenue G
New Cumberland, PA 17070
*

Electronically Reviewed/Signed by: Kelly A Martin, CRNP

KAM /NTS DD: 02/09/16 DT: 02/09/16 19:56

Result Type:	.Outpt Note
Date of Service:	February 09, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Martin, CRNP, Kelly A on February 09, 2016 10:09

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 10:19:10 AM
2 upgraded protocol failure added addressee in recipient box instead of cc box

ES #2746922

Date of Service: 02/10/2016

Addressee Forwardto

,

Dr. Chukwudi Ogbolu
2175 Blakeslee Boulevard
Lehighton, PA

On the afternoon of 02/10/16, [redacted] again returned to the adult cystic fibrosis clinic at the Penn State Milton S. Hershey Medical Center. [redacted] is now 36 years of age and from all perspective, maintains a normal health, continuing his college education at Bloomsburg University, continue to participate in high level functional physical activity including outdoor camping, hiking, Judo and Jiu-Jitsu and denies any limitation from either strength, stamina, endurance or breathing capacity. He has preserved pulmonary physiology. A pulmonary function measurements today showing a forced vital capacity of 5.05 liters, 97% of predicted; an FEV1 of 2.62 liters, 87% of predicted; an FEV1/FVC ratio of 72% and FEF 25-75%, 2.39 liters per second, 59% of predicted. He is on an outpatient regimen of inhaled bronchodilators, inhaled Pulmozyme ____ along with pancreatic supplemental enzymes, supplemental vitamins, Nexium for gastroesophageal reflux, but most importantly a high level of diligence and attention to his overall health and knowledge about his disease process.

On examination, he is a healthy robust appearing gentleman almost 200 pounds with a resting respiratory rate less than 20 and at rest, no accessory muscle activation. His cardiac examination is normal without gallops, murmurs or rubs. Abdomen soft, nontender, no rebound, no rigidity, no obvious organomegaly. Extremities well perfused. No cyanosis, no edema. His lung examination is normal, clear and full breath sounds, no adventitial sounds and full air entry.

IMPRESSION AND PLAN: At this time, from all the perspective, we monitored the patient with cystic fibrosis, nutrition, metabolic and pulmonary respiratory. [redacted] continues to maintain a near normal health from his perspective bothered mostly by sinus disease, which is not active at this time. He is on appropriate medications in terms of health maintenance, thus no adjustments were made. We continued to compliment him on his attention to his overall health, positive health habits and is knowledgeable basis in relation to his disease process of cystic fibrosis.

#2746922

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

Sincerely,

This page contains no comments

#2746922

Robert L Vender, MD, FACP
Associate Professor of Pulmonary, Allergy & Critical Care Medicine
PennState Milton S. Hershey Med Ctr, H041
PO Box 850
Hershey, PA 17033 (717) 531-6525

RLV /NTS DD: 02/10/16 DT: 02/10/16 22:31

Result Type:	.Outpt Ltr
Date of Service:	February 10, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Vender, MD, Robert L on February 10, 2016 12:36

This page contains no comments

ES #2745616

Date of Service: 02/09/2016

Benjamin Fogel MD
General Pediatrics
35 Hope Drive, Suite 102
Hershey, PA 17033

Dear Dr. Fogel:

Your patient, [redacted] was evaluated at your request and that of pediatric neurology to see if there were additional services, particularly to enhance communication skills that could be provided for [redacted].

Review of medical information shows that he was born at 36 weeks gestation. His weight was 6 pounds 5 ounces. He had jaundice in the newborn period, but no other complications. He developed a seizure disorder in 2009, which has been very hard to control. He also has had irritable bowel syndrome, possible gluten intolerance and is taking gluten, dairy and soy free diet since age 4.

Around age 2, he began to lose skills, including language but other skills as well. At that age, he was thought to have PANDAS. He received 1 year of IVIG treatments for this problem. He also has been treated with a number of supplements and vitamins in past but not currently.

In young childhood, he was evaluated at Kennedy Krieger Institute in Baltimore for a metabolic workup because of loss of skills around age 2. No abnormalities were found. I did ask for a copy of the evaluation because there may be some additional tests that have evolved in the interim that could be completed, but after that regression, he has had no other episodes of loss of skills except during flurries of seizures, when it often takes him 2-3 weeks to return close to his previous baseline. At present, he is taking clobazam 5 mg morning and noon, and 10 mg at bedtime; lamotrigine 200 mg twice a day, Levetiracetam 400 mg twice per day, and lorazepam 0.5 mg q. 6 hours if he is having a seizure cluster. In addition, he takes Vimpat 50 mg twice per day. He takes vitamin B6 and vitamin D3 in addition to calcium supplementation.

At present, he is attending New Story, a specialized program for individuals with autism at the seventh grade level. With regard to communication, he is using some signs and does use gestures at times, but very rarely does he verbalize he is able to make some syllable sounds, but generally not for communication. A diagnosis of speech apraxia had been suggested at his evaluation at Kennedy Krieger when he was a young child.

Neuropsychological evaluation was completed at 9 years 10 months using the Stanford-Binet with standard scores at the 1st percentile on a nonverbal IQ of 42, which is in the moderately impaired range. An evaluation was completed through the Central Dauphin School District at age 13, when he was in sixth grade. His Wechsler Nonverbal Scale and Ability score was 31 or in the borderline between moderately and severely impaired range. His teacher rating scales indicated scores within the significantly autistic range for the Gilliam Autism Rating Scale.

At school, his family and teaching personnel are working to balance teaching him functional skills and maintaining some instruction of functional academics. He is uninterested in the academics and has started to display avoidance behaviors. Fortunately, these are not aggressive in nature, but he may look away, ignore the question or tap on the table to indicate that he is not interested in what is going on. In the current program, he is receiving occupational and physical therapy, but he has just begun to receive speech therapy because they did not have a speech therapist available. Information from his classroom

This page contains no comments

#2745616

notes difficulty with the following qualities: Social interaction, distractibility, motor skills, language skills, occasional aggression and unusual behaviors. Academically, they note that Sean has problems attending to and scanning an array of pictures for receptive identification. His teacher agrees with his family that communication the biggest road block. He knows a few signs, but does not seem to use them consistently. He had an iPad with Proloquo2Go app, but did not either understand how to use it or was uninterested in using it.

Review of family history shows of several individuals with anxiety, but no one in the family with either seizure disorder or autism.

NEURODEVELOPMENTAL EVALUATION: [redacted] weight was 53.7 kg (49th percentile). Height was 165.1 cm (39th percentile). Blood pressure was normal at 106/58. During the initial part of the evaluation, when Mr. Mark Domoto, behavior management and education specialist, was working with [redacted], he was cooperative and very quiet. He had his head phones in place, but responded despite using the head phones. He did not interrupt adult conversation and was not agitated. He did use some gestures and, at times, grunted or tapped his foot, probably to indicate discomfort.

One-on-one with me, he made good eye contact at times, but as soon as I presented him with a task such as identifying pictures, he looked away and it was clear that he was uninterested and was actively avoiding the task. When I took his hand, which he readily allowed me to do, and helped point to the correct picture, usually he actually assisted with this. It was very evident that he was able to identify a number of pictured objects, but could not get himself to do this on request. I persisted with this for multiple pictures, including things I thought might be interesting to him such as fire engines and emergency vehicles. His favorite color is red and he could easily point out red, but he continued to be avoidant of virtually anything I asked him to do.

To his credit, he smiled at times and was personable, but one could see that he was actively seeking to avoid the tasks at hand and, therefore, it was very difficult to gauge his true level of understanding. I then played ball with him. He is able to catch and throw a ball, but quickly lost interest in that activity as well. He did follow simple directions to give the ball or throw the ball to people in the room.

Physical examination does not show any unusual physical features. Strength and tone appear to be normal. There is no nystagmus or tremor as might be seen in an individual with a mitochondrial or metabolic disorder and no features to suggest a genetic syndrome.

IMPRESSION AND TREATMENT PLAN: I suggested the following diagnoses:
1. Autism spectrum disorder.
- Language skills, level 3; social skills, level 3.
2. Probable speech apraxia.
3. Avoidant behavior when working on academics and many other tasks as well.
4. Significant cognitive impairment, but very difficult to quantify what he actually knows.
5. Pleasant personality with very uncommon agitation or aggression, usually very accepting of redirection.

With regard to medical issues, I asked to review information from testing at Kennedy Krieger Institute. There may be additional studies that could be done to make certain that there is not a metabolic disorder; however, his course of growth and development suggest that this is not an issue because I would have expected him to continue to lose skills or plateau. We could check for acidosis with lactate and pyruvate levels during sickness or flurries of seizures. There may be other tests that would be appropriate as well.

I did suggest use of N-acetylcysteine, a supplement that has some support in the medical studies for moderation of irritability and improved awareness of environment in individuals with autism. I suggested starting with 600 mg once a day to increase to 600 mg twice a day in 2-3 weeks. I asked for an update at that point. I suspect he would need between 2 and 2.4 grams. This has generally been the optimal dose

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 10:23:39 AM
2 upgraded protocol failure Incorrect CC format. Choose from database

#2745616

in the studies. Side effects can include upset stomach, but otherwise it is usually well-tolerated other than poor taste if the capsule needs to be opened.

One could consider using memantine, a medication that was developed for individuals with Alzheimer disease. There is some data in individuals with autism to suggest that it is helpful for awareness of the environment and language disorder. However, I would want to work with pediatric neurology to make certain that they are comfortable with using this medication in the setting of a fragile seizure disorder and multiple medications. Therefore, I did not recommend starting it now. The other road block to this medication is that it is frequently not covered by insurance in his age group and it is costly.

Family has just obtained medical assistance for [redacted] which should be of help in funding services outside of school, particularly for communication. I requested the consult with Marie Kurtz, speech and language pathologist here, who specializes in speech apraxia to see if she thinks Sean has this diagnosis and can make recommendations for further therapies. The therapy for apraxia differ in many ways from those for straightforward language disorder and autism.

Mr. Mark Domoto is available to work on strategies at home to help with communication. A picture system that uses photos of [redacted] in particular activities might be the most effective way to get communication started, using pictures for things other than foods. We also mentioned the possibility of wraparound services at home to work with [redacted], to help with learning day-to-day tasks as well as communication. We did provide a list of providers in Dauphin County, who could provide these services. I do want to see [redacted] again and an appointment was scheduled in fall, but in the meantime, I asked for updates from his family both regarding the supplements and also, I will review information as we get regarding his language disability and I am available to answer any questions that arise.

CC: [redacted]
11 Carousel Circle, Hershey, Pennsylvania, 17033.

#2745616

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

CC: Benjamin N Fogel, MD
35 Hope Drive
Suite 102
Hershey, PA 17033

Sincerely,

Jeanette C Ramer, MD
Developmental Pediatrician

JCR /NTS DD: 02/09/16 DT: 02/10/16 06:56

This page contains no comments

#2745616

Result Type:	.Outpt Ltr
Date of Service:	February 09, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Ramer, MD, Jeanette C on February 09, 2016 17:14

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 11:53:15 AM
2 upgraded protocol failure Incorrect addressee format. Choose from database.

ES #2745490

Date of Service: 02/09/2016

Spencer Phillips, M.D.

Dear Dr. Phillips:

It was a pleasure to see [redacted] in our allergy and immunology clinic today for a followup visit for chronic idiopathic urticaria and chronic rhinitis. As you know, [redacted] is a 34-year-old male who has had chronic idiopathic urticaria that is well controlled on sulfasalazine. He has had chronic hives for about 2 years now. At the last visit because he was doing well, we tried to taper the sulfasalazine down. He went from 2000 mg a day to 1500 mg per day and after about a week or so developed a rash on his eyelids and wrists. He used topical hydrocortisone and he eventually went back up to the 2000 mg and his symptoms improved. He has continued using that dose and is currently well controlled with the hives. He does also have some hydroxyzine as needed and does not need to use this medication very often.

Regarding his chronic rhinitis and sinusitis, he continues to have symptoms of nasal congestion that are persistent. We had tried azelastine nose sprays, but this did not provide significant benefit and had a bad taste, so he stopped taking it. He has also tried nasal steroids in past as well as oral antihistamines and these have not been very helpful.

There are otherwise no other changes in his past medical, social or family history.

Fourteen-point review of systems is negative today.

CURRENT MEDICATIONS: Azelastine nose spray 2 sprays each nostril daily, Claritin 10 mg daily, hydroxyzine 50 mg at bedtime as needed, sulfasalazine 500 mg tablets 2 tablets twice a day.

Vital signs, blood pressure 137/83, pulse 106, respirations 18. HEENT exam, sclerae anicteric, no conjunctival injection, nasal mucosa without edema, oropharynx clear, mucous membranes moist, tympanic membranes clear bilaterally. Neck without lymphadenopathy or thyromegaly. Lungs are clear to auscultation bilaterally. Cardiac exam, normal S1 and S2; regular rate and rhythm; no murmurs, rubs or gallops. Abdomen soft, nontender, nondistended. Extremities, no cyanosis, clubbing or edema. Skin exam without rash.

ASSESSMENT:
1. Chronic idiopathic urticaria.
2. Chronic rhinitis and sinusitis.

[redacted] presents today for a followup visit for chronic idiopathic urticaria. We had tried to taper the sulfasalazine down, but he broke through with a rash and so this was titrated back up. I recommended he continue sulfasalazine for at least another 3 months and if at that time he has been doing well without any more outbreaks, we can consider trying another taper off. However, at this point, he will continue the 2 tablets twice a day and I would like to do some blood work including a CBC with diff and a CMP to make sure he does not have any toxicity from this medication.

This page contains no comments

#2745490

I would like to see him back in about 6 months for a followup visit. He will call me prior to that with questions or concerns.

#2745490

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

Sincerely,

Faoud T Ishmael, MD

FTI /NTS DD: 02/09/16 DT: 02/10/16 03:46

Result Type:	.Outpt Ltr
Date of Service:	February 09, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Ishmael, MD, Faoud T on February 09, 2016 16:16

This page contains no comments

ES #2746694

Date of Service: 02/10/2016

Mark Smith MD
795 Cherry Tree Court
Suite 2
Hanover, PA 17331

Dear Dr. Smith:

I had the pleasure of meeting your patient, [redacted] today in our outpatient inflammatory bowel disease clinic at Penn State Hershey. As you well know, [redacted] is a 70-year-old female who states that she was admitted with severe diarrhea in August 2015. At that time, she had a flexible sigmoidoscopy that had features suggestive of ulcerative colitis. She subsequently had repeated episodes of dehydration and was found to be C. diff for the first time in September 2015. She was started on Delzicol and has responded to prednisone on which she is on a taper. Unfortunately, her C. diff has been problematic. She was first on a dose of Flagyl to which she responded, but had recurrence of her symptoms. On repeat symptomology, she was started on vancomycin, which she did well with formed stool and then ultimately went on a vancomycin taper at that point second C. diff positivity or recurrence of her symptoms. Unfortunately, her white count dropped with decreased neutrophils. A consult from hematology assessed that they felt that this blood dyscrasia was related to vancomycin. Once she stopped her vancomycin, her blood counts completely normalized. The idea was to put her then after continued symptoms on Dificid; however, this was not done as the patient is on Medicare and they could not afford the cost. She is now on a Flagyl taper and on prednisone taper and has had more ____ stool for the last week. Today, however, is her last day of Flagyl. As you well know, I take care of [redacted] daughter for her IBD as well. They have been concerned because [redacted] has lost over 20 pounds of weight since this all started and obviously they have concern whether her underlying ulcerative colitis is controlled, which you have brought up in your notes as well. Currently, she has 3-4 bowel movements a day which is completely at her baseline that are formed. She has no fevers or sweats.

REVIEW OF SYSTEMS: She has never had any hematochezia. She otherwise feels well other than some chronic fatigue.

PAST MEDICAL HISTORY: Parkinson disease, early dementia, depression and restless legs and history of breast cancer.

PAST SURGICAL HISTORY: Mastectomy, foot surgery and cholecystectomy as well as C-section.

SOCIAL HISTORY: She was a smoker in her teens, quit in her 20s. Very rare alcohol. She has 3 children. She is retired.

FAMILY HISTORY: A daughter with Crohn disease and severe kidney disease on transplant listing, status post already a kidney transplant. Her sons have no medical problems.

ALLERGIES: PENICILLIN AND VANCOMYCIN.

CURRENT MEDICATIONS: Bacid oral capsule, calcium and vitamin D, carbidopa and levodopa, Delzicol 400 mg 3 tabs p.o. t.i.d., Flagyl 500 mg 1 tab p.o. b.i.d., lorazepam 0.5 mg p.r.n., multivitamin, prednisone 30 mg p.o. daily on a taper, ropinirole 1 mg p.o. t.i.d., tramadol 50 mg 1 tab p.o. q. 4 hours and venlafaxine 150 mg extended release.

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 12:00:42 PM
2 upgraded protocol failure pended document for template did not follow MTI.

#2746694

On physical exam, today, temp is 36.8, blood pressure is 132/66, heart rate is 74 and respiratory rate is 20. Pain is listed as 0. Her weight is 140 pounds for a BMI of 23.84. In general, this is a Caucasian elderly female in no apparent distress. Oropharynx is clear. Anicteric sclerae. Mucous membranes are moist. Cardiovascular: Regular rate and rhythm. Lungs are clear with some coarse breath sounds at the bases. Abdomen is soft, nontender, nondistended with no organomegaly. Positive bowel sounds in all four quadrants. Extremities without edema. Skin without rashes. Affect is flat.

Labs available to me, I have a C. diff that was positive on 01/13/16. I do have a negative one from 12/29/15 and no others are available. Labs were reviewed. White count 16.1, hemoglobin 12.4, hematocrit 38.5, MCV is 92 and platelet count is 324. Creatinine 0.67. GFR more than 60. She has repeatedly had a TPMT enzyme activity, which was normal and a QuantiFeron that was negative as well. I do not have hep serologies nor these actual labs myself. Endoscopy reports a flex sig dated 01/05/16, biopsies consistent with ulcerative colitis. Flexible sigmoidoscopy at that time showed ulcerative colitis involving the visualized sigmoid and rectum. The study was limited and the proximal margin of inflammation was not achieved. Her symptoms had improved since steroids at that time. It is unclear to me whether she had a positivity of C. diff, which I suspect was continued on 08/24/15, severe colitis from rectum to the splenic flexure with ulcerations, edema and erythema. Biopsies were obtained and biopsies showed that features were consistent with ulcerative colitis. Of note, the patient had been positive for C. diff at that time.

IMPRESSION: This is a 70-year-old woman with presumed ulcerative colitis that has been plagued with repeated episodes of C. diff to my count, and per her husband, she has had five episodes. She has been on Flagyl, vancomycin taper, which was complicated by pancytopenia and now she is on a Flagyl taper. She has responded to the Flagyl. They have not tried Dificid. She is coming today for further evaluation.
1. Ulcerative colitis, unknown extent.
2. C. diff repeated infection. At this time, we discussed given that her multiple infections, we need to have 3 positive C. diff for her to be evaluated for fecal transplant, though I think she would be a good candidate. I reviewed with her the success rate of fecal transplant and the possibility of flare in the setting of ulcerative colitis. In addition, we discussed with her that her ulcerative colitis may not be completely controlled on her Delzicol, though this is difficult to assess while repeated symptoms of C. diff. It is encouraging to me that while she is on treatment for C. diff, she does well; however, it would be important to see how she does off the prednisone taper. If the patient cannot tolerate prednisone taper and she was found to be negative for C. diff, I agree with you that escalating her therapy would make sense and I do agree that options would include Imuran or an anti-TNF. At this time, I gave the patient a script for C. diff. She will see how she does off Flagyl. If her symptoms recur, she will get a C. diff that will make for a second positivity and we will ask your office to send us a possible third if available. We will then set her up for fecal transplant evaluation. In the meantime, her husband plans to see if you can get Dificid as a lower cost and I recommended that this would be a good option as well to try a course of Dificid before going to fecal transplant. Ultimately, the patient will need a full colonoscopy, but she would like to continue under your care if that is possible depending on how her C. diff infection, evaluation and treatment moves forward.

Thank you so much for allowing me to participate in the care of this complex patient.

Insert template.

#2746694

Signature Line
Electronic Signature on File

This page contains no comments

#2746694

CC: Erin M Roberts, MD
310 Stock Street
Suite 4
Hanover, PA 17332

*

CC: Mark A Smith, MD
795 Cherry Tree Court
Suite 2
Hanover, PA 17331

*

Sincerely,

Emmanuelle Williams, MD
Assistant Professor of Medicine
Division of Gastroenterology & Hepatology
PennState Milton S. Hershey Medical Center
PO Box 850, MC HU33, Hershey, PA 17033
Tel (717) 531-3694 Fax (717) 531-6770

EW /NTS DD: 02/10/16 DT: 02/10/16 22:44

Result Type:	.Outpt Ltr
Date of Service:	February 10, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Williams, MD, Emmanuelle on February 10, 2016 11:41

This page contains no comments

ES #2745528

Date of Service: 02/09/2016

Lisa Myers DO
11 Sprint Drive
Suite 4
Carlisle, PA 17015

Dear Dr. Myers:

Your patient, [redacted] was reevaluated in followup of a high activity level in the setting of autism and seizure disorder. His seizure disorder has remained under good control and very recently, Dr. Mainali, pediatric neurologist, has suggested weaning Keppra. He will continue to take Lamictal and Onfi. At present, I am prescribing Guanfacine for high activity level and previous agitation. We had tried weaning this medicine after the last visit because it was not completely clear that it was of value. However, when it was weaned, he was much more hyperactive and, therefore, it was restarted over the last several months, with improvement but not quite to previous baseline.

[redacted] continues to have a high activity level and difficulty with attention focus. Even with Guanfacine, he is never aggressive, but there is avoidance behavior both at home and at school, which interferes with learning.

He is communicating particularly around food issues. He enjoys eating and, therefore, food choices are a good area to address. He is able to consistently make choices using gestures and some words. He has less success when trying to convey feelings or needs. At present, he enjoys listening to music and some of what he listens to would be quite appropriate for most adolescents his age.

[redacted]is able to get ready for school with some help. He also uses the toilet largely by himself, except he needs some help with wiping after bowel movements. At present, he is sleeping from about 9:30 in the evening until 6:00 in the morning, using melatonin 3 mg at bedtime.

NEURODEVELOPMENTAL EVALUATION: [redacted] weight was 71.4 kg (95th percentile) and his height was 170.5 cm (83rd percentile). [redacted] was pleasant but very busy and active. He tapped his feet frequently and vocalized. When I began to work with him using pictures and a book, it was evident that there were avoidance behaviors present. He looked away, ignored me or vocalized loudly. At that point, he wanted to know what color my car is and he also repeatedly told me that his car is red, his grandfather's car is black and silver, etc. I suspect that at least much of his language was done to avoid the task that I had put before him. When I could get him to respond, he was largely accurate. He was not at all aggressive in my setting, but in the classroom, I could see that it would be difficult to get him to comply consistently throughout the day.

Fine motor skills were reasonably well-developed. He was able to complete rapid alternating and sequential finger movements without difficulty.

IMPRESSION AND TREATMENT PLAN: I continue to endorse the following diagnoses:
1. Autism spectrum disorder
- Language skills, level 2; social skills level 2-3.
2. Impaired attention to task with restlessness, still problematic.
3. Cognitive impairment, moderate.
4. Seizure disorder, under good control, plan to wean Keppra.

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 1:44:23 PM
2 upgraded protocol failure Incorrect CC format. Choose from database.

#2745528

Weaning of Keppra may be of help to [redacted] and some individuals Keppra can be associated with behavioral problems and as it is withdrawn, he may become calmer and more redirectable. I also suggested use of N-acetylcysteine, a supplement that over the last several years has been found to be of benefit in some studies for individuals with autism and irritability or agitation. I would begin with 600 mg once a day in the morning and, after 2-3 weeks, increase to 600 mg twice a day. His dose is likely to need to be between 2 and 2.4 grams per day for full effectiveness.

I also suggested changing over to a long-acting preparation of clonidine. I had look at the possibility of using Intuniv since he is taking Guanfacine, but his insurance does not cover this medication, but does cover the long-acting clonidine preparation. Therefore, I suggested using it twice a day after beginning to wean Guanfacine. I provided a schedule to start to wean Guanfacine, add long-acting clonidine and then finish weaning Guanfacine if this is successful. I hope that clonidine will help with attention, focus and overall level of calmness as well. I did ask for an update from Mrs. Himes in about 3-4 weeks during this changeover in medication.

I do want to see [redacted] again and an appointment was scheduled in fall.

CC: [redacted]
4th Wagstone Drive, Carlisle, Pennsylvania, 17013.

#2745528

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

CC: Lisa C Myers, DO
11 Sprint Drive
Suite 4
Carlisle, PA 17015

*

Sincerely,

Jeanette C Ramer, MD
Developmental Pediatrician

JCR /NTS DD: 02/09/16 DT: 02/10/16 04:52

Result Type:	.Outpt Ltr
Date of Service:	February 09, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Ramer, MD, Jeanette C on February 09, 2016 16:35

ES #2749343

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 1:47:41 PM
9 Protocol failure chose wrong encounter

Date of Service: 02/11/2016

Current dose 2600 cGy in 13 fractions over 3 weeks to the mediastinum and left hilum following resection of a carcinoid tumor with N2 nodal metastases.

Weight is 95.7 kilos, blood pressure 174/88, pulse 100, respirations 16, temperature 36.2, ECOG performance status 2, pain score 1.

NARRATIVE: The patient is seen for on treatment evaluation. She is beginning to notice some discomfort swallowing and is using a soft and relatively bland diet. Her appetite is decreased a bit. She continues to have difficulty sleeping, which has been an ongoing problem for the past year. She does not wish to try local anesthetic such as viscous lidocaine for her swallowing as it is not that bad at the present. Her portal imaging has been reviewed and approved. Planned course will be to continue postoperative radiation to a dose of 50 Gy in 25 fractions over 5 weeks.

#2749343

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Henry Wagner, Jr, MD
Director, Radiation Oncology
Penn State Cancer Institute
PO Box 850, H063, Hershey, PA 17033

HW /NTS DD: 02/11/16 DT: 02/11/16 23:18

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Wagner, MD, Henry on February 11, 2016 12:59

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:39:48 PM
2 upgraded protocol failure Incorrect CC format. Choose from database

ES #2748604

Date of Service: 02/11/2016

CHIEF COMPLAINT: Left breast asymmetry.

HISTORY OF PRESENT ILLNESS: I had the pleasure of seeing [redacted] in the office. As you know, she is a very pleasant 61-year-old female who initially underwent followup diagnostic mammogram of the left breast and was noted to have an asymmetry in the left breast in the upper outer quadrant and for which biopsy was recommended. They could not find an ultrasound _____ and they tried to do it with sterotactic; however, they were unable to perform this. So she was sent to my office. After my visit, we did undergo an MRI of the bilateral breast on 12/30/15 and they were able to see the area of suspicious finding on MRI. She subsequently underwent a biopsy of the left breast using ultrasound guidance on 01/25/16 and they were able to biopsy the area of architectural distortion, which returned as fibrocystic changes of the breast. The patient reports since then she does notice some bruising in the breast, no nipple discharge, nipple inversion, nipple pruritus and the breast is slightly uncomfortable.

PHYSICAL EXAMINATION: The patient is awake and alert and oriented x3. Blood pressure is 112/74, temp of 36.6, pulse of 78. She is 62.5 kilos, 172.7 cm. She is well-nourished, in no acute distress. On exam, she does have a palpable hematoma in the left breast in the upper outer quadrant.

IMPRESSION AND PLAN: In summary, [redacted] is a 61-year-old female with a left breast asymmetry seen on mammogram and on MRI. She is status post biopsy, which returned benign. However, due to the findings on mammogram and on MRI recommendation is for wire localization excisional biopsy. We discussed the use of wire localization for identification of the area of concern and the recommendation for excisional biopsy to obtain definitive diagnosis. The risks and benefits of the procedure, specifically the risk of bleeding, infection, hematoma, seroma, as well as the risk of missed target were all discussed with the patient and the patient was consented for left breast wire localization excisional biopsy. The patient to be called to be scheduled for surgery. The patient's questions were answered to her satisfaction and she expressed understanding of my recommendation. I appreciate the opportunity to participate in the patient's care and please do not hesitate to contact me in the future should you develop any questions or concerns.

cc: Debra Miller, M.D.
PO Box 850 University Hospital
Hershey, PA 17033

#2748604

Signature Line
Electronic Signature on File
CC: Forward 1 to:

Electronically Reviewed/Signed by: Kristine L Widders, MD

KLW /NTS DD: 02/11/16 DT: 02/11/16 13:12

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Widders, MD, Kristine L on February 11, 2016 09:43

ES #2749534

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:32:54 PM
9 Protocol failure chose wrong encounter

Date of Service: 02/11/2016

CURRENT DOSE: 900 cGy in 3 fractions to the esophagus for esophageal carcinoma with known liver metastases.

NARRATIVE: The patient is seen for on-treatment evaluation. He has just started a course of palliative radiation therapy for his esophageal carcinoma, which was causing dysphagia. He has known biopsy-proven liver metastases, which will be treated with chemotherapy after he completes his radiation. The patient is seen today, has just started treatment and is tolerating it well so far. His weight is 63.1 kilos, blood pressure 138/87, pulse 72, respirations 18, temperature 36.4. ECOG performance status 1, pain score 4. The patient notes that he is having pain in his right side in the region of the hip, this is apparently a new complaint that he has not mentioned before. I will review his recent imaging to see if there is any evidence for metastatic disease in this site. We will continue his planned radiation to the esophagus. His portal imaging has been reviewed and approved.

#2749534

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Henry Wagner, Jr, MD
Director, Radiation Oncology
Penn State Cancer Institute
PO Box 850, H063, Hershey, PA 17033

HW /NTS DD: 02/11/16 DT: 02/12/16 00:14

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Wagner, MD, Henry on February 11, 2016 13:56

ES #2749336

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:35:42 PM
9 Protocol failure Inappropriate pend

Date of Service: 02/11/2016

CURRENT DOSE: 800 cGy to the right clavicle, left proximal humerus and 1200 cGy in the current course of treatment to the whole brain, which is an addition to 3000 cGy given 6 months ago. Weight is 61 kilos, blood pressure 103/73, pulse 87, respirations 16, temperature 37.1. ECOG performance status 2. Pain score 10.

NARRATIVE: The patient is seen for on-treatment evaluation. He is receiving radiation therapy to recurrence of disease in the brain and has received treatment to 2 painful lesions in his left proximal humerus and right clavicle. He is also scheduled for simulation for treatment of the lesion in the L5 as well as the left flank. However, on Tuesday of this week when he was scheduled, he reports that he called to cancel this and unfortunately the message was never delivered to us, so we were somewhat at a loss as to where he was. He has now been rescheduled for simulation tomorrow morning and the plan will be to treat each of these sites with 8 Gy in a single fraction. We will continue treating his brain to an additional 20 Gy in 10 fractions in addition to the 30 Gy in 10 fractions given in last summer. Portal imaging has been reviewed and approved.

#2749336

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Henry Wagner, Jr, MD
Director, Radiation Oncology
Penn State Cancer Institute
PO Box 850, H063, Hershey, PA 17033

HW /NTS DD: 02/11/16 DT: 02/12/16 00:07

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Wagner, MD, Henry on February 11, 2016 12:57

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:39:38 PM
2 upgraded protocol failure pended document for template did not follow MTI.

ES #2750825

Date of Service: 02/12/2016

[redacted]
222 Crescent Street
Harrisburg, PA 17104

Dear [redacted]:

I had the pleasure of performing your colonoscopy at the Hershey Endoscopy Center on 02/12/16. As you know, we found 3 small polyps and 1 much larger polyp. Biopsies have returned showing ____. I recommend that you have a repeat colonoscopy in ____ years.

insert template.

#2750825

Signature Line
Electronic Signature on File

CC: Pauline K Bridgeman, MD
2626 North 3rd Street
Harrisburg, PA 17110

CC: Forward to Addressee:

Sincerely,

Emmanuelle Williams, MD
Assistant Professor of Medicine
Division of Gastroenterology & Hepatology
PennState Milton S. Hershey Medical Center
PO Box 850, MC HU33, Hershey, PA 17033
Tel (717) 531-3694 Fax (717) 531-6770

EW /NTS DD: 02/12/16 DT: 02/12/16 21:41

Result Type:	.Outpt Ltr
Date of Service:	February 12, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Williams, MD, Emmanuelle on February 12, 2016 08:48

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:41:44 PM
2 upgraded protocol failure never gave information for the cc

ES #2749592

Date of Service: 02/11/2016

[redacted] comes in today for reevaluation of her right knee. She has known arthritic changes in the right knee. She also has a history of right hip trochanteric bursitis and IT band syndrome. She was last seen in November 2015 and had a cortisone injection done for the right knee at that time that worked well for about 6-8 weeks. She is here requesting to try Synvisc-One injection for the right knee today.

PHYSICAL EXAMINATION: On exam of the right knee, there is no swelling, warmth or erythema. She has a slight valgus deformity. She is neurovascularly intact. Active range of motion is 0-115 degrees.

IMPRESSION:
1. Right knee arthritis.
2. Right hip trochanteric bursitis.

RECOMMENDATIONS: In regard to the right knee, we did decide to proceed with the Synvisc-One injection today. Verbal consent and time-out were done prior to the patient's injection being done. The right knee was marked and after prepping with alcohol, she was given an injection of 6 mL Synvisc solution via an inferolateral approach into the right knee. She tolerated the injection well.

In regard to the hip trochanteric bursitis, we discussed that at some point we could try formal physical therapy or possibly a steroid injection for the trochanteric bursa. The patient is going to monitor symptoms here over the next few months and if symptoms were to worsen, she will call and we can move forward with treatment for that. Otherwise, she is going to follow up in 4 months' time for reevaluation of the knee and the hip. Depending on how her knee is doing at that point in time, I did discuss with her that I will be out of the clinic for several months over the summer and if we need to repeat this Synvisc-One injection, I could have this set up with one of our other PAs on the team.

#2749592

Signature Line
Electronic Signature on File
CC: Forward 1 to:

Electronically Reviewed/Signed by: Tammy M Miller, PA

Electronically Reviewed/Signed by: John F Nettrour, MD

TMM /NTS DD: 02/11/16 DT: 02/12/16 00:51

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Miller, PA, Tammy M on February 11, 2016 14:09

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:45:26 PM
11 s/b 2

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:44:27 PM
2 upgraded protocol failure Incorrect addressee format. Choose from database.

ES #2750169

Date of Service: 02/11/2016

Noel Ballentine, M.D.
670 Cherry Drive
Hershey, PA 17033

Dear Dr. Ballentine:

I had the pleasure seeing [redacted] in continued followup in the outpatient urology clinic.

[redacted] is a very pleasant 82-year-old gentleman who underwent a right radical nephrectomy March of 2012 with a level to mid hepatic vena cavotomy for a 7.5 cm Fuhrman grade 3 clear cell renal cell carcinoma. This procedure was performed by Dr. Harpster and Dr. David Campbell. Margins were negative and the final histologic stage was pT3c disease. He returns today for annual visit with hypervascular mets protocol CT scan without contrast due to his estimated GFR of 28.

The patient reports no fever, chills, nausea or vomiting. No weight loss. No gross blood in his urine. No night sweats. No shortness of breath or unusual bony discomfort.

On exam, he is an alert, pleasant gentleman in no acute distress. Abdomen soft, nontender. Midline abdominal incision well healed. No evidence of hernia.

CT scan today without contrast shows an ill-defined 2.5 x 2.4 cm hypodensity in the posterior right hepatic lobe which appears more conspicuous than on study 1 year ago. In fact is very difficult to even see this lesion on prior CT scan and the formal reading was a normal liver. There are evidence of post-surgical changes of right nephrectomy. There is no evidence of recurrent disease in the right renal bed or the left kidney. There is no concerning lymphadenopathy.

ASSESSMENT: Clear cell renal cell carcinoma 3 years out from right radical nephrectomy with cavotomy for Fuhrman grade 3 clear cell renal cell carcinoma measuring 7.5 cm in diameter.

PLAN: I discussed the findings with the folks. We are going to get a dedicated hepatic MRI to further characterize this liver lesion. I scheduled him currently to come back and see me in a year with a hypervascular mets protocol CT scan pending the results of this MRI. All of their questions were answered to the satisfaction at the end of the visit.

Dr. Ballentine, thank you for allowing me to participate in the care of [redacted] Please do not hesitate to call with questions or concerns regarding his care.

#2750169

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

This page contains no comments

#2750169

Sincerely,

Kathy A Mayhue, CRNP

KAM /NTS DD: 02/11/16 DT: 02/12/16 02:38

Result Type:	.Outpt Ltr
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Mayhue, CRNP, Kathy A on February 11, 2016 16:37

ES #2749567

Date of Service: 02/11/2016

CHIEF COMPLAINT: Left shoulder pain for the last 5 months.

HISTORY OF PRESENT ILLNESS: [redacted] is a new patient to me. She is a 36-year-old right-hand dominant female patient with left shoulder pain for the last 5 months. The pain started about September of last year. She had significant migraine, back pain and she felt a right side numbness, so she was placed in a rehab facility and she did an upper extremity rehab. On 1 day in September last year, she was doing some left shoulder exercise using a machine and she started having a significant pain in her left shoulder. She saw an orthopedic surgeon at OIP and was told that she might have possibly rotator cuff tear, frozen shoulder, or avascular necrosis of the humeral head. She underwent physical therapy; however, there was no improvement. She also tried heat and ice, but no improvement. She needs help with all her daily living activities because of significant pain. She has a significant pain at night. She also has occasional pain at rest. She had a history of left shoulder injections, 4 in the past, but these injections did not help. She says those injections were fibromyalgia. Of note, she had a significant asthma and a lupus and she has been on 10 mg of prednisone for last 10 years. She has been taken care of by Dr. Banks and physician as an Emily Hahn at her Camp Hill office. She uses a wheelchair, so she is sitting on a wheelchair today and she uses a cane with the right arm for ambulation.

PAST MEDICAL HISTORY: Lung disease (asthma), anemia, osteoarthritis, rheumatoid arthritis, ____, blood clots, hypothyroidism, migraines and anxiety.

MEDICATION: Amitriptyline, butorphanol, cyclobenzaprine, docusate, DuoNeb, EpiPen, fentanyl patch, Flonase, folic acid, hydrochlorothiazide, levothyroxine, lorazepam, Lyrica, methotrexate, pantoprazole, Phenergan, prednisone, quetiapine, Singulair, Symbicort, Ventolin, ____, Zyrtec.

SHE IS ALLERGIC TO PERCOCET, CEFEPIME, CHLOROQUINE, CODEINE, COMPAZINE, DARVOCET, DEMEROL, DILAUDID, HALDOL, HYDROCODONE, IODINE, IRON, DEXTRAN, IVP DYE, LATEX, MICROBEAD, MACRODANTIN, MAXALT, MORPHINE, OXYCODONE, PEPTO-BISMOL, PERCOCET, REGLAN, SULFA DRUGS, TAPE, TORADOL, TRAMADOL, TURKEY, VANCOMYCIN, ZOFRAN.

FAMILY HISTORY: Heart disease, diabetes, cancer, osteoarthritis, rheumatoid arthritis, bleeding problems.

SOCIAL HISTORY: She is a disabled, so she is not married, but has children. She does not smoke or drink alcohol.

REVIEW OF SYSTEMS: Fever, chills, vertigo, hoarseness, cough, shortness of breath, pneumonia, asthma, stomach pain, nausea, frequent or burning urination, blood in urine, chest pain and swollen ankles, rashes and frequent headaches, anemia and neuropathy, SEASONAL ALLERGIES, ALLERGIES TO FOODS.

PHYSICAL EXAMINATION: She is a 5 feet 2-inch tall, weighs 275 pounds. She is alert and well oriented with appropriate mood. She does show shortness breath with our conversation. However, she is not in acute distress. She has a cushingoid appearance with truncal obesity. She is sitting on a wheelchair. Blood pressure 102/60 and heart rate of 84. She rates her pain as 7/10 today.

Regarding her left shoulder, forward elevation is 30 degrees only actively and 110 degrees passively with a very significant pain. External rotation at the side of 40. She has a negative external rotation lag and a negative belly off test. She has 5-/5 strength with the external rotation, but she has a significant weakness with abduction primarily due to pain. She has intact skin with no visible atrophy or deformity on the shoulder.

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 2:50:35 PM
2 upgraded protocol failure Incorrect CC format x3. Choose from database. (corrected)

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:00:09 PM
11 s/b assistant

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:03:48 PM
1 upgraded due to incorrect medication listed for allergy

#2749567

STUDIES: Her left shoulder x-rays from today showed crescent sign of the humeral head suggesting of subchondral fracture due to avascular necrosis of the humeral head. There is a slight inferior subluxation of humeral head, but there is no visible narrowing of the glenohumeral joint space. The glenoid side appears to be intact.

ASSESSMENT: Left shoulder, avascular necrosis of the humeral head (stage IV).

PLAN: I think we need to investigate further by obtaining MRI because of her significant weakness with rotator cuff testing. I think she has more likely purely avascular necrosis of humeral head, but I would like to confirm that her rotator cuff was intact. She is interested in moving forward for definitive surgical intervention rather than doing nonsurgical treatment, especially repeated steroid injections. She has had this pain for a long time and her pain is very disabling. We discussed the risks and benefits of total or hemi shoulder arthroplasty in her young age including early implant failure and necessity for repeated revision surgeries with a poor outcome with all of complications. After long discussion, she wished to proceed with a shoulder replacement in either in the form of hemi or total shoulder arthroplasty. We will set this up in the near future at main OR. We will obtain medical clearance from Emily Hahn and Dr. Sharon Banks in Camp Hill office. We probably need some coordination in terms of her medication adjustment at the perioperative period. We will review her MRI once it becomes available and if we see anything more than AVN of the humeral head, we will contact her to inform her and possibly changing her treatment options.

#2749567

Signature Line
Electronic Signature on File
CC: Kevin J Poole, MD
3025 Market Street
Camp Hill, PA 17011

CC: Emily G Hahn, PA
3025 Market Street
Camp Hill, PA 17011

CC: Sharon E Banks, DO
3025 Market Street
Camp Hill, PA 17011

Electronically Reviewed/Signed by: Hyun-Min Kim, MD

HK /NTS DD: 02/11/16 DT: 02/12/16 01:22

Result Type:	.Outpt Note
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Kim, MD, Hyun-Min on February 11, 2016 14:14

This page contains no comments

ES #2750205

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:29:15 PM
9 Protocol failure inappropriate pend

Date of Service: 02/11/2016

I spoke with [redacted] today. His Lyme titer was negative. His MRI had been done without gadolinium from the outside hospital, so I ordered an MRI with gadolinium. However, renal test done as well to clear him for dye. I will call him with those results and then follow up with him as scheduled. He voiced understanding.

#2750205

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Gale L Bentz, MEd, PA-C
Penn State Milton S. Hershey Medical Center
PO Box 850 MCH091, Hershey, PA 17033
(717) 531-6822 phone, (717) 531-6160 fax

Electronically Reviewed/Signed by: Andrew J Wren, DO

GLB /NTS DD: 02/11/16 DT: 02/12/16 03:03

Result Type:	.Phone Note
Date of Service:	February 11, 2016 16:43
Authorization Status:	Prelim/Transcribed
Subject:	Phone Note
Author or Import Date:	Bentz, PA, Gale L on February 11, 2016 16:43

This page contains no comments

ES #2750189

Date of Service: 02/11/2016

Obsitu Kelifa, CRNP
UPG Fishburn
845 Fishburn Road
Hershey, PA 17033

Dear Ms. Kelifa.

Thank you for referring [redacted] to our pediatric surgery office for evaluation of a persistent umbilical hernia since birth. As you know, [redacted] is now 4-year-old male with an umbilical hernia defect. Mom and dad accompanied him during today's office visit. Parents report that [redacted] has no complaints of pain or discomfort at the site. He continues to eat well and have normal bowel movements. He is engaging in age-appropriate activities without limitations. During today's office visit, the family had no additional concerns.

PAST MEDICAL HISTORY: Hypospadias.

PAST SURGICAL HISTORY: Hypospadias repair and circumcision in 2012.

He has no known drug allergies.

Medications are none.

His immunizations are up-to-date.

I reviewed the pediatric health assessment form that was completed by the mother. A 14-point systems review was remarkable for constipation and developmental delay. Remaining systems of review were unremarkable.

Family history is remarkable only for hypertension. There is no history of bleeding disorders or complications with general anesthesia.

SOCIAL HISTORY: He lives at home with his mother and father, who are married and 2 other siblings. He is not exposed to tobacco, alcohol or uncontrolled substances. They use well water. School district is Ephrata. He does wear bike helmet and is appropriately restrained in a motor vehicle.

PHYSICAL EXAMINATION: He is a pleasant, interactive 4-year-old male, in no apparent distress. Weight of 16.2 kg. HEENT, sclerae are anicteric, normocephalic, atraumatic. Heart, regular rate and rhythm. Lungs, clear to auscultation bilaterally. Abdomen soft, nontender, nondistended, 1.5 to 2 cm umbilical hernia defect, minimal redundant skin, no evidence of inguinal hernias. Genitourinary, both testes are descended, normal phallus. Extremities, no deformities. Motor and sensory intact. He ambulates with a normal gait. Skin, no rashes. Neuro, awake, alert, verbal.

[redacted] has a persistent umbilical hernia, for which we will plan for repair at our outpatient surgical center. The risks and benefits of the surgical procedure were discussed with parents and they wished to proceed.

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:32:03 PM
2 upgraded protocol failure Incorrect addressee format. Choose from database.

#2750189

Thank you for allowing us to participate in his care and we will continue to keep you apprised of his progress.

#2750189

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

Sincerely,

Dorothy V Rocourt, MD
Pediatric Surgery
Drs R Cilley, P Dillon, B Engbrecht, K Fagelman, D Rocourt, M Santos.
RD: C Greecher.
CRNPs: J Shields, L Simmons, A Bergstresser.

DVR /NTS DD: 02/11/16 DT: 02/12/16 03:18

Result Type:	.Outpt Ltr
Date of Service:	February 11, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Rocourt, MD, Dorothy V on February 11, 2016 16:42

This page contains no comments

ES #2752369

Date of Service: 02/12/2016

CHIEF COMPLAINT: Chronic IT band syndrome.

SUBJECTIVE: [redacted] is here today with chronic right distal IT band syndrome, present now for several years. He would like to compete an upcoming ironman triathlon in September of this year. He has been able to cycle and swim without difficulties. He continues to have recurrent pain of the distal IT band with associated snapping, occasional swelling. Every time he rests from running-related activities, the pain subsequently improves, _____ worsened whenever he tries to resume running. This has been an ongoing difficulty for him. He has no effusion, instability, catching or locking of the right knee. He has no hip or ankle pain. He has been ambulatory without assistance. He has had no injection, no advanced imaging. He has had multiple x-rays taken of his hips, knees which really were unremarkable with exceptions of some cam impingement in his hips bilaterally, although he is asymptomatic from hip perspective. He does come with a medical record at today's office appointment. He is interested in his running gait and _____ contributor.

MEDICATIONS AND ALLERGIES: Updated in PowerChart at the time of this appointment.

PAST MEDICAL HISTORY: He has no chronic medical problems.

PAST SURGICAL HISTORY: No surgeries.

SOCIAL HISTORY: He is a geologist. He is a nonsmoker, no alcohol or recreational drug use. He enjoys swimming, biking and running.

FAMILY HISTORY: Negative for cancer, diabetes, heart, osteoarthritis/rheumatoid arthritis.

REVIEW OF SYSTEMS: A complete 10-point review of systems was obtained and all are negative except as noted.

PHYSICAL EXAMINATION: Height is 5 feet 10 inches, weight 155 pounds. General, in no acute distress, pleasant, interactive. Bilateral knees demonstrate full range of motion, 5/5 strength. He had tenderness to the distal IT band. He had crepitus in this location as well as thickening of the distal IT band. Positive Noble sign on examination. Ober testing did not demonstrate significant difficulties with his flexibility. He did have tight hamstrings bilaterally, 45 degrees demonstrated with popliteal angle testing of the right lower extremity. Left lower extremity approximately 15 degrees. Quadriceps was tight bilaterally as were calf musculature with very little ankle dorsiflexion, approximately 3 degrees bilaterally. He had limited internal range of motion of his hips bilaterally with no pain, negative impingement sign, negative log roll and Stinchfield. The remainder of his hip examination was unremarkable. He is neurovascularly intact in his lower extremities and is ambulatory without assistance. Unremarkable arches on examination.

IMAGING RESULTS: Reviewed with the patient at today's appointment. We had written reports with no disks available.

ASSESSMENT: Chronic intermittent distal right iliotibial band syndrome.

PLAN: The patient's distal IT band syndrome appears to be the main culprit of his symptoms at this period in time. He does have obvious thickening as well as crepitus on his examination. I think he would respond quite favorably to the Graston technique. This was recommended for him. I did contact one of our sports physical therapist here at Penn State Hershey. He will find someone who does Graston technique near his hometown, so he does not have to travel all the way back to Hershey to have this performed. I have also recommended he work on his quadriceps and hamstring musculature. If he does not work on his flexibility, just using the Graston technique on his distal IT band will not help his current

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:38:09 PM
2 upgraded protocol failure Incorrect CC format. Choose from database.

#2752369

symptomatology. We have opted for a followup appointment with me in approximately 4-5 weeks. At which time, we plan to repeat his examination and perform a video gait analysis of his running gait. We performed gait analysis from the anterior lateral and posterior approaches. We do 2D video gait analysis. We described the gait analysis in detail at today's office appointment. He was very interested in proceeding with this plan and will follow up in 1 month to have that performed or sooner if any difficulties arise. He is in agreement with this plan and follow up accordingly. His cell number is 814-806-6261.

CC: Referring provider, Edward Gusick, DO.
Sports Medicine, 1100 Grampian Boulevard, Williamsport, Pennsylvania, 17701.

#2752369

Signature Line
Electronic Signature on File
CC: Forward to Addressee:

Electronically Reviewed/Signed by: Matthew L Silvis, MD

MLS /NTS DD: 02/12/16 DT: 02/13/16 04:04

Result Type:	.Outpt Note
Date of Service:	February 12, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Silvis, MD, Matthew L on February 12, 2016 15:58

This page contains no comments

ES #2752271

Date of Service: 02/12/2016

[redacted] and his mother were seen in the Developmental Specialty Clinic along with Dr. Jairath. The focus of this letter is to address the educational and behavioral components related to [redacted] situation.

The mother stated that her son has been having difficulty in school with focusing and sitting still. He has a tendency of being fidgety. A behavioral chart is utilized to monitor [redacted] situation and one of the components is talking out of turn. He also has difficulty with handwriting as he displays reversals and is very sloppy. The mother feels that her son has displayed these characteristics for a long period of time.

The mother relates that she needs to pace directions as [redacted] tends to get distracted and not remember what he needs to do. She needs to provide reminders in order for her son to be successful. Attention span for preferred activities is considered good especially when her son is playing with his Legos. He is also able to complete non-preferred tasks, but the quality of his efforts is not his best.

[redacted] has also had some anger issues and a program has been provided at school, which lasted for 3 months. The mother also recognizes that change is not easy for her son.

Information from the third grade staff indicated that [redacted] performance was average in math and below average with reading, science, social studies, and language. He was described as being far below average with his effort. Descriptors of his performance are social difficulties emotional, distractible, motor, speech, disorganized, aggression, oppositional, attention, learning, and impulsive overactive. The staff emphasized that lack of focus is of major concern.

The mother graciously stated that she has qualities of attention deficit disorder, obsessive-compulsive disorder, depression, and anxiety. The biological father is described as having bipolar and attention deficit disorder.

[redacted] greeted the hospital staff and introduced his mother. He indicated that it is hard for him to stay focused and it is hard to sit still. He stated that he is in third grade and generally enjoys school.

During the examination, [redacted] was cooperative and demonstrated a reasonable fund of information through the activities presented to him. He displayed good visual perceptual skills and body _____ skills were also within normal limits. He seemed to be inefficient with his fine motor skills despite the fact that he worked hard.

One needs to appreciate that [redacted] difficulties are probably on a neurological basis and therefore, he has less control as compared to typical children in responding to his environment. Hopefully, this develops a sensitive and supportive approach with working with [redacted] so that he can be as successful as possible. A good teacher and staff match would be of benefit in order to develop a positive rapport, so that a good working relationship can evolve over time. A good teacher and curriculum match would be of benefit to arrange on a yearly basis.

It is my understanding that [redacted] tends to reverse numbers and letters and has a significant scatter in his performance in third grade. It would be reasonable to further explore is if [redacted] continues to struggle. Completing comprehensive educational testing could specify the areas that [redacted] is having difficult and also to determine if he has any specific learning disability. This would not only be of benefit to [redacted], but also the individuals that are providing instruction.

Utilizing strategies that have been of benefit with children with similar characteristics may be of help. Providing him with a cue such as calling his name may alert him to focus on the sound source. Also, providing him with choices but still directed towards adult values could provide him with the ownership that he seeks as well as participate in an active exercise of thinking through a situation and verbalizing a response. This may allow him to absorb more of what he needs to do. Also, praising [redacted] when he is

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:43:13 PM
2 upgraded protocol failure Incorrect CC format. Choose from database.

#2752271

successful, providing him with specific descriptors, highlighting the desired qualities may allow him to better appreciate the implications of his actions. The successes can accumulate over time for larger privileges and opportunities.

Also assisting [redacted] to appreciate that if he commits to using language in an appropriate manner, that this can engage support from others. Hopefully, [redacted] will use words to express his feelings to replace his present means of expressing his emotions. Adults may need to model and demonstrate how talking to other people can engage support to work through issues.

Hopefully, the medication trial that is being offered provides [redacted] with support and supplements any adjustments and accommodations that the school develops in discussing [redacted] situation with his family. This is considered to be the most comprehensive type of treatment with individuals like [redacted]. The medical center is also available for further consultation upon the family's request.

This was a 60-minute session.

CC: [redacted]
1220 Woodland St, Lebanon, PA, 17042.

#2752271

Signature Line
Electronic Signature on File
CC: Carol D Sears, MD
Tan and Chestnut Streets
PO Box 9
Fredericksburg, PA 17026
*

CC: Forward to Addressee:

Electronically Reviewed/Signed by: Mark Domoto

MD /NTS DD: 02/12/16 DT: 02/13/16 02:46

Result Type:	.Outpt Note
Date of Service:	February 12, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Domoto, Mark on February 12, 2016 15:38

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:53:46 PM
2 upgraded protocol failure Incorrect CC format. Choose from database.

Author: tdijohnson Subject: Comment on Text Date: 2/23/2016 3:54:14 PM
2 upgraded protocol failure Incorrect addressee format. Choose from database.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:03:11 AM
11 added text

ES #2751804

Date of Service: 02/12/2016

ALLERGIST: Dr. Zemble.

CARDIOLOGIST: Dr. Malick
Heart Care Group
Lehigh Valley
Phone #: 770-2200

Dear Doctors:

It was my pleasure to follow [redacted] in the Penn State Hershey Pulmonary Clinic. He is a 55-year-old gentleman with past medical history of long-standing extrinsic asthma since the age of 23, obstructive sleep apnea on CPAP machine, history of heart failure symptoms, morbid obesity, prior tobacco abuse and a possible history of rheumatoid arthritis, but not on any treatment. He presents today in followup after last being seen on 10/02/15. He still continues to maintain an oxygen requirement of 2 liters. He uses Young's Medical with a conserving device. He reports compliance with his CPAP and uses nasal pillows. He is on 12 cm of water with no ramps. He has not seen a sleep doctor since he has been prescribed machine. He also was treated with steroids for 6 weeks, most recently finished in mid December. There was a possibility of a bronchopulmonary allergic mycosis, but not ABPA. His IgE levels were elevated at 897. After stopping the steroids, he did have a period of time when he was admitted for what "cellulitis," but he says that his legs were very swollen at that time. This may have been more consistent with heart failure symptoms, lower extremity edema, although I do not have any records of this visit to know for sure but what he tells me on history it was also associated with leg swelling. He has also unfortunately been off the Xolair. There still continues to be some insurance issues. He says that after this month his insurance should cover Xolair infusions and he will be returning to Dr. Zemble's office. Over the past 48 hours, he has had increasing shortness of breath and wheezing. He feels that he may be developing upper respiratory symptoms. He continues to use Dulera twice a day, Pulmicort inhaler once a day, Singulair once a day and Allegra. He does have an albuterol rescue inhaler. He is still concerned that he is requiring supplemental oxygen therapy and then unfortunately, he has not been able to come off it. He still has dyspnea on exertion. His lifestyle is unfortunately very sedentary. He has very limited ambulation. He reports that he does not come out of his room until usually noon after he takes his diuretics in the morning because he has a lot of diuresis.

REVIEW OF SYSTEMS: All systems reviewed, otherwise negative except for HPI.

Past medical, surgical, social, family history reviewed and unchanged from my initial dictation on 10/02/15.

ALLERGIES: TO KEFLEX, NEOSPORIN AND TRICOR.

CURRENT MEDICATIONS: ProAir p.r.n., Astelin nasal spray b.i.d., Pulmicort 180 once a day, vitamin D supplement daily, Allegra 180 q. day, Dulera 2 puffs b.i.d., Lasix 40 mg daily, Neurontin 300 mg t.i.d., Synthroid 88 mcg daily, losartan 100 mg daily, Singulair 10 mg at bedtime, Patanol eyedrops b.i.d.

#2751804

PHYSICAL EXAMINATION: Temperature 37.2, blood pressure 132/74, pulse 86, saturating 95 on room air, respiratory rate 16. General: No apparent distress. HEENT: Normocephalic, atraumatic. Pupils equal, round, react to light. Sclerae anicteric, exotropia of the right eye at baseline. Oropharynx is clear. No JVD. Sitting up in a wheelchair. Abdomen: Morbidly obese. Lungs have good air movement, the anterior right upper lobe has an expiratory wheeze not audible posteriorly, bases are clear. His extremities have some pitting edema, 1+ and chronic venous stasis changes.

PFTs reviewed today show FEV1 to FVC ratio of 61%, FEV1 1.6 liters or 51% of predicted, FVC of 2.6 or 64% of predicted. Room air oxygen saturating 91%.

IMPRESSION:
1. Extrinsic asthma.
2. Possible COPD with a history of remote tobacco abuse.
3. Morbid obesity, suspected obesity hypoventilation.
4. Obstructive sleep apnea, on CPAP.
5. Pulmonary nodule, benign, diagnosed as hamartoma by previous biopsy.

[redacted], a 55-year-old with multiple comorbidities, who is here for difficult to control asthma. He is on a maximum regimen with Dulera, Pulmicort, Singulair, and Allegra. He is going to increase his Pulmicort to twice a day dosing. We did treat him for 6 weeks concerning for acute bronchopulmonary mycosis due to elevated IgE but there is no evidence of ABPA. He did improve on his peak flows during that period increased to 350 from the mid 200s after the steroid dosing. He is going to continue to follow his peak flow values. In addition, with the recent 48 hours of upper respiratory symptoms, we will give a 5-day course of Z-PAK. He is going to continue the Singulair, the Pulmicort, Dulera, and I really encouraged him to try to work out the issues with his insurance company to get back on the Xolair and back to see Dr. Zemble. For his sleep apnea, he really needs to be followed more closely and he tells me that he has not had any sleep doctor review his CPAP machine since he has been put on it. I am going to have him referred to the sleep clinic for further management. I would like to get an overnight nocturnal oximetry. I will see if Young's Medical can do this in-house as this may be one of the reasons that he is continuing to require oxygen, although I do strongly suspect that this is an obesity hypoventilation combined with congestive heart failure leading to the oxygen requirement. I did review his CT scan from outside. It is uploaded into our system and available from 09/24/15. There is no intrinsic lung disease. There is no interstitial pattern. There is no bronchiectasis or bronchiolitis and no significant pulmonary nodules. The hamartoma is noted in the right lower lobe. I am going to check an ABG today to see if he is chronically retaining as this may be more evidence that this is simply obesity hypoventilation that we are dealing with. We have considered in the past that there could be a component of tracheobronchial malacia causing the excessive wheezing and difficult to control, but that was considered less likely due to the elevated IgE levels. We will see him back in 3 months with repeat PFTs and a 6-minute walk.

#2751804

Signature Line
Electronic Signature on File

CC: Forward to Addressee:

CC: Forward 1 to:

This page contains no comments

This page contains no comments

#2751804

Sincerely,

Jason R McClune, MD

Electronically Reviewed/Signed by: Janette D Foster, MD

JRM /NTS DD: 02/12/16 DT: 02/13/16 08:59

Result Type:	.Outpt Ltr
Date of Service:	February 12, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	McClune, MD, Jason R on February 12, 2016 13:35

ES #2752777

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:15:16 AM
9 Protocol failure inappropriate pend

Date of Service: 02/12/2016

[redacted] wife, [redacted], called the colorectal surgery resident on call this evening because she was concerned that her husband had developed a fever of 101 degrees. Other than the fever, he is currently feeling well. He experienced some minimal nausea today, which is consistent with his baseline, but no vomiting, no abdominal pain, and no significant change in his ileostomy output. He was recently started on mirtazapine and Lasix and they do not feel that that they see much of a difference in his urine output, though it has remained clear and yellow.

This phone call was discussed with the senior resident on call for colorectal surgery, Dr. Kulayat. Upon returned phone call to [redacted], we instructed her to take her husband's temperature every 3-4 hours throughout the night. He has currently received 1 dose of Tylenol and has already seen a decrease in his fever to 99 degrees. We instructed her to give us a call if the fever spikes again, at which point, we will reevaluate the need to bring [redacted] into the emergency department for further evaluation. If he goes the rest of the night without fever, we encouraged her to give us a call tomorrow during the day at a time that is convenient for her to touch base and let us know how [redacted] is doing. She was in agreement with this plan and can be reached at 717-298-1593.

#2752777

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Elizabeth M Brigham, MD

EMB /NTS DD: 02/12/16 DT: 02/14/16 01:18

Result Type:	.Phone Note
Date of Service:	February 12, 2016 19:46
Authorization Status:	Prelim/Transcribed
Subject:	Phone Note
Author or Import Date:	Brigham, MD, Elizabeth M on February 12, 2016 19:46

ES #2754747

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:19:39 AM
0 No errors

Date of Service: 02/15/2016

[redacted]
60 East Orange Street
Elizabethtown, PA 1722

Dear [redacted]

I had the pleasure of performing your upper endoscopy and colonoscopy at the Hershey Medical Center on 02/15/16. As you know, we took biopsies of your duodenum and these have returned as ____. You also had a tiny polyp in your rectum and this has returned as ____. I recommend that you have a repeat colonoscopy in ____ years. Insert template.

#2754747

Signature Line
Electronic Signature on File

CC: Obsitu Kelifa, CRNP
201 Lefever Road
Mt Joy, PA 17552

CC: Forward to Addressee:

Sincerely,

Emmanuelle Williams, MD
Assistant Professor of Medicine
Division of Gastroenterology & Hepatology
PennState Milton S. Hershey Medical Center
PO Box 850, MC HU33, Hershey, PA 17033
Tel (717) 531-3694 Fax (717) 531-6770

EW /NTS DD: 02/15/16 DT: 02/15/16 21:27

Result Type:	.Outpt Ltr
Date of Service:	February 15, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Williams, MD, Emmanuelle on February 15, 2016 14:22

ES #2757862

Date of Service: 02/16/2016

HISTORY OF PRESENT ILLNESS: The patient is a 56-year-old female who has a past medical history of hypertension, diabetes, ____ ischemic stroke in 2009 and 2015, also history of seizure, who presented to the emergency department as a brain attack after she was found unresponsive by her family around 7:30 p.m. The last known normal was at 3:30 p.m. Since the patient is not responding to questions, most of the history was given by her daughter, who was present during the physical exam. According to her daughter, she resides with her family and her baseline is walking and talking. Her speech is clear and fluent; however, she has some residual right-sided weakness from the previous stroke. At the time of question, patient was found on the floor shaking. EMS was promptly called and upon arrival, they noticed that she was hit in the trash can with right gaze deviation. She was subsequently given 2.5 mg of Versed, which helped with resolution of the symptoms. This recurred again as she was given another 2.5 mg for a total of 5 mg. According to the family, the patient was taking aspirin and Plavix, but that was discontinued because she will undergo a biopsy of the left breast. According to EMS, her initial blood pressure was 196/87, blood glucose 170. Upon arrival at the point of care, blood glucose was 156 and creatinine 1.7. The patient was given 2 mg of Ativan in the CT scan since she continued to have some stereotypical movement of the right upper extremity. Initial CT scan of the head, which was negative for acute abnormalities except for area of encephalomalacia on the left PCA territory corresponding to the last ischemic stroke in 2015 While in the scan, the patient was also noted to have a gaze deviation to the left, she was very rigid, but moving all four extremities. She withdraws from painful stimuli ____ all 4 extremities as well.

REVIEW OF SYSTEMS: Unable to complete secondary to patient's current medical status.

PAST MEDICAL HISTORY: Hypertension; diabetes; stroke in the past, one in 2009 and another one in 2015; seizure with the previous stroke, it is unclear which one, and not on any anti-seizure medications.

FAMILY MEDICAL HISTORY: None according to daughter.

SOCIAL HISTORY: The patient lives with her family. She is independent with all activities of daily living. No smoking, no alcohol overuse. At baseline, the patient has some right-sided weakness.

MEDICATIONS: The patient's daughter does not know the dose of her medications; however, she reports that patient is on metformin, clonidine, nitro, Levemir, atorvastatin, metoprolol, Tylenol, clopidogrel and aspirin, which ____ put on hold for a biopsy and hydrochlorothiazide.

PHYSICAL EXAMINATION: General: The patient is in mild distress. HEENT: Head is normocephalic, atraumatic. Heart: Distant heart sounds, but no murmur appreciated on the aortic area. Lungs: Clear to auscultation. Skin: No obvious skin lesions or rashes at this time. Extremities: No clubbing, cyanosis or edema noted in all 4 extremities.

NEUROLOGICAL EXAMINATION: Mental Status: The patient is awake, but she is not alert. She is not oriented to person, place, time or situation. There is no dysarthria or aphasia. The patient was told to talk in full sentences; however, she was not able to answer questions properly. Cranial Nerves: The patient initially seemed to have left gaze deviation that was reported. The patient had at some point a right gaze deviation as well. After she was given 2 mg of Ativan, the patient was seemed to have a grossly intact extraocular muscle movement. There was no facial asymmetry. The rest of the cranial nerves were not assessed secondary to patient's current medical status. Motor: There is increased tonicity on the upper and lower extremities. At some point, the patient was moving all four extremities; therefore, she was 3/5 grossly in all muscle groups. Sensation: The patient withdraws from painful stimuli on the lower extremities as well as the upper extremities. Reflex: Unable to assess for reflex on the upper extremities. Patellar and ankle are 2+ with no appearance of clonus. Negative Babinski sign. Gait: Unable to assess.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:21:07 AM
9 Protocol failure inappropriate pend

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:22:22 AM
3 incorrect patient entered by QA BHI 126692

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:30:49 AM
11 s/b able

This page contains no comments

#2757862

ASSESSMENT AND PLAN:
1. The patient is a 56-year-old female with a past medical history mentioned above, who presented to the emergency department as a brain attack. The etiology of the symptoms is most likely secondary to seizures; however, because of her stroke and not being on full treatment for stroke prevention, a stroke cannot be ruled out. Other causes could be secondary to metabolic encephalopathy that could be contributing to mental status as well as seizures. Because of this, the patient is going to be admitted to the ____ neurology service for further workup. The patient is going to undergo MRI of the brain, MRA of the head and neck. We will do a complete metabolic workup that includes TSH, vitamin D, B1, ammonia levels, CBC, BMP, blood cultures. We might consider doing a lumbar puncture depending on the results of the CBC and BMP and if there is any indication for meningitis. The patient was given 2 mg of Ativan; however, her daughter reports that whenever she was given Ativan, she becomes more agitated; therefore during this admission, we will try to avoid this medication. The patient was also given a loading dose of 1000 mg of Keppra. We will continue Keppra 500 mg IV since she is not appropriate for p.o. medication. We will do a routine EEG; however, if she continues to have these episodes, we might consider putting her on continuous EEG, loading her on fosphenytoin. In the meanwhile, the patient is going to be placed on seizure- precautions and n.p.o.
2. History of previous stroke. We are not going to start aspirin and Plavix; however, if the MRI is positive for brain ischemia, we might consider putting her back on these medications. Otherwise, we are going to continue other medications such as atorvastatin 40 mg. There is no need to check lipid panel during this admission unless she has areas of ischemic stroke on MRI. We are going to continue the rest of the medications. If she remains uncooperative, we might consider placing a Keofeed for her p.o. medications.
3. Diabetes. We will hold Levemir for now. The patient will be placed on a low sliding scale.
4. History of hypertension. We will continue her home medications. The patient is going to have ____ for p.r.n. blood pressures greater than 200/100.
5. FEN. The patient is going to be placed on IV fluids. While in the emergency department, the patient was given a banana bag.
6. DVT prophylaxis, SCDs and Lovenox.
7. Code: Full. Even though patient has a ____, the patient's daughter requested for full code.

This case was discussed with the stroke fellow who discussed this case with Dr. Adams, the neurology attending.

Initial H&P Coding Selection

Low	Moderate	High	
99221	99222	99223	Diagnosis

#2757862

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Angelica M Lee, DO

Electronically Reviewed/Signed by: Cathleen A Adams, DO

This page contains no comments

#2757862

AML /NTS DD: 02/16/16 DT: 02/16/16 23:57

Result Type:	.HP
Date of Service:	February 16, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	History & Physical
Author or Import Date:	Lee, DO, Angelica M on February 16, 2016 21:51

This page contains no comments

ES #2757050

Date of Service: 02/16/2016

Amy Stauffer CRNP
Penn State Hershey Medical Center -- Women's Health
121 Nyes Road, Suite C
Harrisburg, PA 17112

Dear Colleagues:

My name is Dr. Scott Simon, Assistant Professor of Neurosurgery at Penn State Hershey with a subspecialization in cerebrovascular and endovascular neurosurgery. I am writing you regarding [redacted]

As you may recall, this is an energetic 30-year-old woman who has recently become pregnant. She has a history of an "angioma" in her brain and was sent for me in consultation regarding this.

The patient reports that she was having migraine headaches that included a temporary loss of vision in her left eye. Workup revealed these in 2012 and she was told they were not particularly dangerous. Since she became pregnant, there is concern about how this might impact delivery and she is here for consultation.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: D&C secondary to miscarriage in 2015, polypectomy in 2015.

FAMILY HISTORY: Asthma, cancer, heart disease, high blood pressure, optic neuritis.

PERSONAL HISTORY: The patient is an RN. She lives with her husband [redacted]. She smoked 1 pack a day, but quit 6 months ago. She does not drink. She does not use IV drugs.

A 13-point review of systems is included in the patient's paperwork and is positive for recent weight gain, difficulty sleeping, shortness of breath on stairs, frequent urination, abdominal pain, back pain, joint or muscle pain, dry mouth and eyes.

ALLERGIES: CODEINE AND IMITREX.

MEDICATIONS: Benadryl, Phenergan, prenatal vitamins, Tylenol p.o.

On physical exam, the patient's blood pressure is 142/74, her heart rate is 106. She is awake, alert and oriented x3. Her speech is fluent. Her fund of knowledge is good. Her pupils are equal, round and reactive to light. Her extraocular muscles are intact. Her face is symmetric. Her facial sensation is symmetric. Her hearing is intact to finger rub bilaterally. Her palate elevates symmetrically. She has 5/5 shoulder shrug. Her tongue is midline. She has 5/5 strength with no drift. She has intact sensation to light touch. Her finger-nose-finger is within normal limits. Her reflexes are 2+ throughout.

RADIOLOGY: The patient has an MRI of both the brain and the orbits from 05/29/2012. I reviewed these images myself and I also spoke to our department of neuroradiology. The patient has at least 3 developmental venous anomalies (DVA). The most prominent of which is in the left internal capsule but there was another just below the corpus callosum and then again likely in the inferior left frontal lobe.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:40:48 AM
2 upgraded protocol failure Incorrect CC format. Choose from database.

#2757050

IMPRESSION: Developmental venous anomaly.

PLAN:
1. I told the patient, she had a developmental venous anomaly and she said that she had heard that term before. I told her that there was nothing to do and it did not need to be followed.
2. She has angioma in her _____ diagnoses and I took the liberty of inactivating this and adding developmental venous anomaly.

If there are any questions or concerns about [redacted] or any other patient, please do not hesitate to contact me.

CC: Carrie Hossler, M.D.
121 Nyes Road, Suite A
Harrisburg, PA 17112

#2757050

Signature Line
Electronic Signature on File

CC: Anthony B Dambro, MD
121 Nyes Road
Suite A
Harrisburg, PA 17112

CC: Forward 1 to:

CC: Amy L Stauffer, CRNP
121 Nyes Road
Suite C
Harrisburg, PA 17112

Sincerely,

Scott D Simon, MD

SDS /NTS DD: 02/16/16 DT: 02/16/16 21:50

Result Type:	.Outpt Ltr
Date of Service:	February 16, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Simon, MD, Scott D on February 16, 2016 14:21

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 10:58:46 AM
2 upgraded protocol failure Incorrect CC format. Choose from database.

ES #2757234

Date of Service: 02/16/2016

Denise Montisano MD
4807 Jonestown Road
Suite 141
Harrisburg, PA 17109

Dear Dr. Montisano:

I saw in outpatient otolaryngology clinic today, 2/16/2016, [redacted] for followup of his nonhealing neck wound. As you know, [redacted] is a pleasant 67-year-old gentleman who has a nonhealing neck wound. He has had 2 explorations of his neck with no notable findings. He does not complain of any pain. He is having some crusting. He has had no redness or swelling. No purulence specifically, but does have some yellow crusting on the outside of the wound. He is seeing Dr. Rogers at the wound clinic at Pinnacle Health, but unfortunately I do not have any of his recommendations.

On exam, [redacted] is a pleasant gentleman. He has some crusting along part of the incision _____ ear. He has a large open area behind his ear and has 2 small crusted areas along the incision. This was cleaned. There is no deep wound, no purulence able to be expressed. [redacted] has no pain.

ASSESSMENT AND PLAN:
1. Nonhealing neck wound. We are going to switch [redacted] to just a mild soap and water such as Dove or Cetaphil, cleaning twice a day followed by a layer of Vaseline and covering all of the open areas. I will defer further wound management to Dr. Rogers as he is a wound specialist. I do not see any further intervention warranted at this time. We will plan to have [redacted] back in 3 months' time to reassess. They should call if they have any questions or concerns sooner.

This was reviewed with Dr. David Goldenberg, who agrees with the plan.

CC: Dr. Rogers
Pinnacle Wound and Hyperbaric Center
4310 Londonderry Road, suite 1A
Harrisburg, PA 17109

#2757234

Signature Line
Electronic Signature on File

CC: John J Zurlo, MD
500 University Drive
Hershey, PA 17033

CC: Forward to Addressee:

This page contains no comments

#2757234

CC: Denise F Montisano, MD
4807 Jonestown Road
Suite 141
Harrisburg, PA 17109

*

Sincerely,

Kathryn E Kugler, PA-C
Otolaryngology - Head and Neck Surgery
Penn State Milton S. Hershey Medical Center
PO Box 850, MC HU25, Hershey, PA 17033
(717) 531-6822

Electronically Reviewed/Signed by: David Goldenberg, MD
Professor of Surgery and Oncology
Director, Head and Neck Surgery
Penn State Milton S. Hershey Medical Center
PO Box 850, H091, Hershey, PA 17033
(717) 531-8945

KEK /NTS DD: 02/16/16 DT: 02/16/16 23:34

Result Type:	.Outpt Ltr
Date of Service:	February 16, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Letter
Author or Import Date:	Kugler, PA, Kathryn E on February 16, 2016 15:04

ES #2757889

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 11:02:29 AM
9 Protocol failure inappropriate pend

Date of Service: 02/16/2016

TIME OF THE EVALUATION: 1915.

CHIEF COMPLAINT: Level 2 trauma alert status post fall.

HISTORY OF PRESENT ILLNESS: The patient is an 80-year-old female who fell from standing height tripping while trying to go to the toilet. It was a mechanical fall. She was not amnestic to the event and did not lose consciousness. She had no initial complaints upon arrival. She is on Coumadin.

REVIEW OF SYSTEMS: Musculoskeletal was positive for left hip pain and back pain as well as pain at the site of a left arm abrasion. Eyes, ears, nose, throat, respiratory, GU, GI integumentary, neurologic were negative. Cardiovascular was positive for history of atrial fibrillation. All other systems were negative.

PAST MEDICAL HISTORY: Atrial fibrillation.

MEDICATIONS: Coumadin.

ALLERGIES: IODINE AND IV CONTRAST.

PAST SURGICAL HISTORY: Mastectomy, sigmoid colostomy for what sounded like perforated diverticulitis.

FAMILY HISTORY: No history of bleeding disorders.

SOCIAL HISTORY: No smoking, no alcohol, no drug use. Last meal was around noon. Last tetanus is unknown.

PHYSICAL EXAMINATION: Upon arrival, the patient was evaluated and resuscitated according to ATLS protocol. Airway was patent. She was breathing spontaneously with good bilateral breath sounds. Her initial heart rate was 114, blood pressure 143/72, respiratory rate was 18, oxygen saturation 99% on room air. Her GCS was 15. A full exposure was undertaken. She had an abrasion on her left arm.

Adjuncts to the primary survey included a chest x-ray which demonstrated no pneumothorax, no hemothorax, no obviously displaced rib fractures and a pelvic x-ray which demonstrated no obvious fractures and some right femoral hardware. The x-rays were reviewed and reviewed and discussed with the radiologist.

A complete secondary survey was then obtained. Her heart rate was 129, blood pressure 143/72, respiratory rate 18, oxygen saturation 98%. Examination of her head demonstrated her head to be normocephalic and atraumatic. Eyes, pupils were 3-2 mm equal and reactive bilaterally. She had a left periorbital ecchymosis. On examination of her ears, her TMs were clear bilaterally. There was no Battle sign present. Face, her maxilla was stable, intact and nontender. Mandible was intact. Her nose demonstrated no blood in the nares. Her dentition was intact. Her oropharynx was clear. Her neck demonstrated no cervical spine tenderness, crepitus or deformity. Her trachea was midline. There was no chest wall tenderness, crepitus or deformity. Her lungs were clear bilaterally with normal respiratory effort. Her back was nontender in the thoracolumbar distribution. There was no crepitus present. Her heart was irregular, in atrial fibrillation. Her abdomen was soft, nontender and nondistended with bowel sounds present. Rectal exam was deferred. Perineum was clear. She had a left lower quadrant colostomy present. Her pelvis was stable and nontender. Genitourinary exam, normal external genitalia. Vascular exam, she had 2+ radial, femoral, dorsalis pedis and posterior tibial pulses bilaterally. Neurologically, she had 5/5 strength in all 4 extremities with sensation intact diffusely. Musculoskeletal, she had no obvious long bone deformities of her bilateral upper and lower extremities.

#2757889

LABORATORY EVALUATION: Sodium 137, potassium 3.9, chloride 103, bicarb 24, BUN 33, creatinine 1.33, glucose 99, calcium 12.7. White blood cell count 7980, hemoglobin 12.2, hematocrit 35.0, platelets 231,000. Her INR was 1.9. Her lactate was 0.86. Amylase 76. Alcohol less than 10. Urinalysis was negative.

ADDITIONAL IMAGING: CT scans of the head, cervical, thoracic and lumbar spine, chest, abdomen and pelvis were obtained. These were preliminarily negative for acute traumatic injury. The CT scan was reviewed and reviewed and discussed with the radiologist.

ASSESSMENT: An 80-year-old female with atrial fibrillation ____ coagulopathy due to Coumadin use, status post mechanical fall from standing height with left hip pain, low back pain and pain at the site of left arm abrasion, who presented as a level 2 trauma alert.

PLAN: The patient was evaluated and resuscitated according to ATLS protocol. She underwent CT scans of the head, cervical, thoracic and lumbar spine, chest, abdomen and pelvis and these were preliminarily negative for acute traumatic injury. Serial exams and tertiary survey will be performed. She did not lose consciousness and was not amnestic to the event. At present, it does not appear she ____ any injuries that would require admission or observation. We will follow up on the final reads of her CT scans and triage any identified injuries as identified.

I was present for and directly supervised the trauma evaluation and resuscitation. I reviewed the trauma history and physical examination form and the findings have been confirmed as dictated. I agree with the assessment and plan as documented, dictated and discussed with the resident team.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	

#2757889

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Scott B Armen, MD

SBA /NTS DD: 02/16/16 DT: 02/17/16 00:00

Result Type: .Consult
Date of Service: February 16, 2016 00:00
Authorization Status: Prelim/Transcribed
Subject: Consult
Author or Import Date: Armen, MD, Scott B on February 16, 2016 23:20

This page contains no comments

ES #2757393

Date of Service: ~~02/16/2016~~

REASON FOR VISIT: Hernia.

HISTORY OF PRESENT ILLNESS: [redacted] is a 63-year-old male, who reports a bulging area to the right of his umbilicus over the last 2 years that is very gradually increasing in size over the last year. He reports a minimal discomfort if bumped. He has occasional constipation that he attributed to the hernia. Denies any nausea, vomiting, fever or chills.

PAST MEDICAL HISTORY: Hypertension, sleep apnea.

PAST SURGICAL HISTORY: July 2015, neck surgery for pinched nerve; November 2015, right elbow surgery; 2012 and 2013, bilateral total knee replacement; history of bilateral shoulder surgery, dates and details unknown; umbilical hernia repair without mesh, open procedure, date unknown.

MEDICATIONS: Irbesartan, hydrochlorothiazide, Percocet.

No known drug allergies.

SOCIAL HISTORY: He quit smoking 20-30 years ago. He occasionally drinks alcohol. He does not use recreational or street drugs.

FAMILY HISTORY: Positive for high blood pressure.

REVIEW OF SYSTEMS: Negative. Please refer to the patient questionnaire.

PHYSICAL EXAMINATION: Well-developed, well-nourished male in no acute distress. Body mass index 44.5, weight 138 kg, blood pressure 146/85. HEENT, pupils equal, round; extraocular muscles intact; oropharynx unremarkable. Neck supple. Heart, regular rate and rhythm. Lungs, clear; no wheezes, rales or rhonchi. Abdomen, obese, soft, nontender, no hepatosplenomegaly appreciated. There is a well-healed surgical incision below the umbilicus. There is a large visible hernia to the right of umbilicus. This is nonreducible. He does have a diastasis recti. Extremities, no edema. Musculoskeletal exam, symmetric tone and strength, no deformity.

IMAGING: None.

LABORATORY DATA: None.

ASSESSMENT: Large ventral/periumbilical hernia.

PLAN: [redacted] would be a candidate for surgical repair; however, I would like to obtain a CAT scan for surgical planning. We will arrange to have a CAT scan of abdomen and pelvis without contrast. He is to call the day after and Dr. LynSue will review the findings with the patient over the phone and proceed accordingly. All of his questions were answered and he was agreeable to the plan.

#2757393

Signature Line
Electronic Signature on File
CC: Jonathan Dranov, MD
Mount Nittany Physician Group
1850 East Park Avenue
Suite 201
State College, PA 16803

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 11:11:43 AM
11 changed all male references to female which was incorrect.
(corrected)

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 11:11:59 AM
9 protocol failure inappropriate pend

This page contains no comments

#2757393

*

CC: Robert M Hall, MD
905 University Drive
State College, PA 16801

*

Electronically Reviewed/Signed by: Angelique C Scicchitano, PA
Department of Surgery
Division of Minimally Invasive and Bariatric Surgery
PennState Milton S. Hershey Medical Center
PO Box 850, MC HO75, Hershey, PA 17033
(717)531-7462

Electronically Reviewed/Signed by: Jerome Rudolph LynSue, MD

ACS /NTS DD: 02/16/16 DT: 02/17/16 01:38

Result Type:	.Outpt Note
Date of Service:	February 16, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Scicchitano, PA, Angelique C on February 16, 2016 15:51

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 11:40:28 AM
6 s/b falling

R #2760304

Date of Service: 02/18/2016

CHIEF COMPLAINT: Transfer from Waynesboro Hospital for drug overdose and respiratory failure.

HISTORY OF PRESENT ILLNESS: [redacted] is a 59-year-old woman with a history of breast cancer status post lumpectomy, hyperlipidemia, previous suicide attempts, anxiety and depression and hyperlipidemia, who presents as a transfer from Waynesboro Hospital. She is currently intubated for respiratory failure and therefore most of her HPI is taken from outside records. Per report, she was at home and apparently is a nurse for plastic surgery practice. She had recently been dismissed. Her neighbors called because they mistook her following for a gunshot, but when EMS arrived, there were no firearms in the vicinity. She was found to be intoxicated and her bottle of Effexor 75 mg XR tablets that was filled on 02/09/16 with 60 tabs dispensed had only 14 left. It is estimated that she took about 30 pills. Her son was present at the outside hospital and states that her coworker was worried about her. When he visited her, he noted that she had spilled wine and was very intoxicated. Per report, he asked her what happened and she said that she shot herself, though again no evidence of firearms nor gunshot wound was noted. He also thought that she may have taken narcotics in addition to the Effexor, but it is unclear because she lives alone.

In the outside emergency room, she showed varying levels of consciousness intermittent with combativeness. Upon arrival, her blood pressure was 178/122 with a heart rate of 123 and respiratory rate of 14, oxygen saturation 99% on 2 liters. She had been intermittently hypertensive with blood pressures of 200/133 and 245/176 just prior to transfer to HMC. She required boluses of propofol and because of ongoing agitation, she received 1 mg of Ativan along with 2 liters of normal saline. Because she became apneic, she was subsequently intubated. She was sedated with succinylcholine and propofol and required intermittent boluses of propofol. Because of her history, she received 25 g of activated charcoal through an OG-tube and subsequently transferred to Hershey Medical Center intubated and sedated. She did receive 1 banana bag prior to infusion. She also arrived with 2 peripheral IVs and a Foley prior to arrival, for which she had put out 1.7 liters of urine.

ALLERGIES: No known drug allergies.

REVIEW OF SYSTEMS: Not applicable, unable to be obtained as she is intubated and sedated.

PAST MEDICAL HISTORY:
1. Chronic tobacco use, amount unknown.
2. Anxiety and depression.
3. Breast cancer status post lumpectomies.
4. History of biliary colic.
5. Prior suicidal attempts and suicidal ideation.
6. Hyperlipidemia.
7. Chronic abdominal pain.

PAST SURGICAL HISTORY:
1. Status post lumpectomy.
2. Abdominal surgery and tubal ligation, date unknown.

FAMILY HISTORY: Unable to be obtained.

SOCIAL HISTORY: The patient is an active smoker of an unknown quantity. She lives home alone. She was formerly a nurse at outpatient plastic surgery practice per report. She does use alcohol of an unknown quantity. Illicit drug use is not clear at this time. She does have 1 son.

MEDICATIONS:
1. Effexor XR 75 mg daily.

#2760304

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 11:53:48 AM
2 upgraded due to lab value s/b 271

2. Lipitor 20 mg daily.
3. Zetia 10 mg daily.
4. Levsin 0.125 mg p.r.n. for abdominal pain.
5. Ranitidine 150 mg daily.
6. Mirtazapine 15 mg daily.

OBJECTIVE: Vitals, temperature prior to transfer was 36.5. She was hypertensive with systolics in the 230s, otherwise current blood pressure 131/80, heart rate 97, respiratory rate of 12, currently on SIMV with ____PEEP 5, tidal volume 450, FiO2 of 40%, satting 100%.

PHYSICAL EXAMINATION: In general, intubated and sedated woman. HEENT, small amount of dried blood in her left naris, otherwise no bloody output. She does have an ET tube in place with an OG-tube with remnants of activated charcoal. Pupils are pinpoint and sluggish. Neuro, sedated, not responding to voice, nor pain. Cardiovascular, borderline tachycardic; regular rate and rhythm; no other murmurs, rubs or gallops. Pulm, clear to auscultation in the mid axillary and anteriorly; no rales, rhonchi nor wheezes. Abdomen, normoactive bowel sounds in all 4 quadrants, soft, nontender, nondistended. There is no rebound or guarding. Small tattoo in the right lower quadrant. GU, Foley in place, present on arrival. Extremities, warm and well perfused. There is no clubbing, cyanosis nor edema. Skin, there are no signs of bruising. There are small varicosities in her left lower extremity, otherwise no jaundice nor ecchymoses.

LABORATORIES:
1. CBC drawn on February 17 at 8:00 p.m. showed white blood cell count of 4, hemoglobin 13.4, hematocrit 39.7, MCV 95.4, platelet count 371.
2. BMP shows sodium 143, potassium 3.3, chloride 108, bicarb 26, anion gap 12, BUN and creatinine of 12/0.87, glucose of 106, calcium of 8.8.
3. Lactate of 2.7.
4. CK of 55.
5. Lipase of 78.
6. Magnesium of 2.4.
7. PTT of 23.
8. Urine pregnancy test negative.
9. ABG post-intubation showed a pH of 7.436, pCO2 of 32.3, pO2 272.4, negative carboxy and methemoglobin, FiO2 of 80%.
10. PT/INR of 10 and 1.
11. Troponin negative.
12. Drug screen showed negative salicylate level, negative Tylenol level, ethanol level of 50. Urine drug screen showed positive amphetamine, though she is known to take dextroamphetamine; negative for benzos, barbiturate, cannabinoids, cocaine or PCP.
13. Ammonia level of 29.

STUDIES:
1. EKG showed sinus tachycardia with a rate of 130. There is a normal axis and PR progression, small T-wave inversions in leads III and aVF. Otherwise, there are no other T-wave inversions nor reciprocal changes:
2. Chest x-ray uploaded, not personally reviewed.
3. CT of head uploaded, pending final review.

ASSESSMENT: [redacted] is a 59-year-old woman with hyperlipidemia, anxiety and depression, who presents after an intentional venlafaxine overdose of an estimated 30 pills of 75 mg extended release in addition to alcohol intoxication, currently intubated and sedated with transient signs of serotonin syndrome manifested by hypertension. Overall, no other signs of seizures and her blood pressure has in fact normalized.

This page contains no comments

#2760304

PLAN:
1. Admit to the ICU under the care of Dr. Malhotra, ICU status.
2. Neuro: We will use propofol for sedation and titrate ____ of 3 or 4. We will add Precedex next if necessary. We will recheck a drug screen and wean the extubation with daily sedation holidays.
3. Pulm: We will maintain her current vent settings as she is currently satting well and appears adequately sedated. We will repeat an ABG as well as chest x-ray to check ET tube placement. We will leave her OG tube in place.
4. Cardiovascular: For hypertension secondary to venlafaxine overdose, we will use hydralazine p.r.n. If that does not work, we will try labetalol for a goal systolic of less than 180/100.
5. GU: Her Foley is in place. We will follow her I's and O's closely.
6. GI: We will hold her statin and Zetia for now.
7. Psych: We will continue to monitor her closely and hold her mirtazapine and amphetamines as well as her venlafaxine. She will need a psychiatry consult and evaluation upon extubation.
8. FEN/GI: We will start fluids, IV normal saline at 80 mL an hour. We will follow electrolytes daily. She will be started on IV Protonix.
9. Prophylaxis:
DVT: SCDs while in bed. Prophylactic Lovenox.
GI: IV Protonix.
10. Disposition: ICU status.
11. Full code.

Initial H&P Coding Selection

Low	Moderate	High	
99221	99222	99223	Diagnosis

#2760304

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Michael A Santos, MD

Electronically Reviewed/Signed by: Anita K Malhotra, MD

MAS /NTS DD: 02/18/16 DT: 02/18/16 02:39

Result Type: .HP
Date of Service: February 18, 2016 00:00
Authorization Status: Prelim/Transcribed
Subject: History & Physical
Author or Import Date: Santos, MD, Michael A on February 18, 2016 01:22

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 1:29:08 PM
11 s/b 60

R #2762728

Date of Service: 02/18/2016

PREOPERATIVE DIAGNOSIS: Left lower extremity short distance claudication.

POSTOPERATIVE DIAGNOSIS: Left lower extremity short distance claudication.

OPERATION PERFORMED:
1. Bilateral ultrasounded-guided common femoral artery access.
2. Aortogram.
3. AngioJet thrombectomy of left occluded common and external iliac artery.
4. Right common iliac artery stent using a 9 mm x 40 mm.
5. Left common iliac and external iliac artery stents using a balloon expandable 7 mm x 16 mm stent and a 7 mm x 40 mm stent.

SURGEON: Dr. John Radtka.

ASSISTANT: Dr. Adam Ring.

ANESTHESIA: Local and conscious sedation.

ESTIMATED BLOOD LOSS: 50 mL

DRAINS: Bilateral short 6-French sheath.

URINE OUTPUT: Not recorded.

FLUIDS: 800 mL of crystalloid.

DISPOSITION: Stable to the HVOU.

COMPLICATIONS: None.

SPECIMENS: None.

FINDINGS: Occluded left common iliac artery and left common external iliac artery. Hemodynamically significant stenosis of the right common iliac artery, following stent placement, the patient with bilateral dorsalis pedis pulses.

FLUORO TIME: 11 minutes.

RADIATION: 3539 milligray and 129 mL of Visipaque.

INDICATIONS: [redacted] is a pleasant 57-year-old gentleman who previously had bilateral symptoms of claudication. The patient was managed with best medical therapy and Pletal. However, 5 days ago, the patient noticed an acute onset of numbness in his left foot. For this, the patient went to his vascular surgeon at the VA Medical Center. It was noticed that his ankle-brachial index was decreased from previous exams and also he did not have a left femoral pulse. The patient was then transferred to the Penn State Hershey Medical Center. The patient was admitted and started on heparin drip. Following anticoagulation heparin, the patient's symptoms improved. The patient had a history of possible allergic reaction to the dye used in a stress test. The patient, however, did not have any history of intravenous contrast dye allergy. However, the patient was started on prophylactic Benadryl and prednisone. The risks of the procedure were discussed with the patient. These risks were bleeding, infection, radiation burns, kidney damage, inability to improve the blood flow to his legs, limb loss, heart attack, stroke and death. The patient understood these risks and agreed above procedure.

#2762728

OPERATION: The patient was taken to the operating where he was correctly identified using his wrist band. The patient was on the operating table. Conscious sedation was induced. Preoperative antibiotics were given. A safety timeout was performed. The patient was prepped and draped in normal sterile fashion. Under ultrasound guidance, a micropuncture needle was used to access the right common femoral artery overlying the femoral head. A micropuncture wire was advanced into the infrarenal aorta. An 11 blade was used to make an incision in the skin. A micropuncture sheath was advanced into the artery. A Bentson wire was advanced into the infrarenal aorta. The micropuncture sheath was exchanged for a 5-French sheath. An Omniflush catheter was advanced into the infrarenal aorta. An angiogram was performed. This demonstrated that the patient had 3 right renal arteries and 2 left renal arteries. The patient also had a hemodynamically significant stenosis in the right common iliac. There was a flush occlusion of the left common iliac artery. The inferior mesenteric artery was providing collaterals, which reconstituted the distal left external iliac artery. The right internal iliac artery was patent. The left internal iliac artery was patent through collaterals. The origin was occluded. The right external iliac artery had areas of disease, but these were not hemodynamically significant. We then utilizing a Bentson wire and the Omniflush catheter, tried to go up and over the aortic bifurcation. Our wire would advance slightly. For this reason, we decided to access the left common femoral artery. Under ultrasound guidance, a micropuncture wire was used to access the left common femoral artery at the level of the mid femoral head. A micropuncture wire was advanced into the left common iliac artery. The micropuncture needle was exchanged for a micropuncture sheath. A Bentson wire was used to advance into the left common iliac artery. Our micropuncture sheath was exchanged for a 5-French sheath. A stiff-angled Glidewire was used to traverse the lesion and entered into the infrarenal aorta. An angled-glide catheter was then advanced into the infrarenal aorta and confirmed that we were intraluminal. Because our wire traverse the lesion so easily, I believe that there was a thrombosis of her previous iliac lesion. For this reason, I decided to use an AngioJet _____. A 6 mg of TPA were infused along the left common iliac and external iliac arteries. After 20 minutes, a thrombectomy mode was used. Following this, we could see that there was a severe hemodynamically significant stenosis in the left common iliac artery and external iliac artery. The patient was given 5000 units of heparin. An ACT was checked and additional heparin was given to ensure that our ACT was greater than 200. An angiogram was performed to determine the location of the right internal iliac artery. A 9 mm x 40 mm stent was placed in the right common iliac artery. On the left, a 7 mm x 60 mm was placed in the proximal common and a 7 mm x 40 mm was placed in the external iliac artery. The stents were used to cover the internal iliac artery on the left because the origin was occluded. A completion angiogram was then performed. This demonstrated that the right common iliac artery stenosis showed minimal recoil. The right internal iliac artery was widely patent. The left common and external iliac arteries were patent with good flow down the leg. There was decreased in the collateral blood flow from the inferior mesenteric artery. There was what appeared to be a stenosis in the proximal stent. A 7 mm balloon was used to inflate this area. At this point, we decided to discontinue the procedure. An angiogram was performed through both sheaths and this demonstrated that the common femoral arteries, profunda femoris arteries and superficial femoral arteries were patent. Both sheaths were sutured into place. At the end of the procedure, the patient had bilateral palpable dorsalis pedis pulses which were unchanged from the previous exam prior to the procedure. I was present for the entire procedure. The sponge and needle counts were correct. The patient recovered in the HVOU.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 1:42:14 PM
6 s/b reinflate

#2762728

Signature Line
Electronic Signature on File

This page contains no comments

#2762728

Electronically Reviewed/Signed by: John F Radtka, MD

JFR /NTS DD: 02/18/16 DT: 02/18/16 22:10

Result Type:	.Operative Report
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Operative Report
Author or Import Date:	Radtka, MD, John F on February 18, 2016 21:38

R #2762190

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 2:20:30 PM
2 upgraded protocol failure Did not send cc to physician Dr. Payatakes

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 2:25:38 PM
11 s/b accident

Date of Service: 02/18/2016

REFERRING PHYSICIAN: Dr. Payatakes.

I am seeing [redacted] in initial consultation here at the pain management clinic at the Orthopedic Spine Center on 02/18/16. As you know, he is a 61-year-old Hispanic Peruvian male who speaks Spanish. He is accompanied by an interpreter today who helped facilitate communication between the patient and myself. The patient had a work-related injury in 2014, specifically in 06/07/14, at which point he was cleaning a machine and his right arm and hand were crushed. Apparently, fire fighters dissembled the machine and he was flown via helicopter to Hershey Medical Center where our hand surgery colleagues operated upon him. He has been progressing as far as regaining function of his right hand and he has had recent extensor tenolysis and dorsal capsulotomy and intrinsic releases. He also is complaining of right shoulder pain, which is suspicious for biceps tendinitis. Actually, before coming to my office he did visit with Dr. Kim of shoulder surgery and a right shoulder MRI was ordered. From the order which the patient showed me, it does seem that Dr. Kim is suspecting bicipital tendinitis in this patient. He was previously offered an injection for biceps tendinitis; however, the patient wished to avoid that injection at this point. He states that the pain in his right hand is worse with cold weather. He feels a burning pain during cold weather. It is a sharp pain at times and also throbbing. Sometimes, he feels that his whole hand is numb. He endorses a motor deficit. He also says that he feels a feeling as if there is a grinding ____ in his shoulder when he lifts his right arm. He has been to physical therapy. He is doing home exercises and feels that he has increased stiffness after he performs these exercises. He is currently taking tramadol twice a day as well as ibuprofen, which is helping with his pain. He does not have a primary care physician. He states he got some injections in his wrist after his first surgery.

REVIEW OF SYSTEMS: The patient states that he does not sleep well because of his pain. He takes melatonin; however, he still wakes up around 2:00 a.m. and cannot fall back asleep after that. His appetite is good. He is currently on workman's comp, he has a case pending. He does become emotional when I asked him about his emotional attitudes, but he denies any suicidal or homicidal ideation. He states he does not really have any family in this country and because of the language barrier he is heavily dependent on his son who speaks English and Spanish to communicate and coordinate his healthcare. He did actually dial his son on his cell phone and we did speak briefly about some of what was going on with his father.

PAST MEDICAL HISTORY: Significant only for BPH.

SURGICAL HISTORY: Aside from his multiple hand surgeries is noncontributory.

FAMILY HISTORY: His father was deceased from an accidental when the patient was very young. The patient's mother had a stroke and she has been deceased for the past 14 years at the age of 72.

SOCIAL HISTORY: The patient denies any tobacco, alcohol or illicit substances. He states that prior to coming to the United States, he was an economist in his native country of Peru. He does have one son who is studying nursing; however, he lives at home alone and his son lives at college.

CURRENT MEDICATIONS:
1. Ibuprofen 600 mg 1 tab p.o. t.i.d. with food p.r.n.
2. Tramadol 50 mg 1 tab p.o. q. 12 hours p.r.n.

ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION: In general, this is an age-appropriate 61-year-old well-nourished Hispanic male in no acute distress. Speech is fluent. Comprehension and expression are intact. Mood is appropriate. Affect is concordant. There are no obvious deficits in cognition. The patient is cooperative with physical examination. Vital signs: Temperature 36.8, blood pressure 121/74, heart rate 64, pain

This page contains no comments

#2762190

8/10 in intensity. Visual inspection of his right hand, there are well-healed incisions. Sensation is intact to light touch bilaterally. Strength is 4/5 in the dorsal interosseous muscles in the right hand, 5/5 on the left. There does not appear to be any discrepancy in hair or nail growth between the 2 hands. Likewise, there is no appreciable temperature difference between the digits on the left and right hand. No obvious signs of complex regional pain syndrome.

IMPRESSION:
1. Right hand pain and shoulder pain status post crush injury.
2. Bicipital tendinitis.

PLAN: From a medication standpoint, the patient is on relatively low-dose weak opioids in the form of tramadol. We would deem him an appropriate candidate for these medications. Our clinic has a policy that we do not take over the prescription of opioids as a general rule. If this patient does not have a primary care physician, we certainly would recommend that he establish with one and we did educate him about how he may go about doing that. He should contact his insurance company and see who in this area would be able to provide him with primary care services. This primary care provider would then be able to take over prescriptions. The patient lives very far away in Gettysburg, Pennsylvania. It is not practical for him to travel all the way to Hershey for prescriptions. I explained this to the patient and the patient's son over the cellular phone, both of them understood. Again, the interpreter did facilitate communication. Until such time that the patient is able to obtain a PCP, it would be reasonable for Dr. Payatakes to continue his prescription as our office does not have the resources to prescribe opioids for long term.

It was a pleasure seeing [redacted] today in the pain management clinic here at the Orthopedic Spine Center. Please do not hesitate to contact us with any questions or concerns regarding his care.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	

#2762190

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Bunty J Shah, MD

BJS /NTS DD: 02/18/16 DT: 02/18/16 17:06

This page contains no comments

#2762190

Result Type:	.Consult
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Consult
Author or Import Date:	Shah, MD, Bunty J on February 18, 2016 16:18

This page contains no comments

R #2762404

Date of Service: 02/18/2016

SURGEON: Umur Aydogan, MD

ASSISTANT(s): Justine Clayton, MD and Nicholas Bonazza, MD

PREOPERATIVE DIAGNOSIS: Right foot posterior brevis tear.

POSTOPERATIVE DIAGNOSES:
1. Right foot peroneus brevis severe degenerative tear.
2. Peroneus longus tear.
3. Prominent peroneal tubercle.

OPERATION PERFORMED:
1. Right peroneus brevis severe degenerative tear excision of the torn part up to the level of 3 cm proximal to the insertion.
2. Peroneus longus to fifth metatarsal base tendon transfer.
3. Peroneus longus split tear repair with tubularization.
4. Calcaneal exostectomy of the peroneal tubercle.

ANESTHESIA: General plus ____

ANTIBIOTICS: 2 grams of Ancef IV.

TOURNIQUET: At the level of the thigh 300 mmHg for 60 minutes.

SPECIMENS: There was a degenerative peroneus brevis taken out and sent for pathology.

COMPLICATIONS: None.

POSITION: Supine.

Sponge and sharp count verified correct.

BLEEDING: Minimal.

INDICATIONS: This patient had an inversion injury and treatment for approximately 2-3 weeks ago, and he heard a pop and he had this continued pain, so an MRI was done and a complete tear of the peroneus brevis was seen and so we opted for surgical treatment as indicated above. We also told the patient that we are going to check his heel varus during the surgery as he has a pes cavus and the varus could have led to this tear, so we opted for surgical treatment as indicated above and informed him of the risks and benefits of the surgery, as well as the potential complications, which include but are not limited to infection, nerve/artery damage, no guarantee for success, need for further surgery, DVT, RSD, PE, even loss of limb and digits, and he agreed and would like to proceed with surgery.

OPERATION: On this date, 02/18/16, the patient was taken to the holding area and identified as [redacted] and the right side was marked as the correct side. He was once again examined, which confirmed our diagnosis then he got preoperative antibiotics and a block with catheter then he was transferred to the OR and placed supine on the OR table with all the pertinent parts of the body well padded. After general anesthesia was introduced, a high tourniquet was placed on the right side and he had an SCD on the contralateral side. He was then first scrubbed and then prepped and draped in the sterile orthopedic fashion. After proper time-out, the right lower extremity was elevated and exsanguinated using bandage and the tourniquet was insufflated to 300 mmHg.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 2:58:49 PM
11 should have been deleted

#2762404

First, under fluoroscopy, we actually checked his heel x-ray with multiple Harris heel views and showed that his heel is actually in the subtalar joint in neutral position, straight and there was no bony valgus, flat foot bony varus, so we decided not to do a Dwyer osteotomy.

We made a 10 cm incision along the posterior peroneus brevis tendon sheath and we got down deep preserving neurovascular structures. We did a tenolysis of the peroneus brevis and longus. We saw that the peroneus brevis was ruptured. The distal part was approximately 2-3 cm distal to the fibular head and the proximal side was approximately 2-3 cm proximal to the fibular tip. Both sides were severely degenerated and there was no option to suture them back or repair it, so we decided to excise the ruptured sites up to the level of 3 cm proximal to the insertion to the fifth metatarsal base and we did that and send it to pathology. Then, we relieved the peroneus longus. We thought there was a split tear of the peroneus longus too, so as he has pes cavus and a slight varus deformity of the foot, we decided the peroneus longus to the fifth metatarsal base transfer, which is also going to help his deformity of the foot too, so we cut the peroneus longus at the level distal to the os peroneum. We took the os peroneum from the inside tendon and we used a ____ corkscrew and placed the corkscrew inside the fifth metatarsal base and we pulled the peroneus longus to the fifth metatarsal base and sutured it down there. We put additional 2-0 Vicryl sutures, which was adhering. The fit to the peroneus brevis original distal part of the tendon to the peroneus longus brevis and reinforced it. Then, we will tubularized the peroneus longus nicely and then repaired the tendon tear. Then, as we saw that the peroneal tubercle, which was impinging the peroneus longus, we decided to take it out and we did a nice calcaneal exostectomy, the other peroneal tubercle too. Then, after copious irrigation and hemostasis, we repaired the peroneal retinaculum nicely and made sure that the transfer of peroneus longus was staying in place nicely without any subluxation and then, we sutured the subcutaneous using 3-0 Vicryl sutures and skin using 3-0 nylon sutures. We placed the patient in compression type of dressing and in a splint in slight eversion in neutral dorsiflexion. There were no complications.

POSTOPERATIVE PLAN: The patient is not going to put any weight on it for at least 6 weeks of time. We will see the patient in 3 weeks and if everything is fine, the sutures can come off and he can be placed in a boot and gentle ankle dorsiflexion, plantarflexion exercises can be started, but no side motions or inverted inversion or any rotational motions should be done, should be started at that time.

I will see the patient in another 3 weeks and also 6 weeks of time with new x-rays of the right foot, nonweightbearing 3 weeks and we will go from there.

#2762404

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Umur Aydogan, MD

UA /NTS DD: 02/18/16 DT: 02/18/16 18:34

This page contains no comments

#2762404

Result Type:	.Operative Report
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Operative Report
Author or Import Date:	Aydogan, MD, Umur on February 18, 2016 17:11

R #2759833

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 3:22:39 PM
0 No errors

Date of Service: 02/17/2016

CHIEF COMPLAINT: Chest and nasal congestion.

HISTORY OF PRESENT ILLNESS: [redacted] is a pleasant 76-year-old gentleman with a history of hypertension, hyperlipidemia and TURP, as well as a history of bronchitis, presenting in clinic today due to the above-mentioned chief complaint. He was last seen in our clinic in March 2015, at which point he had been doing well with regards to his bronchitis symptoms while he was being treated with albuterol, Flonase and Mucinex.

He states that over the last 2 weeks, he has noted chest and nose congestion with a cough productive of thick white sputum, which is nonbloody. He denies any fevers or chills associated with these symptoms. He states that the symptoms have remained largely stable over the last 2 weeks and have not significantly worsened. He mentions having bronchitis episodes every year for the past several years around this time. He did receive his flu shot. As far as therapy, he has been using Flonase along with Mucinex with some improvement in his symptoms. Unfortunately, he is no longer taking albuterol because this medication was too expensive for him and he currently does not have insurance. He does endorse having intermittent sore throat, but denies any ear or tooth pain associated with these symptoms. He decided to come in to clinic today for further evaluation given that his symptoms have remained persistent despite conservative management at home.

REVIEW OF SYSTEMS: As mentioned above, otherwise negative.

ALLERGIES: No known drug allergies.

MEDICATIONS:
1. Lisinopril 40 mg daily.
2. Simvastatin 40 mg at night.
3. Mucinex 600 mg 2 tabs every 12 hours as needed for cough and congestion.

PHYSICAL EXAMINATION:
Vitals: Temperature 36.6, heart rate 80, respiratory rate of 24, blood pressure 164/100, saturating greater than 92% on room air. His peak flow showed 200 initially followed by 150.
HEENT: Pupils are equal and reactive to light. Normocephalic, atraumatic. Extraocular movements are intact. No scleral icterus, no conjunctival injection. Examination of the nares shows swelling of the middle turbinate on the right, but otherwise no evidence of erythema. There is evidence of white mucus in the nares. Oropharynx is clear without ulcerations. Bilateral tympanic membranes are clogged with cerumen, although he is not complaining of side effects of cerumen.
Neck: Supple, no lymphadenopathy, no JVD.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs or gallops.
Lungs: Clear to auscultation bilaterally, moderate amount of air movement bilaterally, but no evidence of wheezing or rales or rhonchi.
Abdomen: Soft, nontender, and nondistended, normoactive bowel sounds.
Extremities: No clubbing, cyanosis or edema.

ASSESSMENT: [redacted] is a pleasant 76-year-old gentleman with a history of hypertension, hyperlipidemia and bronchitis, presenting with signs and symptoms consistent with what appears to be chronic bronchitis. Sinusitis is less likely given that he has no sinus pain on exam and has not had any fevers or chills or worsening of his symptoms. He did not perform very long on his peak flow, either suggesting a potential obstructive versus restrictive lung component to his symptoms. Unfortunately, he does not have insurance, which limits our testing capabilities at this time, but he is currently working on obtaining insurance.

This page contains no comments

#2759833

PLAN:
1. Chronic bronchitis. We will prescribe him azithromycin for 5 days in addition to prednisone 20 mg for 5 days for treatment of his acute flare-up of his bronchitis. We did offer albuterol, which would cost him $56 given that he does not have insurance and he prefers to avoid this medication as he is unable to afford that cost. We have foregone the need for a chest x-ray as they will likely not change management currently, but will need one in the future along with PFT once he does have insurance. He was advised to call our clinic back should his symptoms worsen or if he has worsening difficulty with breathing. In the event that he has dyspnea that is severe, he was advised to go to the emergency department.
2. Hypertension. He is hypertensive during today's clinic visit with a blood pressure of 164/100 and would benefit from titration of his blood pressure medications; however, given that he has not been seen by a physician for roughly a year, we will defer this until the next clinic visit. In addition, given that he does not have insurance, we will try to limit the amount of medications he has to pay out of pocket for during today's clinic visit; however, he did have a refill of his current dose of Lisinopril 40 mg daily.
3. Hyperlipidemia. We will continue simvastatin at 40 mg at night and he was also provided with a refill for this medication.
4. Followup: He will follow up in our clinic within 1-1/2 to 2 weeks to readdress his blood pressure as well as to readdress his bronchitis symptoms.

The patient was seen and discussed with Dr. Andreas Achilleos, who agrees with the above assessment and plan.

#2759833

Signature Line
Electronic Signature on File
CC: Jigisha P Patel, MD
35 Hope Drive
Suite 104
Hershey, PA 17033

Electronically Reviewed/Signed by: Nisarg B Patel, MD

Electronically Reviewed/Signed by: Andreas N Achilleos, MD

NBP /NTS DD: 02/17/16 DT: 02/18/16 00:44

Result Type:	.Outpt Note
Date of Service:	February 17, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Patel, MD, Nisarg B on February 17, 2016 16:29

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 3:34:50 PM
11 should have been deleted

R #2762706

Date of Service: 02/18/2016

CHIEF COMPLAINT: Sore throat.

HISTORY OF PRESENT ILLNESS: [redacted] is a 7-year-old previously healthy female who has had approximately 1-month duration of symptoms including sore throat and intermittent fevers. Symptoms began around January 22nd with sore throat and fever of 100 Fahrenheit. She was evaluated by her PCP with a rapid strep negative. Symptoms persisted and she returned to a walk-in clinic on January 31st for evaluation following a temperature of 100.2 Fahrenheit. At that point, a Rapid Strep was repeated and found to be negative and she was treated with a course of Augmentin with some improvement in symptoms. However, symptoms fail to resolve. At that point, she developed a change in her voice and continued to have throat pain and decreased appetite. Parents noted significant swelling of the left tonsil compared to the right in looking in [redacted] mouth. She returned to the PCP and had a Rapid Strep that was completed that was negative and a Monospot test that was also negative. She has continued to have decreased p.o. intake, weight loss, increased fatigue, and continued intermittent fever. This week, she developed worsening of her sore throat and odynophagia leading parents to bring her into the emergency room for evaluation. In the ED, labs were completed and found to be unremarkable. A neck CT showed a 2 cm left tonsillar abscess. ENT was consulted for evaluation. At which point, they determined this was not appropriate for aspiration at this time and recommended admission to pediatrics for IV antibiotic management.

REVIEW OF SYSTEMS: A 12-point review of systems is otherwise negative aside from what is mentioned above.

BIRTH HISTORY: Full-term, uncomplicated.

PAST MEDICAL HISTORY: Strep pharyngitis x2.

PAST SURGICAL HISTORY: None.

FAMILY HISTORY: No significant family history.

SOCIAL HISTORY: Lives at home with mother, father, and 3-year-old sister. All family members are healthy. [redacted] attends first grade.

IMMUNIZATIONS: Up-to-date.

DEVELOPMENT: Age-appropriate.

DIET: Regular diet.

ALLERGIES: No known medication allergies.

VITAL SIGNS: Temp of 36.4, pulse of 103, blood pressure 112/67, respiratory rate 22, SpO2 99% on room air, weight 26.3 kilograms.

PHYSICAL EXAMINATION: General: Sitting up in bed, awake, alert, appropriate, and interactive. No acute distress. HEENT: Pupils are equal, round, and reactive to light. Extraocular motions intact. No nasal congestion or rhinorrhea appreciated. Mucous membranes moist. Mild trismus noted. Left asymmetrical tonsils with left greater than right. Scant exudate, erythema throughout pharynx. No drooling noted. Voice appears muffled. Neck supple, without lymphadenopathy. Full neck range of motion without tenderness. No tenderness to palpation. Cardiac, regular rate and rhythm, 2/6 systolic murmur appreciated, 2+ pulses, brisk cap refill. Lungs clear throughout, nonlabored. Abdomen, soft,

This page contains no comments

#2762706

nontender, nondistended, normoactive bowel sounds. Extremities: No edema, cyanosis, or clubbing. Neuro, symmetrical facies. No focal deficit.
Skin: Warm, dry, and well-perfused. No rashes or lesions noted.

ASSESSMENT: [redacted] is a 7-year-old female, previously healthy with 1-month of intermittent symptoms of sore throat and fever, found to have a left peritonsillar abscess on imaging which corresponds with clinical exam. Based on evaluation by ENT, this is not a drainable lesion at this time and she will be managed medically with close reevaluation. She has no respiratory symptoms and airway is patent. She is hemodynamically stable without evidence of bacteremia or sepsis.

PLAN:
1. We will admit to pediatric service to Anika Kumar. Neuro, Tylenol as needed for pain or fever. Respiratory and cardiac, monitor vital signs as needed.
2. FEN/GI, we will continue regular diet as tolerated, n.p.o. at 2:00 a.m. for reevaluation by ENT. Maintenance IV fluids with D5 normal saline. ID: We will treat with Unasyn and reevaluate if symptoms progress.

Initial H&P Coding Selection

Low	Moderate	High	
99221	99222	99223	Diagnosis

#2762706

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Michaella F Dziedzic, DO

Electronically Reviewed/Signed by: Anika Kumar, MD

MFD /NTS DD: 02/18/16 DT: 02/18/16 20:44

Result Type: .HP
Date of Service: February 18, 2016 00:00
Authorization Status: Prelim/Transcribed
Subject: History & Physical
Author or Import Date: Dziedzic, DO, Michaella F on February 18, 2016 20:13

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 3:40:15 PM
11 s/b from

R #2762748

Date of Service: 02/18/2016

TIME: Approximately 1835 hours.

This is a 53-year-old male who had a self-inflicted gunshot wound to the abdomen with a shotgun. The patient states he did not lose consciousness, does not have amnesia to events. Apparently, the shotgun was loaded with a birdshot. Patient arrived via air ambulance on a long back board, no C-collar. By report, the patient was hypotensive in the ____, received 3 liters of fluid. Upon arrival of the medical crew, they had a blood pressure of 150 systolic.

Previous medical history includes hypertension and depression.

Past surgical history includes an umbilical hernia repair.

Routine medications include metoprolol.

No known drug allergies.

FAMILY HISTORY: Noncontributory.

Socially, patient lives by himself.

Unsure if the patient drinks, smokes or does recreational drugs.

Last meal was at noon.

Last tetanus was not up-to-date.

REVIEW OF SYSTEMS: Negative on a 10-point scale except for GI, he had abdominal pain.

Primary survey was conducted.
Airway was patent, spontaneously protected.
Breathing was spontaneous, nonlabored and clear to auscultation bilaterally.
Circulation: Pulse rate 100, blood pressure 140/92, respiratory rate 20, saturation 100%.
GCS of 15.
FAST exam was adequate and negative x4.

Exposure was completed.

Second set of vitals: Temperature 36.4, pulse rate 99, blood pressure 144/88, respiratory rate 20, saturation 99%.

SECONDARY SURVEY
HEENT: Head: Normocephalic, atraumatic, pupils were 3-2 reactive bilaterally.
Ears: TMs were clear bilaterally. Battle sign was not present.
Face, maxilla, mandible and nose were all stable, no signs of oral trauma. Dentition was intact.
Neck: No C-spine tenderness, crepitus, step-offs or ecchymosis. Trachea was midline.
Chest wall, no tenderness, crepitus, step-offs or ecchymosis.
Lungs were clear on repeat exam.
Back: Nontender, no crepitus, step-offs or ecchymosis.
Heart rate was regular rate and rhythm.
Abdomen was tender. There was a small gunshot wound just superior and left lateral to the umbilicus approximately 4 cm on the midline and about 3 cm above the umbilicus that was a 2 x 3 cm wound.

Author: tdijohnson Subject: Comment on Text Date: 2/24/2016 3:42:32 PM
9 Protocol failure did not add heading of PLAN:

#2762748

Much larger wound was more lateral just above the left iliac crest anterior superior iliac spine, which was approximately 10 x 11 cm.

Rectal tone was deferred. There was no blood at the rectum.
Pelvis was stable, nontender.
Vascular exam: Radial, femoral, DP and PT pulses are 2+.

Cranial nerves 2 through 12 were intact grossly. Motor was 5/5 bilateral upper and lower extremities and sensorium was intact.

Labs are pending. We did get a bedside ABG which showed a pH of 7.30, a pCO2 of 48, pO2 of 23, base excess of -3, bicarbonate 24. He had a hemoglobin of 14.6 and hematocrit of 43.

RADIOLOGY: Chest film showed no traumatic findings.

KUB and pelvic film showed multiple small pellets in the left flank, unknown depth.

CT of the abdomen and pelvis showed at least 3 ____ fragments inside of the abdominal cavity.

ASSESSMENT: Gunshot wound to the abdomen with penetration of the peritoneum.

Initially, we were told that the patient was hypotensive in the ____, received 3 liters of fluid. We are unsure about if this patient was truly hypotensive as he remained hemodynamically stable and actually hypertensive throughout his course in the trauma bay. With the exam of the patient and the fact that the wound looked very tangential and given his debility, we elected to take this patient to the CAT scan, whereupon we found multiple fragments inside his abdomen. He was therefore taken to the OR emergently for exploration. Please see operative report for further details. Postoperatively, patient was taken to the PACU, extubated.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	

#2762748

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Justin D Chandler, MD

This page contains no comments

#2762748

JDC /NTS DD: 02/18/16 DT: 02/18/16 23:36

Result Type:	.Consult
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Consult
Author or Import Date:	Chandler, Justin D on February 18, 2016 22:55

R #2760299

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 11:53:36 AM
0 No errors

Date of Service: 02/17/2016

PREOPERATIVE DIAGNOSIS: Incarcerated transverse loop colostomy.

POSTOPERATIVE DIAGNOSIS: Incarcerated distal portion of transverse loop colostomy.

OPERATION PERFORMED: Resection of incarcerated portion of transverse loop colostomy and additional 10 cm of transverse colon, colostomy revision having an end transverse colostomy with a mucous fistula.

SURGEON: Evangelos Messaris, M.D.

ASSISTANT: Afif Kulaylat, M.D. third-year surgical resident.

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: Less than 10 mL.

INTRAVENOUS FLUIDS: 300 mL of crystalloid.

SPECIMENS: Colostomy and transverse colon.

FINDINGS: The distal loop of the transverse colostomy was prolapsing through the ostomy and it was incarcerated. Several attempts for the last 6 hours of the day using ____ were done in order to reduce the prolapsed ostomy; however, that was not possible. The patient has been taken to the operating room in a semi-urgent fashion to reduce the distal portion of the transverse colostomy to avoid complete necrosis.

OPERATION: After the patient was taken to the operating suite, she was placed in supine position on the operating table. After general endotracheal anesthesia was administered, the patient was prepped and draped according to standard surgical fashion using Betadine. We did not provide the patient with antibiotics because the patient would not have a new incision. The patient received preoperative heparin subcutaneously. After that, an incision was performed along the mucocutaneous junction between the mucosa of the distal transverse colostomy on the skin. The incision was carried down from the skin down to the subcutaneous tissue and then we entered the hernia sac. All the adhesions to the hernia sac were taken down sharply using the Bovie cautery. After that, we fully mobilized the distal portion of the transverse colon and we detached it from the proximal colon. The mesocolon was transected using the EnSeal device. After that, all the redundant transverse colon was pulled out of the abdominal cavity and using a GIA-75 stapler with a blue load, we transected the transverse colon exact at the level of the skin. The anterior mesocolic side of the staple line was secured in place at the skin level using 3-0 Vicryl sutures. A small opening was done to the staple line and the distal loop of transverse colon was matured as a mucous fistula in the incision. Because the opening of the fascia was very big, we decided to reapproximate the portion using #1 Prolene suture. One figure-of-eight stitch was placed to approximate the fascial defect. After that, the proximal transverse colostomy was matured in a standard fashion using 3-0 Vicryl sutures. Appropriate hemostasis was achieved. Instruments, sponge and needle counts were reported as correct at the end of the procedure. I was present and scrubbed for the whole procedure.

#2760299

Signature Line
Electronic Signature on File
CC: Walter A Koltun, MD, FACS, FASCRS
500 University Drive
Hershey, PA 17033

This page contains no comments

#2760299

CC: Mary Varkey, MD
820 5th Avenue
Chambersburg, PA 17201

*

CC: Harold A Harvey, MD
500 University Drive
Hershey, PA 17033

CC: Heath B Mackley, MD
500 University Drive
Hershey, PA 17033

Electronically Reviewed/Signed by: Evangelos Messaris, MD

EM /NTS DD: 02/18/16 DT: 02/18/16 01:32

Result Type:	.Operative Report
Date of Service:	February 17, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Operative Report
Author or Import Date:	Messaris, MD, Evangelos on February 18, 2016 00:46

R #2761496

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 11:56:08 AM
0 No errors

Date of Service: 02/18/2016

PREOPERATIVE DIAGNOSIS: Posterior scalp epidermal inclusion cyst measuring 3.3 cm.

POSTOPERATIVE DIAGNOSIS: Posterior scalp epidermal inclusion cyst measuring 3.3 cm.

PROCEDURE PERFORMED: Excision of posterior scalp epidermal inclusion cyst and intermediate closure measuring 3.5 cm.

SURGEON: John Potochny, M.D.

RESIDENT: William Albright, M.D.

ANESTHESIA: Local anesthetic consisting of 1% buffered lidocaine for a total of 10 mL injected subcutaneously.

SPECIMENS: Posterior scalp epidermal inclusion cyst sent for permanent pathology.

COMPLICATIONS: None.

CONDITION: Stable upon discharge from clinic.

ESTIMATED BLOOD LOSS: Less than 5 mL.

INDICATIONS: [redacted] is a 57-year-old female with a recurrent posterior scalp epidermal inclusion cyst. The patient denies any recent infection of the cyst. After a thorough discussion of risks, benefits and alternatives, the patient gave consent to undergo the following procedure.

OPERATION: A surgical timeout was performed, which correctly identified the patient, the operative site and the operation to be performed. The patient then identified the cyst on her scalp, which was then marked with ink. The area was anesthetized with local anesthetic as described above. The scalp was then cleansed with chlorhexidine, and her hair was moved out of the way with hair braids. The site was then draped in normal sterile fashion.

We began by making an ellipse around the draining epidermal inclusion cyst through full-thickness dermis with a 15-blade scalpel. We then carried our dissection in a subcutaneous plane circumferentially, dissecting the inclusion cyst from the surrounding normal tissue using a combination of 15-blade scalpel and Littler scissors until the specimen was completely excised. The specimen was sent for permanent pathology. Hemostasis was achieved with limited use of electrocautery, being careful not to damage the hair follicles. The wound was then closed in layers using 3-0 Monocryl in a subcutaneous fat plane to close dead space. This was followed by 4-0 Monocryl simple interrupted sutures at the skin. A thin layer of bacitracin was then applied to the incision.

The patient tolerated the procedure well and there were no complications. We did discuss the signs and symptoms of infection; the patient will call if she develops these. The patient may wash her hair with soap and water starting this evening. We did recommend that she limit her activities over the next week while the site heals.

#2761496

Signature Line
Electronic Signature on File

This page contains no comments

#2761496

Electronically Reviewed/Signed by: William B Albright, MD

Electronically Reviewed/Signed by: John D Potochny, MD

WBA /NTS DD: 02/18/16 DT: 02/18/16 13:48

Result Type:	.Outpt Proc
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Procedure
Author or Import Date:	Albright, MD, William B on February 18, 2016 13:29

R #2764385

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 2:00:08 PM
0 No errors

Date of Service: 02/19/2016

SERVICE REQUESTING CONSULT: Trauma surgery.

REASON FOR CONSULTATION: Suicide attempt.

ASSESSMENT: The patient is a 52-year-old employed, married, Caucasian male who was brought to HMC status post gunshot injury to the abdomen. The patient is status post repair of small bowel serosal tear, abdominal wound washout and rigid proctoscopy. The patient admits that he shot himself in a suicide attempt as he no longer wanted to live due to marital issues with his wife. The patient's wife moved out of the home approximately 3 weeks ago and has been refusing to speak to the patient. The patient states that he went to the place that she is staying at yesterday in order to talk with her, and that he was in her kitchen and she refused to speak with him, which is when he took his 12-gauge shotgun and shot himself. The patient states that his wife called 911. The patient has a history of depression, but denies any prior history of suicide attempts. The patient has medical history of hypertension. The patient currently denies suicidal ideation and states he is happy to be alive. The patient denies homicidal ideation, denies auditory or visual hallucinations. The patient is agreeable to inpatient psychiatric hospitalization once medically stable.

RECOMMENDATIONS: Risk: Suicide attempt, history of depression, marital issues. Protective factor: The patient's faith and support system.
1. Recommend inpatient psychiatric hospitalization when patient is medically stable. The patient is in agreement with plan.
2. Recommend initiation of psychotropic medication at inpatient psychiatric hospital.
3. Recommend maintaining 1:1 companion for patient's safety.
4. Thank you for the consult. Please call with any questions or concerns. Psychiatry to follow.

DIAGNOSIS: Major depressive disorder, recurrent, severe, without psychotic features

HISTORY OF PRESENT ILLNESS: The patient is a 52-year-old employed, married, Caucasian male currently living alone after his wife moved out of the home 3 weeks ago, and is status post self-inflicted gunshot wound to the abdomen. The patient states that his mood has been "up and down" for the last 3 weeks due to his wife moving out of the home. The patient wants his wife to be living in the home again, but states she is not willing to do this. The patient is unhappy that his wife has been saying things that he feels are not true such as that she left the home with her son, who is 10 years old, because her son did not like the patient. The patient states that this is not true and that he and his stepson would go to a dairy farm together. The patient has had decreased motivation and energy, poor concentration and attention, has had difficulty focusing, has had a poor appetite, has had decreased sleep for the last 3 weeks and began isolating yesterday. The patient admits that he is still able to enjoy activities, but only when the activity is presented to him to do that he does not actively seek out activities. The patient states that the suicidal thought started yesterday and that he had a plan to shoot himself. The patient denied any homicidal thoughts or any auditory or visual hallucinations. The patient's stressors include his wife leaving the home, finances and his sister-in-law died approximately 2 weeks ago from cancer.

PAST PSYCHIATRIC HISTORY: The patient has a history of depression for a long time, states that as a child, his siblings would blame him ____ and that he was always getting in trouble. The patient admits he had a "nervous breakdown" in 2012 due to marital issues at that time and that he had suicidal thoughts at that time and was hospitalized at a psychiatric hospital. The patient has one inpatient psychiatric hospitalization in 2012 at Lewistown Hospital where he was on the inpatient unit for 10 days. The patient has a history of anxiety "lately" since his wife left him and states that he has not been joking around with friends. The patient has been on psychotropic medication in the past in 2012, but the patient was unable to recall what this medication was or when he stopped taking the medication. The patient is not currently seeing a psychiatrist. The patient recently went to see a therapist, states he saw a therapist approximately 2 weeks ago due to feeling "down in the dumps." The patient denies any prior history of

This page contains no comments

#2764385

suicide attempts, denies any history of self-harm, mania, auditory or visual hallucinations, paranoia, eating disorder, OCD, physical or sexual abuse. The patient has a history of aggression, states that he used to kick stuff when he was upset and the last time this occurred was several years ago.

DEVELOPMENTAL/CHILDHOOD HISTORY: The patient was born and raised in Port Royal, Pennsylvania and said that this in ____ County. The patient described his childhood as "not so good" due to his mother being an alcoholic. The patient has a history of learning disabilities and developmental delays, states initially that he is unable to read and write, but then stated that he has poor reading and writing skills, attended regular classes on school but was "pushed through" and graduated high school.

SOCIAL HISTORY: The patient is currently employed at a factory in a labor position and has been there for 22 years and ____ full-time. The patient states that he enjoys his work. The patient has been married once for 6-1/2 years and has no biological children. The patient's hobbies include watching racing cars, hunting and fishing. The patient's support system consists of a friend, 2 neighbors and several cousins. The patient's faith is important to him, he is Protestant and active in a church.

LEGAL/MILITARY HISTORY: The patient denies any history of legal issues, patient has never been in the military.

FAMILY HISTORY: The patient has 2 brothers and 3 sisters and states that he has recently gotten closer to 1 brother due to the death of the brother's wife. The patient's mother has history of alcoholism, seizures and heart issues. One of the patient's sisters is deceased several years ago from thyroid cancer. The patient has a maternal uncle with alcohol issues. The patient has a brother with a history of cannabis use. The patient's father died when the patient was 4 years old in a construction accident. The patient admits he had a baby brother who died 2 hours after he had been born.

SUBSTANCE USE HISTORY: The patient has a history of alcohol use as a teenager, states that he does not currently drinks and at the last time that he "drunk" was 8 years ago. The patient was unable to quantify how much he was drinking in the past and endorses a history of occasional blackouts when he would drink too much, but denies any history of withdrawal or seizures. The patient has never been to rehab or detox. The patient has a history of trying cannabis approximately 28 years ago and states he did not like it and did not use it again. The patient has a history of occasional tobacco use when he would go fishing and states the last time he smoked a cigarette was approximately 27 years ago.

MEDICAL AND SURGICAL HISTORY: The patient has a history of hypertension and history of umbilical hernia repair approximately 1 year ago.

MENTAL STATUS EXAMINATION: The patient was awake and alert when I entered the room, lying in bed with the head of the bed elevated approximately 40 degrees, wearing a hospital gown, appears younger than his stated age, fair hygiene, fair eye contact, patient periodically closed his eyes due to feeling tired, speech was mostly spontaneous with occasional pauses before answering a question, irregular rate and rhythm, low volume at times, fair attention, fair concentration, fair memory, logical and coherent thought process, no tics or tremors noted, no psychomotor retardation or agitation noted, mood "tired," affect dysphoric, sleepy, the patient was cooperative with assessment, denies suicidal or homicidal ideations. Denies auditory or visual hallucinations, fair insight and judgment.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	

This page contains no comments

#2764385

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Rachel C Perrin, CRNP

RCP /NTS DD: 02/19/16 DT: 02/19/16 16:38

Result Type:	.Consult
Date of Service:	February 19, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Consult
Author or Import Date:	Perrin, CRNP, Rachel C on February 19, 2016 15:44

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 2:05:29 PM
6 s/b lens

R #2763466

Date of Service: 02/19/2016

CHIEF COMPLAINT: Evaluation and management of her obesity, and discussion of her recent lab analyses.

SUBJECTIVE: The patient is a 68-year-old female, who presents today with the above concerns. She states that she still has been able to lose weight in spite of the fact that she is walking usually up to 30 minutes each day without difficulty. She even walked in the recent bad weather. She has not noted any worsening symptoms related to this. She did have some questions about an extra layer of skin underneath her bra. She has some low back pain when she is standing on her feet for any significant period of time.

She has not really engaged in any other weight loss activities such as calorie reduction at this time.

PAST MEDICAL HISTORY: Significant for:
1. Hypertension.
2. Obesity.
3. History of major depression with anxiety trait that was previously treated with medications.
4. History of colitis by colonoscopy that subsequently resolved without a definitive diagnosis.
5. Fibrocystic breast disease with history of abnormal mammograms and followup ultrasound that was negative.
6. Hyperlipidemia.
7. Osteopenia improved after bisphosphonate therapy.
8. GERD.
9. Herpes zoster virus infection in 1997.
10. History of community-acquired pneumonia in 2011.
11. Bilateral stenosing tenosynovitis.
12. History of significant tobacco usage, which now has been reduced to 1-2 cigarettes each day.

PAST SURGICAL HISTORY:
1. Left bunionectomy.
2. Left wrist surgery in 2008.

ALLERGIES: THE PATIENT HAS ALLERGY TO SULFA CAUSING HIVES. SHE HAS AN INTOLERANCE TO VENLAFAXINE THAT CAUSE DRY HEAVES. SULFASALAZINE CAUSE ORAL ULCERATIONS.

SOCIAL HISTORY: The patient is single with a grown male child. She is a retired legal supervisor for the state of Pennsylvania. Her alcohol intake is minimal. She smokes approximately 1-2 cigarettes each day, but not everyday. She has been walking at least a mile each day or up to 30 minutes. Caffeine intake is usually decaffeinated beverages up to twice a day.

FAMILY HISTORY: Father deceased at an older age due to a cerebral aneurysm. He had type 2 diabetes mellitus and osteoarthritis. Mother was deceased in her 70s due to natural causes. She has 2 brothers that are alive and well. She has some second-degree relatives with type 2 diabetes mellitus.

REVIEW OF SYSTEMS: Her weight is unchanged over the last year. She does not report any headache or visual changes. She has an eye exam each year and does wear corrective lense. She reports no hearing changes. She does not report any shortness of breath or chest pain with her activities. She has some very fleeting atypical chest pain that lasts less than seconds and responds to rubbing it that could be either right or left-sided. She does not report any cough or wheezing. She reports no reflux symptoms, abdominal pain, melena or bright red blood per rectum. She reports no urinary incontinence. She denies any new arthralgias, myalgias or skin changes.

#2763466

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 2:08:00 PM
11 omitted (cell)

PHYSICAL EXAMINATION: In general, she is an obese pleasant female in no acute distress. Her weight today is 91.2 kg, height is 158 cm, BMI is 36.5, blood pressure 140/86, pulse 72 and temperature 36.5. She reports no acute pain. HEENT is PERRL and EOMI. She has mild exophthalmus, which is chronic in nature. TMs are scarred, but her nares and pharynx are clear. Dentition is well maintained. She is partially edentulous in the mandible. She does not wear any prostheses. Her neck is supple without any adenopathy, thyromegaly or masses. There is no JVD or bruits. Lungs are clear to auscultation bilaterally. Cardiac exam was regular rate and rhythm. She has a normal S1 and S2. No murmurs, rubs, gallops or clicks were appreciated. Abdomen soft, nontender with positive bowel sounds and no hepatosplenomegaly. There were no periumbilical bruits or pulsatile masses. Extremities show no edema, clubbing, or cyanosis. She has 2+/4 dorsal pedal pulses. Breast and GU exam were deferred to gynecology. Skin exam did not show any dysplastic appearing macules or papules. Skin folds under her breasts were skin and subcutaneous adipose, and there were no discrete masses. Neurologically, she has no resting tremor. DTRs are 3- and symmetric throughout. She had a negative Romberg's. She has some mild arch collapse on her right foot versus her left.

Lab values that were reviewed with the patient showed a normal metabolic panel and CBC with the exception of some minor changes in her red blood indices that are none nonsignificant. Total cholesterol 198, LDL 124, HDL 48, triglycerides 132 and her TSH is 0.87.

HEALTH MAINTENANCE: Influenza vaccine is given annually. She had a pneumococcal 13-valent done in January 2015 and a 23-valent in December 2013. She has declined Tdap and Zostavax at this time. Her last colonoscopy was December 2006 and she has declined followup at this time. Last mammogram was February 2014 with a followup ultrasound. She did not have that repeated last year. I have ordered it today. Pap smear was May 2013 and she should have this scheduled this year.

ASSESSMENT AND PLAN:
1. Cardiovascular -- hypertension, female over 55 with obesity, but reasonable exercise tolerance -- I encouraged the patient to start focusing on weight loss by reducing her calories, particularly in the evening. I have asked her to focus on one specific area one specific item to see if she can reduce it by 500 calories a day. Her goal would be 10-12 pound weight loss in the next 6 months before follow up with me. She will continue her aerobic activities. Blood pressure is top normal and will need to follow this if it needs to be adjusted over time. Given her lipid panel and likely moderate risk under 10-year cardiovascular assessment, she is not willing at this point to engage in any statin therapy.
2. GI -- history of colitis that subsequently resolved -- The patient has declined colonoscopy, but she is also asymptomatic from the symptoms she had with colitis. I will continue to encourage screening and followup.
3. Endocrine -- mild osteopenia -- We discussed the risk of progressing osteoporosis. At this point, I would not encourage her to have another bone density done. Her last one showed only mild osteopenia in one area. She has completed the bisphosphonate therapy. She is not taking any vitamin D supplementation at this time, which I will encourage again on followup. She previously was screened for vitamin D deficiency and her vitamin D level was normal.
4. Health maintenance -- The patient is up-to-date on her health maintenance, which she requests. I did strongly encourage mammogram and ordered it again today.

FOLLOWUP: I will see the patient back in 6 months.

PENDING LABS AND STUDIES: At this time are none.

Initial H&P Coding Selection

Low	Moderate	High	
99221	99222	99223	Diagnosis

This page contains no comments

#2763466

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Edward R Bollard, MD, DDS,
Professor of Medicine
Associate Dean of Graduate Medical Education Designated Institutional Official
PennState Hershey Medical Center
PO Box 850, MC HO39, Hershey, PA 17033
Phone: (717)531-8390

ERB /NTS DD: 02/19/16 DT: 02/19/16 11:52

Result Type:	.HP
Date of Service:	February 19, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	History & Physical
Author or Import Date:	Bollard, MD, Edward R on February 19, 2016 11:23

R #2764929

Date of Service: 02/19/2016

PREOPERATIVE DIAGNOSES:
1. Right knee traumatic arthrotomy with dissection of right popliteal artery, status post superficial femoral artery to below-knee popliteal artery bypass with the lateral reversed great saphenous vein.
2. Right lateral tibial plateau fracture, status post ORIF.
3. Right leg lateral and medial fasciotomy wounds.
4. Multiligamentous knee injury including partial patellar tendon tear, tibial avulsion of ACL, MCL laceration, medial meniscal tear.

POSTOPERATIVE DIAGNOSES:
1. Right knee traumatic arthrotomy with dissection of right popliteal artery, status post superficial femoral artery to below-knee popliteal artery bypass with the lateral reversed great saphenous vein.
2. Right lateral tibial plateau fracture, status post ORIF.
3. Right leg lateral and medial fasciotomy wounds.
4. Multiligamentous knee injury including partial patellar tendon tear, tibial avulsion of ACL, MCL laceration, medial meniscal tear.

PROCEDURE PERFORMED:
1. ACL repair, patellar tendon repair, medial meniscal repair, MCL repair.
2. Irrigation and debridement down to the level of bone of medial and lateral fasciotomy wounds, replacement of VAC dressing.

SURGEON: Aman Dhawan, MD

ASSISTANT: Jyoti Sharma, MD

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 100 mL

DRAINS: VAC dressing x2, Foley.

FLUIDS: 4 units packed red blood cells, 2500 mL lactated Ringer solution, 500 mL colloid.

URINARY OUTPUT: 1 liter.

SPECIMEN: None.

FINDINGS: Torn medial meniscus, avulsion of ACL from tibial insertion, transverse complete laceration of MCL at the level of the joint, partial tear of medial aspect of the patellar tendon.

CONDITION: Stable to recovery room.

COMPLICATIONS: None immediate.

INDICATIONS: The patient is a 43-year-old male who was involved in an MVC on 02/13/16. He suffered a traumatic laceration arthrotomy of the right knee along with a tibial plateau fracture and a popliteal artery injury previous. He previously underwent placement of an external fixator spanning the right knee as well as medial and lateral fasciotomies of the leg, which have been irrigated and debrided and covered with VAC dressings previously. The patient also has a history of undergoing a vascular bypass of his popliteal artery injury. Secondary to his injury, he was noted to have a multiligamentous knee injury and therefore, treatment in the form of ligamentous repair was discussed with the patient. Informed consent was obtained after the risks and benefits of the procedure were discussed in great detail.

This page contains no comments

#2764929

PROCEDURE: The patient was brought to operating room 11 where he was identified via name and date of birth. Laterality of the procedure was confirmed with the patient to be the right leg. It had previously been marked in the preoperative area. The patient was transferred to the operating room table in the supine position. All bony prominences were well padded and an SCD was placed on the left down leg. The patient was intubated without complication by our anesthesia colleagues. The patient was on standing IV Ancef, which had been administered previously. A Foley was placed by nursing. The right lower extremity was then prepped and draped in the usual sterile fashion including the external fixator. A surgical time-out was then performed, which verified the patient's name, date of birth, laterality of procedure as well as availability of instrumentation. Once all were in agreement, the procedure was begun.

Prior to prep and drape, the VAC dressings had been removed from the medial and lateral fasciotomy wounds. There were also previous partial closures of the traumatic arthrotomy as well as the laceration to the knee. These sutures were removed. 6 liters of irrigation were utilized through cysto tubing to irrigate the joint as well as the fasciotomy wounds. The transverse incision along the joint line was extended midline anterior on the patella. The bursa and capsule were incised for access directly into the joint for direct visualization of the ACL. The ACL was noted to be avulsed off the tibial insertion. An Allis clamp was used to pull traction on the ACL. A 5.5 mm Healicoil Smith & Nephew suture anchor was then utilized to tack down the ACL. This was done with 2 strands of FiberWire and Mason-Allen sutures to the ACL. This was noted to be taut and down to bone. Attention was then turned to the medial meniscus, which was noted to be completely avulsed off of its anterior insertion. Three 4.5 mm Smith & Nephew anchors were utilized around the rim of the tibial plateau to tack down the medial meniscus. Horizontal mattress sutures were placed, so that the knots would be extra-articular. The capsule was also tacked down with the use of these anchors. Attention was then turned to the patellar tendon which was noted to be approximately 40% torn on the medial aspect. Two more 4.5 mm Smith & Nephew anchors were placed at the tibial tubercle. Mason-Allen sutures were utilized to the patellar tendon to tack it down. It nicely approximated down to bone and had solid fixation. ____ MCL was noted to be completely lacerated at the level of the joint from the traumatic arthrotomy. The proximal as well as distal ends of the MCL were identified. A free #2 FiberWire was utilized to place Krakow sutures on both limbs. The MCL was then approximated and tacked down. The overlying pes anserinus fascia was also closed using #2 FiberWire. The remaining capsule which had been damaged on the medial aspect of the knee was closed with a running FiberWire stitch. Irrigation was once again used to irrigate the fasciotomy wounds. A 2-0 nylon suture was then utilized to close the extension of the incision, which was made today as well as the previous lateral aspect of the traumatic arthrotomy. VAC dressings were then applied on the fasciotomy wounds. Good seal was obtained. Fluoroscopy was utilized to verify appropriate knee position after the external fixator was replaced. Once this was noted to be appropriate, the case was ended and dry dressings were placed on all incisions. This included Xeroform, 4 x 4s, and Primapore dressing. The ex-fix pin sites were also dressed with Kerlix. All needle and sponge counts were correct at the end of the case and Dr. Aman Dhawan was present for the critical portions of the case. The patient was then awoken from anesthesia and taken to recovery room in stable condition.

POSTOPERATIVE PLAN: The patient will remain in the external fixator at this time. He will be nonweightbearing on the right lower extremity. He will resume DVT prophylaxis in the form of Lovenox on postoperative day 1. He will remain on IV Ancef due to open wounds, which are being managed by the orthopedic trauma team and Dr. Copeland.

#2764929

Signature Line
Electronic Signature on File

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 2:49:17 PM
11 s/b through

This page contains no comments

#2764929

Electronically Reviewed/Signed by: Jyoti Sharma, MD

Electronically Reviewed/Signed by: Aman Dhawan

JS /NTS DD: 02/19/16 DT: 02/19/16 21:09

Result Type:	.Operative Report
Date of Service:	February 19, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Operative Report
Author or Import Date:	Sharma, MD, Jyoti on February 19, 2016 20:17

R #2762248

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 3:16:47 PM
0 No errors

Date of Service: 02/18/2016

[redacted] is a 63-year-old gentleman here to establish care as a new patient. He was previously followed by Dr. Ferner in the Harrisburg area, who has recently retired. He has a concern today at around January; he developed URI symptoms that consist of sinus tenderness, congestion, sore throat, profound fatigue, cough and anorexia with some early satiety. He reports that his wife has noticed some intermittent wheezing as well. He did have a seasonal flu shot. Since that time, symptoms have been gradually improving; however, for the past few days he has had some recurrent sore throat and cough, now nonproductive that is keeping him awake at night. Still no fevers or chills and he denies any night sweats. His fatigue, anorexia and cough has persisted; however, he has lost 5 pounds during the course of his illness so far. He denies any joint pains or rash. He has had some intermittent headache with his symptoms. He has been self-treating with Mucinex. He finds if he lies down in bed at night, he has difficulty sleeping because of paroxysms of cough. He denies any prior history of pulmonary disease including reactive airways disease. His wife was ill with similar symptoms, but a much more abbreviated course in early January.

PAST MEDICAL HISTORY: Includes:
1. Hyperlipidemia, hypertriglyceridemia. He has had difficulties with myalgias on Zocor and has been gradually weaned down to 5 mg daily. He reports being on multiple statins in the past, unclear the full list, but they do include both Crestor and Lipitor.
2. Environmental allergies with primary symptoms of conjunctivitis.
3. Nephrolithiasis requiring stenting and stone extraction in 2012.
4. Rosacea, which has been treated with laser therapy
5. Seborrheic dermatitis.
6. Dry eye with punctal plugs, following with Dr. Rosenwasser.
7. He has a history of depression dating back to 1984, and OCD treating with a psychiatrist in the Carlisle area, as well as a regular counseling.
8. Lumbar disk disease that has been treated conservatively.
9. History of colonic polyps, unknown details.
10. Wisdom teeth extraction.
11. Right elbow fracture.
12. Left shoulder recurrent dislocation, treated nonsurgically.

SOCIAL HISTORY: He is retired from the state, work for Labor and Industry, also been a letter carrier for 14 years until his lumbar disk disease precluded continuing in that field. He has never smoked. He uses no regular alcohol, and has never experimented with drugs. He generally enjoys both basketball in the Rec league, as well as tennis for exercise. He does wear a back brace with those activities and bowls. He has not been performing any of his normal activities for exercise; however, since early January with the onset of his infectious symptoms.

FAMILY HISTORY: His mother is living. She developed rheumatoid arthritis in her 70s. She is hard of hearing and has macular degeneration. Father died in his 60s of an MI, he was a nonsmoker. He has 2 healthy sisters and a brother who died at the age of 18 in an MVA. No history of diabetes, colon or prostate cancer in the family.

HEALTH MAINTENANCE: He did receive a seasonal flu shot. It is unclear his tetanus status. He has not had prior Zostavax. He had a colonoscopy at the age of 58, told to return in 5-10 years. He is up-to-date with Dr. Rosenwasser for his eye care and does see the dentist regularly.

REVIEW OF SYSTEMS: A 10-point review of systems was otherwise negative.

On exam, temperature is 95.1, blood pressure 132/88, pulse 84, respiratory 16, 183 pounds. He is alert, pleasant, well appearing, in no acute distress. Pupils equal, round, reactive to light. Extraocular muscles intact. He is anicteric. Oropharynx is clear. TMs and canals are unremarkable. Neck supple. Thyroid

#2762248

smooth without nodules. Normal JVD and no bruits. Heart is regular rate and rhythm without murmurs, gallops or rubs. Lungs are clear to auscultation and percussion with normal expiratory phase. No audible wheezing, rales or rhonchi and no egophony. Abdomen is soft, nontender with good bowel sounds. No hepatosplenomegaly or masses. Extremities without clubbing, cyanosis or edema. Neurologically has 2+ reflexes throughout and normal gait. On musculoskeletal exam, there is no warm or tender joints. No signs of active synovitis. No subcutaneous nodules were appreciated.

ASSESSMENT AND PLAN:
1. A 6 to 7-week history of profound fatigue, early satiety, anorexia and dry cough. I would like [redacted] have a CBC with a diff today, as well as a PA and lateral chest x-ray. He will be placed on a course of azithromycin 500 mg daily x3 days. In order to help him sleep, he will be tried on Robitussin with codeine 1-2 teaspoons every 6 hours as needed. I have asked him particularly to try at bed time. He was warned about sedation and constipation. He received the ProAir inhaler today, 2 puffs 4 times daily as needed for cough or wheeze with an Aero-Chamber. He understands this may be viral; however, with progressive symptoms now 6 weeks out, we will treat him empirically for bacterial bronchitis. I would also like to check a Monospot. I could not detect any splenomegaly, although that might explain some early satiety. He will be seen back in 2 weeks for close followup.
2. Hyperlipidemia, hypertriglyceridemia, we will await his outside records from Dr. Ferner. He reports having updated labs including a lipid profile in November and he does not need any prescription refills today.
3. Remote history of kidney stones, treated here at the Med Center. He should maintain well hydrated state.
4. Seborrheic dermatitis and rosacea. He continues with Dr. Miller in dermatology.
5. Depression. He will continue with his outside psychiatrist in counseling. He reports being weaned from his Lexapro due to dry mouth and dry eye. He continues on amitriptyline, and his benzodiazepine.
6. History of colonic polyps. We will review his outside records to see when his next colonoscopy is due.
7. Health maintenance. He will check with his insurance regarding Zostavax. Again we will check on tentative date of his colonoscopy. We will need to check on when his tetanus is due to be updated.

#2762248

Signature Line
Electronic Signature on File

Electronically Reviewed/Signed by: Stacy L Hess, MD

SLH /NTS DD: 02/18/16 DT: 02/19/16 00:30

Result Type:	.Outpt Note
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Hope Drive Note
Author or Import Date:	Hess, MD, Stacy L on February 18, 2016 16:31

This page contains no comments

R #2763694

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 3:28:18 PM
0 No errors

Date of Service: 02/19/2016

I had the pleasure of meeting [redacted] in consultation today for her lower back and leg pain. As you know, she is a very pleasant 22-year-old who has had pain for a few years that she attributes to 2 falls. She is describing bilateral pain in the upper buttock, worse on the right than the left, which then wraps around toward the lateral anterior hip and then down the anterior thighs. The pain is worse in the back/buttock area where it is a constant pain with occasional exacerbations that get quite severe. Present pain is 4/10, but it gets worse than that. When the pain gets to its worst levels, she will then get pain in the anterior thigh which will be followed by numbness in the anterior thigh for about 10 minutes. She also notes some occasional giveaway weakness in the legs, especially on the right. She states that walking hills and stairs, sitting too long, twisting and crouching will exacerbate the pain. She denies any association with Valsalva maneuvers. She states that TENS unit application helps. She uses it daily. She also feels the Relafen helps but uses it infrequently. She does not note any bowel or bladder dysfunction.

I was able to review her MRI report and imaging. It does demonstrate some desiccation of the L4-5 and L5-S1 for disk spaces with small central to right disk herniation at L4-5 and a small central to left disk herniation at L5-S1. There is some suggestion of mild inflammation in the facets at L5-S1 bilaterally. Her x-rays were interpreted as normal for the lumbar spine as well as for the pelvis and hips. The SI joints were commented to be symmetric but not necessarily normal.

She has been using as above, Relafen occasionally. She went to physical therapy for a month. She uses a TENS unit already. She has not done any cognitive behavioral therapies or injections. She had done chiropractic care in the past as well.

REVIEW OF SYSTEMS: Questionnaire is reviewed and available in the electronic medical record. She notes her sleep is okay so long as she uses her sleeping aid. Her appetite and activity are normal. She is a student up at Penn State main campus. She is not employed. There is no litigation. She is not depressed.

CURRENT MEDICATIONS: Amitriptyline 50 mg nightly, vitamin D, phentermine 30 mg daily, Relafen 500 mg daily as needed, Seasonique, Topamax 100 mg b.i.d. and Vyvanse 30 mg each morning.

ALLERGIES: TO CLONIDINE, CODEINE, PEANUTS, PREDNISOLONE, PROZAC, SSRI, SULFA DRUGS AND TREE NUTS.

PAST MEDICAL HISTORY: ADHD, Tourette's, migraines and a "spot on her left lung."

PAST SURGICAL HISTORY: Cervical polypectomy and wisdom tooth extraction.

FAMILY HISTORY: Carcinoid lung tumor in her mother, which was resected. Her maternal grandmother had rheumatoid arthritis.

SOCIAL HISTORY: Negative for any tobacco use or illicit substance use. She rarely will have ethanol-containing beverages.

On exam, temperature 36.7 degrees centigrade, BP 150/78, heart rate 89, respiratory rate 20, pain 4/10. In general, age appropriate, mildly obese young Caucasian female in no acute distress who presents with her mother. The patient is alert and appropriately interactive with no obvious deficits in cognitive or speech function. Her mood and affect are appropriate. She is very pleasant and cooperative. She ambulates independently with a normal gait. Strength is 5/5 throughout the bilateral hip flexors, hip adductors, knee extensors, foot dorsi and plantar flexors. Reflexes are 1 bilateral patella, 2 bilateral Achilles. She has no clonus. There is no decreased light touch sensation on examination today. On musculoskeletal examination, she is tender on the right more than the left SI region, more so than the

This page contains no comments

#2763694

facet region. FABER on the right does cause some groin area pain. Straight leg raise, FADIR and facet loading were negative.

IMPRESSION:
1. Low back/buttock pain, which may be due to lumbar spondylosis with discogenic pain versus facetogenic pain. She also may have an element of sacroiliac joint pain and given the severity and her young age, should be screened for inflammatory sacroiliitis.
2. Past medical history of ADHD, Tourette's and migraine.
3. Lung lesion of unclear significance, being followed by her other physicians.

PLAN: At this point in time, I discussed my impression with [redacted] and her mother, they voiced understanding. They were in agreement to expand her diagnostic investigation to see if we can get a better explanation for the precise etiology of her pain symptoms. We will get an MRI of her pelvis and rheumatologic panel to screen for secondary causes of pain in this area. We will see her back in 4 weeks approximately after the testing is completed to go over the results and plan further management from there.

We did discuss the different treatment options in the pain world including psychological approaches, physical approaches, electrostimulation, medications, injections and surgical consultations. We will discuss all this further once again at the followup.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	

#2763694

Signature Line
Electronic Signature on File
CC: Chris P Lupold, MD
222 Willow Valley Lakes Drive
Suite 1900
Willow Street, PA 17584
*

Electronically Reviewed/Signed by: David M Giampetro, MD

DMG /NTS DD: 02/19/16 DT: 02/19/16 12:38

Result Type: .Consult
Date of Service: February 19, 2016 00:00
Authorization Status: Prelim/Transcribed
Subject: Consult
Author or Import Date: Giampetro, MD, David M on February 19, 2016 12:14

R #2762612

Author: tdijohnson Subject: Comment on Text Date: 2/25/2016 3:37:53 PM
0 No errors

Date of Service: 02/18/2016

CURRENT COMPLAINT: Fracture followup.

HISTORY OF PRESENT ILLNESS: [redacted] is a very pleasant 70-year-old female who presents to clinic today for continued evaluation of a closed right ankle fracture with syndesmotic disruption sustained on 02/24/15 when she fell from a standing height outside her home. She underwent open reduction and internal fixation of her fracture on 02/25/15 with fibular plating and syndesmotic screw placement by Dr. Copeland. She presents to clinic today for reevaluation approximately 1 year from injury. She reports she has had no interval falls. She continues to ambulate with a slight Trendelenburg gait. She reports loss of balance when attempting a single leg stance, fully weightbearing on her right lower extremity. She does have discomfort that extends from her right knee down into her right ankle along the lateral aspect of her leg. She also has experienced clawing of her fourth and fifth toes of the right foot. She takes no medications for pain except for an occasional Tylenol, but not on a regular basis. She participates in a water exercise program twice weekly. She has remained very active. She notes no drainage from her surgical incision. No pain with palpation over her ankle hardware. She does have swelling of her right foot and ankle, which is worse at the end of physically active days, but this resolves with elevation and rest.

PHYSICAL EXAMINATION: Alert, very pleasant 70-year-old female, appearing in no acute distress. She ambulates without ambulatory aid with a slight Trendelenburg gait. She is able to do a single leg stance, but needs to hold on to the wall for support when standing on her right leg. She is able to do a toe-raise on bilateral feet. When doing a single leg toe raise, she is unable to perform this on the right foot. She is able to ambulate on toes bilaterally as well as on her heels without increased pain. Examination of the right foot and ankle reveal intact surgical incision with no erythema, open areas. Ankle dorsiflexion 5 degrees, plantar flexion 15 degrees. She is able to invert and evert her foot weakly against resistance with 4/5 strength. Quad, hamstring and TA strength 4+/5. Dorsalis pedis, posterior tibial pulses 2+. Diffuse tenderness about the ____-Achilles insertion with no erythema, increased warmth or swelling.

IMAGING: X-rays of the right ankle were obtained and reveal intact fibular plate with no evidence of hardware failure. There is some lucency around the syndesmotic screw which is not fractured nor backing out. Ankle mortise is symmetric and well maintained on mortise view.

IMPRESSION: Closed right Weber B ankle fracture status post ORIF with syndesmotic screw placement.

PLAN:
1. The patient was encouraged to return to physical therapy for further ankle strengthening. She was also provided with exercises for lower extremity strengthening to include abductor strengthening exercises.
2. The patient was again advised that removal of the syndesmotic screw remains an option. She expressed concern about an infection undergoing surgery, she was reassured while the risk of infection with removal of the screw is not zero it is far less than when her ankle fracture was repaired. At this time, she is not interested in pursuing removal of hardware.
3. She was referred to foot and ankle service for evaluation of her clawing toes and peroneal irritation.
4. No scheduled followup with orthopedic trauma was provided; however, the patient was advised she may contact clinic for reevaluation on an as needed basis. She was reassured that many of her concerns regarding her lower extremity weakness may resolve with consistent lower extremity strengthening.

All questions were answered. The patient and her husband verbalized understanding of all instructions. They were advised to contact clinic with any questions or concerns. The plan of care as noted above was reviewed with Dr. Copeland.

This page contains no comments

#2762612

Signature Line
Electronic Signature on File
CC: William M Bird, DO
121 Nyes Road
Suite A
Harrisburg, PA 17112

Electronically Reviewed/Signed by: Carol C Forsyth, CRNP

CCF /NTS DD: 02/18/16 DT: 02/19/16 09:59

Result Type:	.Outpt Note
Date of Service:	February 18, 2016 00:00
Authorization Status:	Prelim/Transcribed
Subject:	Outpatient Note
Author or Import Date:	Forsyth, CRNP, Carol C on February 18, 2016 18:38