CUNY York College Physician Assistant Program
Fall 2020
Mariyanthie Linaris
Surgery Rotation – New York Presbyterian/Queens Hospital

Write-Up 1

Identifying Data:

- *Name:* KMT
- *Sex:* Female
- *Age:* 13 years, 10 months
- *Date and Time:* 8/31/2020, 6:30 AM
- *Location:* New York Presbyterian/Queens Hospital – Pediatric Inpatient Unit
- *Source of Information:* Self, mother
- *Source of Referral:* Self, mother

Chief Complaint:

Abdominal pain x 9 hours

History of Present Illness:

KMT is a 13 year, 10-month-old well-developed Latina female meeting all age-appropriate milestones accompanied by her mother at bedside with a significant past medical history of recurrent intussusception (spontaneously resolved without intervention) and unspecified mass in neck s/p surgical excision in 2017 who presents with abdominal pain x 9 hours. She indicates that the pain is in the left upper quadrant and periumbilical areas. She admits that the pain is intermittent and lasts for a few minutes at a time. She describes the pain as crampy. She reports that her pain is improved with positioning into the fetal position and worsens with standing. She did not take any medication for her pain. She denies pain radiation. She denies any pain association with timing or feeding. She rates her pain as an 8-9/10. She also complains of nausea and 10 episodes of non-bloody, non-bilious vomiting associated with her pain.

She reports similar symptoms of abdominal pain with headaches on 3 other occasions beginning in January 2020, for the first of which she presented to the NYPQ ED. A CT scan at that time had findings consistent with a small bowel intussusception, however her pain resolved spontaneously, and she was discharged home without intervention. She reports that she did not seek medical attention for the other 2 episodes because she felt like the pain was not as severe and spontaneously resolved within a few hours. She admits that her pain has been localized to the same spot on all previous episodes. KMT followed up with a gastroenterologist concerning her symptoms and was told that the abdominal pain and headaches were likely due to migraines. She has never had an upper or lower endoscopy.

KMT reports that she ate normally over the past day but has not felt hungry since the pain started. She denies any food allergies or intolerances and has not had food prepared outside of the home or introduced any new foods into her diet recently. Her last bowel movement was last night at 8pm and was unremarkable. She does not recall when she last passed flatus. She denies any fever, chills, dysuria, coughing, shortness of breath, blood in her stool, abnormal vaginal bleeding or discharge, diarrhea, or sick contacts. She presented to the emergency department today because of increased severity of her symptoms compared to previous episodes and failure to resolve spontaneously within a few hours as in the past.

Past Medical History:

- *Present Illnesses:*
  - Patient denies any current medical conditions
- *Past Illnesses:*
  - Recurrent intussusception x 9 months
    - 1st episode January 2020 – presented to NYPQ ED

        - Spontaneously resolved – no intervention, discharged home
    - Unspecified mass in neck – 2017
        - Surgically excised at Mount Sinai Hospital in Manhattan
            - No complications
        - Patient and her mother unable to provide further information
        - Does not follow-up with a specialist
- *Hospitalizations:*
    - Patient denies any other hospitalizations not mentioned above
- *Immunizations:*
    - All childhood immunizations up to date for patient's age
    - Endorses receiving the influenza vaccination annually
- *Screenings:*
    - Follows with her pediatrician annually
    - Last eye check within the year
    - Dental visits every 6 months

Past Surgical History:
- Excision of unspecified mass in neck – 2017
    - Mount Sinai Hospital in Manhattan – unable to provide surgeon's name
    - No complications, healed well
    - No current follow-up

Medications:
KMT does not take any medications on a daily basis

Allergies:
KMT denies any known allergies to medications, foods, or environmental factors

Family History:
- Great-grandfather – pancreatic cancer
- Denies family history of colon cancer or IBD
- Otherwise non-contributory

Social History:
KMT is a 13 year, 10-month-old Latina female who lives at home with her parents and siblings. She has met all appropriate milestones for her age and will be starting the 9th grade next week. She reports that she enjoys hanging out with her friends and playing games. She denies any alcohol, tobacco, or illicit drug use. She eats a balanced diet and usually sleeps 8-9 hours each night. She denies any recent travel. She uses all appropriate safety measures, including a seat belt in the car and helmet when riding a bike.

Review of Systems:
General:
Endorses some loss of appetite since symptom onset. Denies fever, chills, fatigue, weight changes, and weakness.
Skin:
Denies rashes or lesions

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Eyes:
Wears glasses, endorses annual eye checks. Denies swelling, redness, discharge, blurred vision, vision changes, and eye pain.
ENT:
Denies otalgia, changes in auditory acuity, sore throat, voice changes, and pain with swallowing.
Neck:
Denies neck pain, decreased range of motion, and lumps/masses.
Pulmonary:
Denies dyspnea, shortness of breath, cough, and wheezing.
Cardiovascular:
Denies chest pain and known heart murmur.
GI:
See HPI.
GU:
Denies irritative voiding symptoms, urinary frequency/urgency, vaginal bleeding, and vaginal discharge.
Musculoskeletal:
Denies joint pain, swelling, deformity, decreased ROM, or any other abnormalities throughout.
Hematological:
Denies easy bruising or known coagulopathies.
Neurological:
Denies loss of sensation, paresthesia, or numbness.

Physical Exam:

- *Vital Signs:*
  - BP – 110/77
  - HR – 93 beats/minute, regular
  - RR – 14, nonlabored
  - Temperature – 36.9 C, oral
  - SpO2 – 98%, room air
  - Height – 150 cm
  - Weight – 57.5 kg
  - BMI – 25.6
- *General Appearance:*
  - 13-year-old female accompanied by her mother. Alert and oriented x 3. Well-groomed with good hygiene. Dressed appropriately. Appears her stated age. In no acute distress.
- *Skin*:
  - No rashes or bruising observed. Skin warm and moist throughout without cyanosis or jaundice. Good skin turgor. Capillary refill < 2 seconds throughout.
- *Chest/Lungs:*
  - Symmetrical without deformity or signs of trauma. Respiration unlabored and without use of accessory muscles. Non-tender to palpation. Clear to auscultation bilaterally with no adventitious lung sounds.
- *Cardiovascular:*
  - Regular rate and rhythm (RRR); S1 and S2 present without any murmurs, rubs, or gallops.
- *Abdomen:*

- Abdomen distended. Soft and tender to palpation in the left mid abdomen. No palpable hepatosplenomegaly.

Labs:

138 | 105 | 15.1
----------< 148
3.9 | 18 | 0.45

Calcium: 9.7

Anion gap: 15

13.5
15.13) -------(214 89.7% neutrophils, 7.90% lymphocytes, 1.8% monocytes
39.6

Urinalysis:
Yellow/cloudy appearance
Specific gravity: 1.032
pH 8.5
Glucose: negative
Protein: 30
Blood: negative
Glucose: negative
Nitrite: negative
Leukocyte esterase: small
COVID-19 nasal swab PCR negative

Imaging:

CT Abdomen with Contrast – Long segment of distal ileal small bowel to small bowel intussusception with dilated small bowel proximal to this as well as a second more proximal transition point concerning for closed loop obstruction.

Given repeated occurrence of small bowel intussusception in this location, underlying etiologies should be investigated (for example inflammatory bowel disease, Henoch-Schoenlein purpura among several possibilities).

Diffuse colonic and distal ileal wall thickening suspicious for enterocolitis.

Differential Diagnoses:

1. Intussusception
    a. Given the presentation of the patient's symptoms (abrupt onset, intermittent, progressively worsening, crampy abdominal pain and episodes of vomiting) in conjunction with the patient's positive history of diagnosed intussusception in January 2020 as per previous CT findings, this is the most likely diagnosis.
2. Acute appendicitis

   a. While appendicitis is typically associated with RLQ pain, it begins poorly localized and can be periumbilical in a similar region the patient localizes her pain to. Given her history of recurrent intussusception and the clinical presentation, however, this is less likely.
3. Midgut volvulus
   a. The presentation of midgut volvulus appears quite similar to that of intussusception, our confirmed diagnosis. Since the patient presented with abrupt onset abdominal pain and episodes of vomiting, midgut volvulus should be considered. Most often with midgut volvulus, the patient's vomit is bilious, which was not the case. Additionally, the patient was not appreciably distended. Imaging can be used to differentiate between intussusception and midgut volvulus
4. Acute gastroenteritis
   a. Acute gastroenteritis can be considered as a differential because of the patient's vomiting and abdominal pain. However, this is less likely because gastroenteritis would more commonly present with abdominal pain and the patient denied any food prepared outside of the home or any new food, and denies that anyone else at home had any symptoms to consider gastroenteritis due to a viral pathogen or bacterial cause secondary to food contamination.
5. Ovarian torsion
   a. Ovarian torsion can be considered in any female with acute onset abdominal pain. Of course, unlike in our patient who described the pain in the left upper region, the pain is generally localized to the pelvic region. Ovarian torsion can also present with nausea and vomiting, both of which the patient endorsed, so it can still be considered, but lower on the list of differentials.

Assessment:

KMT is a 13 year, 10-month-old well-developed Latina female meeting all age-appropriate milestones accompanied by her mother at bedside with a significant past medical history of recurrent intussusception (spontaneously resolved without intervention) and unspecified mass in neck s/p surgical excision in 2017 who presents with abdominal pain x 9 hours. CT of abdomen is consistent with small bowel intussusception.

Plan:

1. Small bowel intussusception
   a. Admit to surgery service - Team A Green
   b. NPO
   c. Nasogastric tube placement to low wall suction
   d. IV fluids
      i. D5W Lactated Ringers 1000 mL IV continuous infusion
   e. Serial abdominal exams
   f. OR for diagnostic laparoscopy with possible small bowel resection and exploratory laparotomy today
   g. Pain control as needed
      i. Oxycodone 2.5 mg PO Q6hr PRN

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SOAP Note 9/2/2020

Identifying Data:

Name: KMT
Age: 13 years, 10 months
Race: Latina
Date & Time: 9/2/2020, 5:40 AM
Location: New York Presbyterian/Queens Hospital, Pediatric Inpatient Unit
Source of Referral: None
Source of Information: Self/mother
Mode of Transport: Personal vehicle

S:

KMT is a 13 year, 10-month-old well-developed Latina female meeting all age-appropriate milestones accompanied by her mother at bedside with a significant past medical history of recurrent intussusception (spontaneously resolved without intervention) and unspecified mass in neck s/p surgical excision in 2017 who was admitted for recurrent small bowel intussusception on 8/31/2020, POD 2 s/p laparoscopic small bowel resection with Meckel's Diverticulum correction and primary anastomosis. On presentation to the ED, she complained of intermittent, non-radiating, crampy left upper quadrant and periumbilical pain x 9 hours. She rated her pain as an 8-9/10 and was only alleviated by sitting in the fetal position. She also complained of nausea and 10 episodes of non-bloody, non-bilious vomiting associated with her pain. She reported similar symptoms of abdominal pain with headaches on 3 other occasions beginning in January 2020, for the first of which she presented to the NYPQ ED. A CT scan at that time had findings consistent with a small bowel intussusception, however her pain resolved spontaneously, and she was discharged home without intervention.

A repeat abdominal CT scan on presentation to the ED showed findings consistent with small bowel intussusception. KMT was taken to the OR for a diagnostic laparotomy with small bowel resection and correction of Meckel's Diverticulum with primary anastomosis. Patient's intraoperative and hospital course have been uncomplicated with no acute events overnight. Patient has an NG tube placed prior to surgery that was dislodged on 9/1/2020 (3:45 AM), but was not replaced because she was advanced to a clear diet as tolerated.

Today, the patient reports that she is feeling significant improvement of her pain and rates it as a 3-4/10 that improves with Acetaminophen and Ketorolac. She is currently on a clear liquid died and reports that she has had small sips of juice but has not felt very hungry yet. She denies nausea, vomiting, and bloating with oral intake. She admits to ambulating around the unit unassisted with minimal pain. She denies passing flatus or having a bowel movement since prior to her surgery and is urinating without complication. She endorses a few episodes of eructation. She denies fever, chills, nausea, vomiting, and diarrhea.

PMHx:

1. Recurrent small bowel intussusception
2. Unspecified mass in neck

PSHx:

1. Surgical excision of unspecified mass in neck – 2017, Mount Sinai Hospital (Manhattan)
2. Laparoscopic small bowel resection with correction of Meckel's Diverticulum and primary anastomosis – 2020, NYPQ

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

1. Acetaminophen 975 mg PO Q6hrs PRN
2. Keterolac 15 mg IV Q6hrs PRN
3. Oxycodone 2.5 mg IR PO Q6hrs PRN for breakthrough pain

Fluids:

1. D5W Lactated Ringers 1000 mL IV continuous infusion

FHx:

Negative for colon cancer or IBD
Great grandfather – Pancreatic cancer

O:

Vitals:

- BP – 97/65
- HR – 96 beats/minute, regular
- RR – 20, nonlabored
- Temperature – 36.8 C, oral
- SpO2 – 95%, room air
- Height – 150 cm
- Weight – 57.5 kg
- BMI – 25.6

I & Os:

- I – 500 mL LR, 510 mL oral fluid
- O – Not measured; urinating freely

Physical Exam:

General:

13-year-old female, well-developed; well appearing, alert and oriented x 3, sitting up in bed. IV placed on right antecubital fossa. In no acute distress.

Skin:

Warm and well-perfused throughout. Skin is pink without cyanosis or jaundice. Capillary refill < 2 seconds throughout.

Lungs:

Lungs clear to auscultation bilaterally without adventitious lung sounds.

Heart:

No visible abnormal pulsations or heaves. RRR; S1 and S2 present without murmurs, rubs, or callops.

Abdomen:

Abdomen appears mildly distended. Surgical wound dressings are clean, dry, and intact. BS absent. Abdomen soft and minimally tender to palpation.

Labs:

139 | 104 | 11.5
----------< 109
3.6 | 23 | 0.47

Calcium: 8.5

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11.7
10.83) -------(174 73.6% neutrophils, 16.60% lymphocytes, 9.3% monocytes
34.9

13.6
------(1.19
29.0

A:

KMT is a 13 year, 10-month-old well-developed Latina female meeting all age-appropriate milestones accompanied by her mother at bedside with a significant past medical history of recurrent intussusception (spontaneously resolved without intervention) and unspecified mass in neck s/p surgical excision in 2017 who was admitted for recurrent small bowel intussusception on 8/31/2020, POD 2 s/p laparoscopic small bowel resection with Meckel's Diverticulum correction and primary anastomosis.

P:

1. Small bowel intussusception with Meckel's diverticulum lead point
    a. Pain well-controlled
        i. Continue pain management with current regimen
    b. Continue IVF until evidence of bowel function
    c. Monitor for bowel function
    d. Follow-up morning labs
    e. Continue clear diet, advance as tolerated
    f. Discharge after evidence of bowel function
        i. Follow-up on 9/17/2020
    g. Patient encouraged to ambulate around the unit

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SOAP Note 8/26/2020

Identifying Data:

Name: JH
Age: 65 years
Race: Asian
Date & Time: 8/25/2020, 5:35 AM
Location: New York Presbyterian/Queens Hospital – 5 West
Source of Referral: None
Source of Information: Self (via Cantonese interpreter)
Mode of Transport: EMS

S:

JH is a 65-year-old Cantonese-speaking Asian male with a significant past medical history of hyperlipidemia who was admitted for acute cholecystitis on 8/24/2020, POD 1 s/p laparoscopic subtotal cholecystectomy. On presentation to the ED, JH was complaining of sharp and throbbing RUQ and epigastric pain x 5 hours. He reports that the pain was constant and ranked it as a 9/10. He denies pain radiation. He reports that he felt similar pain and symptoms on Friday, 8/21/2020, and that it was relieved with over-the-counter pain medication before recurring. He also reports subjective fevers and chills during both episodes of pain. He denied nausea, vomiting, diarrhea, constipation, changes in urination, or jaundice.

On presentation to the ED the patient was afebrile and hemodynamically stable. His labs were significant for a leukocytosis of 21.27 with a bandemia of 7 and 86% neutrophilia, and lactic acidemia of 2.6 that normalized to 1.4 following a 1 L normal saline IV bolus. He also received famotidine and Toradol for mild symptomatic relief. An ultrasound in the ED was significant for gallbladder wall thickness of 3.6 mm and a 2 cm stone in the gallbladder neck consistent with acute cholecystitis. JH was taken to the OR on 8/25 for planned laparoscopic cholecystectomy converted to laparoscopic subtotal cholecystectomy with Jackson-Pratt drain placement. He was on a clear liquid diet, but reported bloating and discomfort after introduction so was regressed to NPO status. He admits to urinating freely and had a bowel movement overnight. He reports that he ambulated minimally in his room. He currently

Patient was hypotensive to 90s/50s overnight. BP improved after administration of IV normal saline bolus.

PMHx:

1. Hyperlipidemia

PSHx:

Patient denies past surgeries, injuries, or blood transfusions

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

1. Ceftriaxone 1g IV in 50 cc D5W x 7 days
    a. Day 3
2. Metronidazole 500 mg IV in 100 cc x 7 days
    a. Day 3
3. D5W ½ NS + 10 mL KCl
4. Acetaminophen 650 mg PO Q6hrs PRN
5. Oxycodone 5 mg PRN for breakthrough pain (≥ 7/10)
6. Enoxaparin 40 mg SQ QD at bedtime

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FHx:

Non-contributory

O:

Vitals:

Temperature: 37.8 C, oral
HR: 78 bpm, regular
BP: 94/56
RR: 16, nonlabored
SpO2: 95%, room air

Physical Exam:

General:

65-year-old male, well-developed; well appearing, alert and oriented x 3, sitting up in bed. In no acute distress.

Skin:

Warm and well-perfused throughout. Skin without cyanosis or jaundice. Capillary refill < 2 seconds throughout.

Lungs:

Lungs clear to auscultation bilaterally without adventitious lung sounds.

Heart:

No visible abnormal pulsations or heaves. RRR; S1 and S2 present without murmurs, rubs, or callops.

Abdomen:

Abdomen flat and non-distended. Surgical wound dressings are clean, dry, and intact. BS present in all 4 quadrants. Abdomen soft and minimally tender to palpation

Labs:

140 | 101 | 7.7
----------< 124
4.3 | 25 | 0.85

Calcium: 9.5

WBCs 15.79

AST 21, Alkphos 76, Tbili 1.1, Dbili 0.38, Protein 7.3, Albumin 4.5, Lipase 15

Preliminary bile culture negative

I & Os:

I – 220 mL LR, 1000 mL NS, 150 mL oral intake
O – 100 mL from JP drain, 300 mL urine

A:

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JH is a 65-year-old Cantonese-speaking Asian male with a significant past medical history of hyperlipidemia who was admitted for acute cholecystitis on 8/24/2020, POD 1 s/p laparoscopic subtotal cholecystectomy.

P:

1. Acute cholecystitis
    a. POD 1 s/p laparoscopic subtotal cholecystectomy

    b. Advance to clear liquid diet and monitor for tolerance
    c. LR 110 cc/hour
    d. Continue IV antibiotics x 7 days (currently day 3)
    e. Continue pain control regimen
    f. Serial abdominal exam
    g. Encouraged to ambulate
    h. Continue DVT prophylaxis with lovenox and SCDs while in bed
2. Hypotension
    a. Repeat BP reading
    b. Continue IVF

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SOAP Note 9/16/2020

Identifying Data:

Name: RD
Age: 68 years
Race: African American
Date & Time: 9/16/2020, 5:40 AM
Location: New York Presbyterian/Queens Hospital – 5 West
Source of Referral: None
Source of Information: Self

S:

RD is a 68-year-old African American female with a SPMHx of anal cancer s/p chemotherapy and radiation 2 years ago, HIV positive status on medical management, and current squamous cell vulvar malignancy s/p radical vulvectomy with a right thigh advancement flap on 7/13/2020, POD 7 s/p right vulvar re-excision with right vulvar and thigh wound debridement and wound VAC placement, and POD 1 s/p right vulvar and thigh wound delayed closure V-Y enhancement flap and incisional wound VAC placement with black sponge, 2 white foams, and 2 Penrose drains placed. She reports that the pain in her right thigh and groin at the wound site is poorly controlled and stabbing in quality, and rates it at 9-10/10, worse with movement, and with only brief relief after IV morphine 2 mg. RD is currently tolerating a regular diet well and is ambulating in her room with pain. She denies nausea, vomiting, fever, and chills.

No acute events overnight.

PMHx:

1. Squamous cell vulvar cancer s/p chemotherapy and radiation
2. Anal cancer s/p chemotherapy and radiation – 2018
3. HIV positive
    a. Managed on Biktarvy

PSHx:

1. Radical vulvectomy with right thigh advancement flap – 7/13/2020
2. Right vulvar re-excision with right vulvar and right thigh wound debridement and wound VAC – 9/9/2020
3. Right vulvar and thigh wound delayed closure V-Y enhancement flap and incisional wound VAC placement – 9/15/2020

Medications:

1. Cefazolin sodium 2 g in D5W IV Q8h
2. Acetaminophen 650 mg PO q6h
3. Gabapentin 200 mg PO BID
4. Enoxaparin 40 mg SC QD
5. Docusate sodium 100 mg PO TID
6. Pantoprazole DR 40 mg PO QD
7. Bactrim DS 1 tab PO QD – 9/9/2020 –
8. Percocet 5/325 mgPO Q6h
9. Oxycodone 5 mg PO Q4h PRN for 4-6/10 pain
10. Biktarvy
    a. Not on formulary – patient taking home meds

Allergies:

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Denies any known allergies to medications, foods, or environmental factors

O:

Vitals:

Temperature: 37.4 C, oral
HR: 107 bpm, regular
BP: 105/61
RR: 18, nonlabored
SpO2: 93%, room air
Height: 5'4"
Weight: 265 lbs
BMI: 45.5

Physical Exam:

General:

68-year-old obese female seen at bedside. Appears uncomfortable but in no acute distress. Wound VAC working on right thigh/groin. IV in right hand. Foley catheter in place.

Skin:

Warm and moist throughout. Incisional wound with wound VAC and white/black foam in place. Dressing clean, dry, and intact. No surrounding erythema or wound leakage. Capillary refill < 2 seconds throughout.

Lungs:

Clear to auscultation bilaterally without adventitious lung sounds. Incentive spirometer at bedside – best inspiratory volume 1750

Cardiovascular:

RRR; S1 and S2 present without murmurs, rubs, or gallops. Peripheral pulses 2+ bilaterally.

Abdomen:

Protuberant and nondistended. BS+ in all 4 quadrants. Soft and nontender to palpation.

Lower Extremity:

Mild non-pitting edema in ankle and foot compared to the left. Proximal thigh/groin wound dressing clean, dry, and intact. Moderate pain to palpation of incision sites. All pulses 2+. FROM with pain. Wound VAC in right thigh working.

Labs:

133 | 101 | 13.8
----------(80 Calcium: 8.0
4.2 | 25 | 1.02

10.3
4.22)---------(220 N: 37.2%, L: 45.50%, M: 14.2%
31.2

PT: 15.1, PTT: 32.9, INR 1.31

Is & Os:

I – oral intake
O – Wound VAC 200 cc, serosanguinous
Foley 1000 cc

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A:

68-year-old HIV+ female with a SPMHx of squamous cell vulvar malignancy POD 1 s/p right vulvar and thigh delayed closure V-Y advancement flap and incisional wound VAC placement. Patient complains of 9-10/10 pain with current pain regimen. Wound VAC draining serosanguinous fluid appropriately. Doing well overall.

P:

1. Surgery service – Team C
2. Adjust pain management regimen
    a. Tylenol 975 mg PO Q6h
    b. Keterolac 15 mg IV Q6h
    c. Oxycodone 5 mg PO Q 6h PRN for moderate breakthrough pain (4-6/10)
    d. Oxycodone 10 mg PO Q 6h PRN for severe breakthrough pain (7-10/10)
3. Continue Cefazolin
4. Maintain Foley to prevent wound soiling
5. Wound VAC change scheduled for Saturday
6. Potential discharge home on Friday, 9/18/2020
    a. Patient unwilling to be discharged sooner because her daughter is away and she fears that she will be unable to care for herself
    b. Arrange for home wound VAC
    c. White foam must be removed before discharge
7. Monitor wound VAC output and strict Is & Os
8. Continue mechanical and pharmacological VTE prophylaxis
9. Monitor vitals and O2 saturation per floor protocols
10. Encourage ambulation
11. Encourage incentive spirometry 10 times/hour
    a. Instructed on how to use at bedside

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SOAP Note 9/16/2020

Identifying Data:

Name: JS
Age: 82 years
Race: African American
Date & Time: 9/16/2020, 7:00 AM
Location: New York Presbyterian/Queens Hospital – CVRU
Source of Referral: None
Source of Information: None -

S:

JS is an 82-year-old African American male with a SPMHx of T2DM, HTN, HLD, dementia, and maggot infestation admitted on 9/1/2020 for respiratory failure 2/2 flash pulmonary edema, POD 12 s/p MV replacement 2/2 torn mitral valve leaflet and severe MR in TEE requiring IABP preoperatively due to vascular collapse and POD 1 s/p IVC filter placement 2/2 left leg DVT. Patient's hospital course was complicated by multifactorial shock requiring persistent vasopressors, which have since been weaned. A right arterial line was placed for hemodynamic monitoring and has since been removed. Vascular surgery was consulted due to duskiness of digits in all extremities, most severe in the RUE, concerning for thrombus likely 2/2 arterial line. Patient is intubated and sedated and remains on mechanical ventilation with pressers. Doppler revealed dopplerable ulnar and palmar arch signals but no dopplerable radial signal in the RUE. Patient is in rate-controlled atrial fibrillation but cannot be anticoagulated due to thrombocytopenia. No acute events overnight.

PMHx:

1. Limb ischemia
2. Respiratory failure
3. MV leaflet rupture
4. Atrial fibrillation
5. Maggot infestation (on presentation to ED)
6. T2DM
7. HTN
8. HLD
9. Dementia

PSHx:

1. IABP – 9/1/2020
2. MV replacement 2/2 leaflet rupture and severe MR – 9/4/2020
3. IVC filter placement – 9/15/2020

Medications:

1. Norepinephrine drip 2 mcg/min IV continuous infusion
2. Meropenem 1000 mg IV BID
3. Polymyxin V 600,000 units IV BID
4. Rifampin 600 mg per NGT QD
5. Metoprolol Tartate 2.5 mg IV Q4h
6. Docusate sodium 200 mg per NGT QD at bedtime
7. Pantoprazole 40 mg IV push QD
8. Insulin Lispro 2 U SC Q6h
9. Acetaminophen 650 mg pe NGT Q6h

10. Heparin 30 U IV flush Q12h
11. Tube feeds 35 ml/hour
12. Continuous NS
13. D5W

Lines and Tubes:

1. Peripheral IV
2. Endotracheal tube
3. Indwelling Foley Catheter
4. NG tube

O:

Vitals:

Temperature: 37.2 C
HR: 107 bpm, irregular
BP: 121/86
RR: 15, on mechanical ventilator
SpO2: 98%, mechanical ventilator
Vented at 35%, PEEP of 5

Physical Exam:

General:

82-year-old man intubated and sedated. On mechanical ventilation. In no acute distress.

Skin:

All 4 distal extremities appear cyanotic distally to proximally at the digits, most severe in RUE. Early mummification in right upper extremity digits with black nail discoloration and thickening. Skin cool to the touch at the extremities with poor capillary refill throughout. Right groin puncture site wound dressing clean, dry, and intact without bleeding or signs of infection.

Lungs:

Intubated on mechanical ventilation. Clear to auscultation bilaterally without adventitious lung sounds.

Cardiac:

Heart rate irregular in rate-controlled atrial fibrillation. No murmurs, rubs, or gallops.

Abdomen:

Non-distended. BS + in all 4 quadrants. Soft and non-tender to palpation.

Peripheral Vascular:

Lower extremities edematous bilaterally. All extremities appear cyanotic distally to proximally and are cool to touch. Right hand with early mummification and positive ulnar sign only and no radial pulse. Capillary refill > 2 seconds throughout. Palpable ulnar and radial pulses in LUE. Decreased pulses in RLE and LLE.

Labs:

136 | 101 | 81.5
----------(249 Calcium: 7.4, Magnesium: 2.4, Anion gap: 17
4.8 | 18 | 3.15

10.0
18.40)---------(56
29.1

PT 17.2, PTT 32.4, INR 1.48

Is & Os:

I: D5W – 450 cc
Tube feeding – 385 cc
NE drip – 131 cc
NS – 244
Sterile water – 450 cc
Total – 1660 cc
O: Foley – 325 cc
Net: 1335 cc

Imaging:

Bilateral LE US Venous Doppler – d/t LE duskiness, rule out DVT
Thrombus identified within the left common femoral vein through proximal superficial femoral vein compatible with DVT.

A:

68-year-old male with SPMHx of T2DM, HTN, HLD, dementia, and maggot infestation admitted on 9/1/2020 for respiratory failure 2/2 flash pulmonary edema, POD 12 s/p MV replacement 2/2 torn mitral valve leaflet and severe MR in TEE requiring IABP preoperatively due to vascular collapse and POD 1 s/p IVC filter placement 2/2 left leg DVT. Vascular surgery consulted for bilateral hand ischemia, right worse than left. Findings consistent with fingertip ischemia 2/2 pressers. Patient intubated and sedated, in no acute distress

P:

1. Left leg DVT with thrombocytopenia
    a. POD 1 s/p IVC filter placement
    b. No further vascular surgery intervention; service will follow peripherally
2. Respiratory failure
    a. Wean from mechanical ventilation as tolerated
    b. Continue antibiotics for HAP due to prolonged ventilation
3. Cardiac
    a. Hemodynamically stable on pressers
        i. Wean as tolerated
    b. Patient in rate-controlled atrial fibrillation
        i. Unable to anticoagulate due to thrombocytopenia
4. Renal failure
    a. Nephrology following
5. Continue tube feedings and ulcer prophylaxis
6. Monitor daily labs and vital signs as per unit protocols
7. Monitor blood glucose and continue titrating insulin.
8. Strict Is & Os

CUNY York College Physician Assistant Program
Fall 2020
Mariyanthie Linaris
Surgery Rotation – New York Presbyterian/Queens Hospital

SOAP Note 9/8/2020

Identifying Data:

Name: JA
Age: 34 years
Race: Latino
Date & Time: 9/8/2020, 9:30 AM
Location: New York Presbyterian/Queens Hospital – Emergency Department
Source of Referral: None
Source of Information: Self

S:

JA is a 34-year-old Latino male with no SPMHx who presented to the ED complaining of sudden onset intermittent, sharp 6-7/10 left flank and lower abdominal pain x 1 day. He reports that the pain radiates towards his groin and he is unable to stay still because of it. He did not take any OTC pain medication and denies any exacerbating factors. He denies fever, chills, nausea, vomiting, changes in bowel habits, irritative voiding symptoms, urinary hesitancy or incontinence, hematuria, penile discharge, sick contacts, or any other symptoms. He denies ever having had similar symptoms in the past. Urology service consulted for CT abdomen/pelvis consistent with renal calculus.

PMHx:
Denies
PSHx:
Denies
Medications:
Does not take any medications on a daily basis
FHx:
Non-contributory
Social Hx:
Drinks 1-2 beers on the weekends
Denies tobacco or illicit drug use
Sexually active with women only, 1 partner in the last 12 months; endorses regular condom use
Allergies:
Denies any known allergies to medications, foods, or environmental factors

O:

Vitals:
Temperature: 37.3 C, oral
HR: 87 bpm, regular
BP: 138/88
RR: 18, nonlabored
SpO2: 98%, room air
Physical Exam:
General:
34-year-old male, well nourished, well-groomed dressed appropriately, seen at ED bedside. Sitting up comfortably in bed, in no acute distress.
Skin:

Warm and well-perfused throughout. No cyanosis, jaundice, or erythema noted.

Lungs:

Clear to auscultation bilaterally without adventitious lung sounds.

Cardiac:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Abdomen:

Flat and nondistended. No abnormal lesions or obvious masses. BS+ in all 4 quadrants. Tympanic to percussion. Abdomen soft and nontender to palpation throughout. No palpable masses. No organomegaly appreciated. No CVAT bilaterally.

Male GU:

Uncircumcised adult male. Penis and testicles unremarkable without observed lesions, masses, bulges, or discharge. No scrotal swelling or discoloration. Foreskin easily retracted and replaced. No palpable masses in the inguinal areas or testicles. No inguinal lymphadenopathy palpated. Genitalia nontender to palpation throughout.

Labs:

Urinalysis negative for UTI, positive for hematuria
CBC and BMP within normal limits

Imaging:

CT abdomen/pelvis without contrast showed a 6mm stone at the left UV junction without evidence of hydronephrosis.

A:

34-year-old male with no SPMHx presented to the ED complaining of left flank and lower abdominal pain x 1 day. Clinical presentation and CT imaging are consistent with a left renal calculus at the UV junction.

P:

1. Left renal calculus at UVJ
    a. Conservative management
        i. Flomax 0.4 mg PO QD
        ii. Encouraged to drink lots of fluids
        iii. OTC analgesia
        iv. Instructed to strain urine until patient notices passed stone
            1. Bring stone to outpatient urology clinic for analysis
    b. Discharge home with instructions to follow-up with outpatient urology clinic
    c. Return to ED if fever develops or pain becomes significantly worse

CUNY York College Physician Assistant Program
Fall 2020
Mariyanthie Linaris
Surgery Rotation – New York Presbyterian/Queens Hospital

SOAP Note 9/10/2020

Identifying Data:

Name: CLL
Age: 55 years
Race: Asian
Date & Time: 9/10/2020, 6:30 AM
Location: New York Presbyterian/Queens Hospital
Source of Referral: None
Source of Information: Patient's daughter

S:

HH is a 55-year-old Asian female with a SPMHx of HTN, noncompliant with medications, POD 9 s/p Left sterotactic NICO craniotomy and intraparenchymal hemorrhage evacuation for large acute parenchymal hemorrhage in the left basal ganglia with mass effect and 5 mm left-to-right midline shift likely due to her uncontrolled HTN. Patient has expressive aphasia and right extremity weakness as a result of the stroke. Surgical incision wound was closed with staples, scheduled to be removed on 9/11/2020. Patient is unable to express questions or concerns but is able to follow commands. Since her surgery, patient has been purposefully moving the left upper and lower extremities and sporadically moving the RUE with no movement in the RLE. She has displayed improving neurological functioning. Patient is currently tolerating a Dysphagia 1 diet (puree with honey thick liquid) and ensure pudding supplementation.

Overnight, the patient had sporadic movement in the RUE and pulled out her NG tube, which was then reinserted. Patient was also hypokalemic at 3.2 and was given 40 mEq of KCL PO.

PMHx:

1. HTN

PSHx:

Denies

Social Hx:

Denies alcohol consumption and tobacco/illicit drug use

FHx:

Unknown

Medications:

1. Amlodipine 10 mg per NGT QD
2. Losartan 50 mg per NGT QD
3. Levetiracetam 500 mg per NGT BID
4. Enoxaparin 40 mg SC QD
5. Atorvastatin 10 mg per NGT QD at bedtime
6. Famotidine 20 mg per NGT BID
7. Labetalol HCL 10 mg IV push Q15min
8. Acetaminophen 650 per NGT Q6h
9. Ondansetron 4mg IV push Q8h
10. Metoclopramide 10 mg IV push Q6h

Allergies:

Denies known allergies to medications, foods, or environmental factors

Lines and Tubes:

1. Indwelling Foley Catheter

2. NG tube

3. Peripheral IV left hand

O:

Vitals:

Temperature: 36.6 C, oral
HR: 69 bpm, regular
BP: 127/78, left arm
RR: 18 bpm, unlabored
SpO2: 97%, room air

Physical Exam:

General:

55-year-old Asian female well nourished, appropriately dressed in hospital gown seen at bedside, reclined comfortable in bed. Awake and alert but expressively aphasic so unable to assess orientation. In no acute distress.

Head:

Incision site on left scalp closed with sutures. Wound site clean and dry with staples intact and no signs of infection. Otherwise NC/AT.

Lungs:

Clear to auscultation bilaterally without adventitious lung sounds

Cardiac:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Abdomen:

Abdomen flat and nondistended. No obvious masses, lesions, or pulsations observed BS+ in all 4 quadrants. Soft and nontender to palpation throughout.

Neuro:

Awake and alert. Patient is expressively aphasic due to stroke, so orientation cannot be assessed. Patient follows commands appropriately. Patient's speech is extremely limited, dysarthric, and incoherent.
EOMI and with eye tracking. PERRLA.
5/5 muscle strength with FROM and purposeful movement in LUE and LLE. 2/5 muscle strength in RUE with sporadic movement and occasional purposeful movement. 1/5 muscle strength with purposeful movement of the RLE.
Unable to assess gait.
Cerebellar tests within normal limits on left side, unable to assess on right side.

Labs:

141 | 101 | 21.1
----------(151 Calcium: 9.2, Magnesium: 2.1, Anion gap: 3.9
4.5 | 27 | 0.48

13.6
8.21)---------(338 N 74.1%, L 14.70%, M 7.1%
42.1

Is & Os:

I – Oral intake
O – Foley – 500 cc

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Imaging:

CTH 9/1/2020 – Status post interval left parietal craniotomy with at least partial location with postsurgical changes, including significant reduction in size of the left-sided intraparenhymal hematoma, along with decreased left to right midline shift and decreased sulcal effacement, as well as pneumocephalus. Small new foci of subarachnoid hemorrhage in the frontal regions bilaterally.

A:

55-year-old Asian female with a SPMHx of poorly controlled HTN due to medication noncompliance POD 9 s/p Left stereotactic NICO craniotomy and intraparenchymal hemorrhage evacuation for large acute parenchymal hemorrhage in the left basal ganglia with mass effect and 5 mm left-to-right midline shift likely due to her uncontrolled HTN. Patient has expressive aphasia and weakness in the right upper and lower extremities with improving neurologic functioning and appropriate surgical site wound healing.

P:

1. Intraparenchymal hemorrhage in left basal ganglia with mass effect
    a. S/p craniotomy on 9/1/2020
    b. Stroke team consulted
    c. Neurosurgery following for surgical wound monitoring and dressing changes
        i. Staples to be removed tomorrow, 9/11/2020
        ii. No further neurosurgerical intervention
    d. Speech and swallow failed as per speech therapy
        i. Maintain NGT
    e. Elevate head of bed to 30 degrees
    f. PT/OT consults ordered
    g. Discuss goals of care with patient and family
    h. Sign off patient to medicine team
    i. Continue neuro checks
    j. Outpatient follow-up on 9/15/2020
2. HTN
    a. Continue current medications
    b. Keep SBP <140
3. Continue to monitor morning labs and supplement electrolytes as needed
4. Oropharyngeal dysphagia
    a. Maintain current diet
5. Foley to remain in place
6. Possible discharge tomorrow afternoon
7. Monitor vitals as per floor protocols