Trans
119

Flowers Hospital
4370 West Main Street
Dothan, AL 36305
334 794 5000 ext 1175

HISTORY AND PHYSICAL

Name: HALL, WILLIE

MRN:	367127	Room #:	627	DOB:	09/16/1945
Account #:	1100800042	Bed #:	P	Age:	65 Y
Service Code:	HOS			Sex:	M
ADM DATE:	01/08/2011				

Dictated By: FIONA I MASTERS, MD
Attending Physician: FIONA I MASTERS, MD
Primary Care Physician:

IDENTIFYING INFORMATION: The patient is a 65-year-old African American male from Georgetown, Georgia, normally followed by Dr. Danny King in Eufaula and Dr. Roland Brooks and Dr. David Gayle in Cardiology. History was obtained from the patient, old records, ER records, and oldest daughter.

CHIEF COMPLAINT: Diarrhea.

HISTORY OF PRESENT ILLNESS: The patient has presented today with a 3 to 4-week history of watery diarrhea. States he has 3 to 4 bowel movements a day, usually precipitated by eating. He has generalized diffuse abdominal pain. He is not aware of any precipitating illness. Denies any recent antibiotic use, travel, change in diet, or exposure to well water. He has been increasingly fatigued and his daughter noticed he appeared jaundiced with his eyes appearing yellow on Monday. She took him to see Dr. King who did blood work and an ultrasound. These results are still pending. He was also taken off his Zocor at that time. Due to persistent worsening malaise, fatigue, abdominal discomfort, nausea, and diarrhea, he presented to the emergency room today for evaluation.

Workup does demonstrate CT shows a gallstone in the common bile duct and in the head of the pancreas. Total bilirubin is elevated at 17.9 with elevated transaminases. He does not have a significant white count or left shift. He does have mild elevation of his lipase at 659, some evidence of acute pancreatitis on CT. Remarkably, he has not had any renal insufficiency with this persistent diarrhea and ongoing use of diuretics and ACE inhibitors. He is also on an NSAID.

He is complaining of frontal sinus pain but it has been ongoing for several weeks. He denies any nasal drainage, postnasal drainage, cough or shortness of breath, orthopnea, PND, or ankle swelling. He denies having any chest pain. His defibrillator last discharged last January. He has not been having any cardiac issues. He sees Dr. Brooks and Dr. Gayle regularly. He denies any night sweats or weight changes. He does feel his abdomen has become markedly distended. He denies any hematemesis, hematochezia, melena, or vomiting. He does have a history of reflux. He has a history of cardiomyopathy but as stated above, he has no symptoms of decompensated congestive heart failure or unstable angina.

REVIEW OF SYSTEMS: An 11-system review is otherwise negative.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Nonobstructing coronary artery disease per cardiac catheterization in 2006 by Dr. Chris Byard.
3. Syncope secondary to ventricular arrhythmias, nonsustained ventricular tachycardia.
a. Status post DDD - ICD implantation, October 27, 2006, by Dr. Gayle.
4. History of atrial fibrillation with conversion on Betapace therapy.

5. Cardiomyopathy with left ventricular ejection fraction of 35% and moderate left ventricular hypokinesis.
6. Hyperlipidemia.
7. BPH.
8. Arthritis.
9. History of hypokalemia, diuretic induced.
10. Family history of heart disease and hypertension.

PAST SURGICAL HISTORY: Pacemaker placement in October 2006 with AICD.

ALLERGIES: **NO KNOWN DRUG ALLERGIES. PRESUMED INTOLERANCE TO ZOCOR ASSOCIATED WITH THIS ILLNESS.**

SOCIAL HISTORY: He lives with his wife in Georgetown, Georgia. He is retired from Alabama Interforest. He drinks an occasional beer. He is a rare smoker with history of only a few cigarettes in his lifetime. He does state he does regular exercising riding a bicycle 2 to 3 times a week.

FAMILY HISTORY: His father was killed in an accident. His mother is 95 years old with no health problems. He had 3 brothers, 1 deceased in an accident, 2 were twins who died shortly after birth. His sister died at 57 from acute myocardial infarction. He has 4 sons and 5 daughters. 1 daughter deceased.

PHYSICAL EXAMINATION:
Vital Signs: Temp 98, blood pressure 141/81, heart rate 67, and respirations 16.
General: Well-developed, well-nourished, obese male, obviously icteric, in no acute distress.
HEENT: Sclerae icteric. Pupils equal, round, and reactive to light. Oropharynx is clear. Oral mucosa is icteric. He is edentulous in upper front teeth.
Neck: Supple. No lymphadenopathy. No thyromegaly.
Lungs: Clear to auscultation bilaterally with normal work of breathing.
Cardiovascular: Regular rate and rhythm. No S3.
Abdomen: Soft, obese. Mildly tender in the right upper quadrant. No rebound, guarding, or rigidity. Hyperactive bowel sounds.
Skin: Warm and dry. No rashes evident. Icteric.
Neurologic: Alert and oriented x4. Moves all extremities well. Cranial nerves II through XII are grossly intact.

LABORATORY DATA: CMP shows sodium 137, potassium 3.6, CO2 of 28, BUN 20, creatinine 0.9, glucose 87, albumin 2.9, total bili 17.9, alk phos 387, ALT 176, AST 145. Magnesium 1.7. Lipase 659. White count 6.5, 56% neutrophils, 2% bands, lymphocytes 27%; hemoglobin 11.8; hematocrit 34.7; platelets 317. Ammonia is 17, INR 1.30. Amylase 94. Urinalysis is positive for bilirubin, small amount of ketones, specific gravity 1.02, small amount of blood, pH 6.5, protein small, nitrite positive, small amount of leukocyte esterase, 2 to 5 white cells, 2 to 5 rbc's, 1+ bacteria. 12-lead EKG, AV sequential pacing at 68 beats per minute, normal intervals except for prolonged QRS secondary to pacing complex. No PVCs. No interval change from 2006. Chest x-ray, no acute infiltrates. No evidence of pulmonary edema or pleural effusions. CT of abdomen and pelvis shows mild pancreatitis and biliary dilation. Gallstones in the gallbladder with suspicion for a stone in the pancreatic head.

ASSESSMENT AND PLAN:
1. Obstructive cholelithiasis.
2. Hepatitis.
3. Acute pancreatitis, probable obstructive.

4. Mild hypomagnesemia.
5. Acute diarrheal illness.
6. Hypertension.
7. History of nonobstructive coronary artery disease.
8. Cardiomyopathy with history of complex ventricular arrhythmias requiring automatic implanted cardioverter defibrillator and pacer placement.
9. Hyperlipidemia.
10. Enlarged prostate.
11. Arthritis, on nonsteroidal antiinflammatory drug therapy.

PLAN: He is being admitted to the hospital. We will consult GI Medicine and General Surgery to assist with further management of obstructive gallstone disease with hepatitis and acute pancreatitis. In addition, we will ask Cardiology to consult to assist with perioperative management given his complex cardiac history, although currently he is asymptomatic from any of his cardiac disease.

We will hold his medications. Currently, use p.r.n. labetalol for blood pressure control. Amazingly, he did not develop acute renal failure given the persistent diarrhea, decreased oral intake, NSAID, diuretic, and ACE inhibitors. He has been placed on IV fluids. Monitor closely for any overload, and adjust antihypertensive therapy according to condition.

I will place him on broad-spectrum antibiotics, provide antiemetics and pain control. Stool studies to further evaluate the diarrhea. Further recommendations and treatment will be dependent on clinical course and expanded database.

FIONA I MASTERS, MD

Disclaimer: PRELIMINARY Report until Authenticated.

Print CC: William "Danny" D. King, MD

Fax CC: S Roland Brooks, MD
David Gayle, MD
D Date / Time: 01/08/2011 04:16 PM CT
T Date / Time: 01/08/2011 11:00 PM CT
S Job #: FH41696512
D Job #: 1044521
MT: 85133 /111448

Flowers Hospital Laboratory, 4370 West Main Street, Dothan Al
Thu Jan 20, 2011 12:04 am
Discharge Cumulative Trend Report from 01/08/11 1120 to 01/19/11 0203

Patient Name: HALL,WILLIE
Med Rec #: 0000367127
Dis Date 01/19/11
Phys-Service: MASTERS,FIONA I - HOSPITALIST
Acct #: F1100800042

****

LABORATORY CANCELLED AND SPECIMEN REJECTED TESTS

****SPECIMEN REJECTED****

Accn: 4096327
Spec: BLOOD
Priority: *ER PAT*

Acct: F1100800042
Collected: 01/08/11 1120
Ord Phys: MCDONALD,J MARK

Test Name: AMYLASE BLOOD
COMPREHENSIVE METABOLIC PANEL
MAGNESIUM BLD
LIPASE

Rejected: 01/08/11 1231 Rejected by: 3652
Rejection Reason: SPECIMEN HEMOLYZED
Reordered: 01/08/11 1232 Reorder Accession Number: 4096362

End of Report

** DO NOT DISCARD **
Discharge Cumulative Trend Report
P=PANIC, C=CORRECTED, H=HIGH
L=LOW, R=REPEATED, A=ABNORMAL

HALL,WILLIE
0000367127
I/P I/P 01/19/11
(M-09/16/45)
Dr. MASTERS,FIONA I

Flowers Hospital Laboratory, 4370 West Main Street, Dothan Al
Thu Jan 20, 2011 12:04 am
Discharge Cumulative Trend Report from 01/08/11 1120 to 01/19/11 0203

Patient Name: HALL,WILLIE
Med Rec #: 0000367127
Dis Date 01/19/11
Phys-Service: MASTERS,FIONA I - HOSPITALIST
Acct #: F1100800042

Adm: 01/08/11

****

In: 01/13/11 0525
Out: 01/13/11 0604
Coll Time: 01/13/11 0450
Order Phys: CRITTENDEN,JEFFREY J

HEPATIC FUNCTION PANEL

Spec: BLOOD
Techs: V6306 T6418

[F1100800042/4100116]

Result Name	Result	Reference Range
Albumin(g/dL):	2.3 L	3.4-5.0
Bili Total(mg/dL):	15.0 H	0.10-1.00
Bili Direct(mg/dL):	12.65 H	0.00-0.20
Alk Phos(U/L):	324 H	50-136
ALT/SGPT(U/L):	138 H	30-65
AST/SGOT(U/L):	114 H	15-37
Prot Total(g/dL):	6.4	6.4-8.2

In: 01/12/11 0440
Out: 01/12/11 0510
Coll Time: 01/12/11 0428
Order Phys: DIAVOLITSIS,STAVROS A

HEPATIC FUNCTION PANEL

Spec: BLOOD
Techs: V6120 T5548

[F1100800042/4099635]

Result Name	Result	Reference Range
Albumin(g/dL):	2.5 L	3.4-5.0
Bili Total(mg/dL):	16.3 H	0.10-1.00
Bili Direct(mg/dL):	13.72 H	0.00-0.20
Alk Phos(U/L):	347 H	50-136
ALT/SGPT(U/L):	152 H	30-65
AST/SGOT(U/L):	131 H	15-37
Prot Total(g/dL):	6.9	6.4-8.2

** DO NOT DISCARD **
Discharge Cumulative Trend Report
P=PANIC, C=CORRECTED, H=HIGH
L=LOW, R=REPEATED, A=ABNORMAL

HALL,WILLIE
0000367127
I/P I/P 01/19/11
(M-09/16/45)
Dr. MASTERS,FIONA I

Patient Name: HALL,WILLIE
Med Rec #: 0000367127
Dis Date 01/19/11
Phys-Service: MASTERS,FIONA I - HOSPITALIST
Acct #: F1100800042

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>> CULTURE SPUTUM <<
Source: Sputum

Coll. Time: 01/08/11 1600
In at: 01/08/11 1622
Acct #: F1100800042
Order Phys: MCDONALD,J MARK
Techs : V-ER109

Out at: 01/10/11 0656
Final [4096486]
Techs: T4912*

Normal Flora, No Pathogens in 48 hours

>> GRAM STAIN <<
Source: Sputum

Coll. Time: 01/08/11 1600
In at: 01/08/11 1622
Acct #: F1100800042
Order Phys: MCDONALD,J MARK
Techs : V-ER109

Out at: 01/08/11 2132
GRAM STAIN [4096486]
Techs: T6642*

Few white blood cells, Few gram positive cocci

>> CULTURE URINE <<
Source: Clean Catch

Coll. Time: 01/08/11 1130
In at: 01/08/11 1237
Acct #: F1100800042
Order Phys: MCDONALD,J MARK
Techs : V-ER129

Out at: 01/10/11 0558
Final [4096347]
Techs: T4912*

no growth in 48 hours

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OPERATIVE REPORT

Name: HALL, WILLIE

MRN:	367127	Room #:	627	DOB:	09/16/1945
Account #:	1100800042	Bed #:	P	Age:	65 Y
Service Code:	HOS			Sex:	M
ADM DATE:	01/08/2011			DOS:	01/09/2011

Dictated By: JEFFREY CRITTENDEN, MD
Attending Physician: FIONA I MASTERS, MD
Primary Care Physician:

PROCEDURE: Endoscopic retrograde cholangiopancreatography with a papillotomy, balloon sweep and stent placement.

PREOPERATIVE DIAGNOSIS: Biliary obstruction.

POSTOPERATIVE DIAGNOSES:
1. Short stricture in distal third of common bile duct.
a. 2 to 3 cm of distal common bile duct of normal caliber.
2. Small amount of debris swept from distal common bile duct.
a. Markedly dilated biliary tree proximal to the above-described stricture.

MEDICATIONS: MAC anesthesia.

DESCRIPTION OF PROCEDURE: After the patient was sedated, a side-viewing duodenoscope was inserted in the cervical esophagus, advanced through the esophagus, in the stomach, to the duodenum. The ampulla was identified and was unremarkable. Using a papillotome backloaded with a fusion wire, I was able to cannulate the common bile duct. Initially, only the cystic duct and distal common bile duct along with gallbladder were visualized. With reposition of the cannula and the wire, I was able to pass the wire up into the proximal biliary tree. Biliary tree was then filled with contrast. This revealed a markedly dilated biliary tree and common bile duct down to a stricture that only measured about a centimeter in length. Distal to this was 2-3 cm of what appeared to be normal-caliber CBD. Perhaps some debris in this on initial images.

Papillotomy was then performed. Following this, a balloon was passed over the wire into the proximal biliary tree and blown up to 12 mm, pulled distally, confirming the presence of a stricture. We then pulled the balloon below the stricture and swept the distal common bile duct 2 times. Small amount of debris was extracted, but no significant stones. Following this, a 7 cm 10-French stent was passed across the biliary stricture in the usual fashion. The patient tolerated the procedure well.

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Account #:	1100800042	ADM DATE:	01/08/2011

PLAN: Will monitor the patient's liver enzymes. I suspect that his primary problem is a biliary stricture, probably malignant. We will need to arrange an EUS for diagnosis and staging.

JEFFREY CRITTENDEN, MD

Disclaimer: PRELIMINARY Report until Authenticated.

Print CC:
Fax CC:
D Date / Time: 01/09/2011 10:26 AM CT
T Date / Time: 01/09/2011 02:27 PM CT
S Job #: FH41702806
D Job #: 1044577
MT: 100345 /575630

Flowers Hospital
4370 West Main Street
Dothan, AL 36305
334 794 5000 ext 1175

DISCHARGE SUMMARY / TRANSFER

Name: HALL, WILLIE

MRN:	367127	Room #:	626	DOB:	09/16/1945
Account #:	1100800042	Bed #:	P	Age:	65 Y
Service Code:	HOS			Sex:	M
ADM DATE:	01/08/2011			DIS DATE:	01/19/2011

Dictated By: TOM LEWIS, MD
Attending Physician: FIONA I MASTERS, MD
Primary Care Physician:

ATTENDING PHYSICIAN: Tom Lewis, MD

DIAGNOSES:
1. Obstructive jaundice.
2. Paroxysmal supraventricular tachycardia status post implanted implantable cardioverter defibrillator shock.

PROCEDURE: Endoscopic retrograde cholangiopancreatography with stenting x2.

CONSULTATIONS:
1. GI.
2. Cardiology.

Admission history and physical, please see the note dictated separately on the date of admission. Briefly, the patient is a 65-year-old gentleman from Georgetown, Georgia who presented on January 8, 2011, with a 3-4 week history of watery diarrhea. He was found to have obstructive cholelithiasis and acute obstructive pancreatitis.

HOSPITAL COURSE:
1. GI. The patient was admitted to the hospitalist service with obstructive jaundice. A GI consult was obtained and the patient had an ERCP performed which showed a short stricture in the distal common bile duct and no definite stones. He had a stent placed. Following placement of the stent, the patient had improvement in his total bilirubin as well as his other labs. After further evaluation by GI, it was determined the patient would potentially need referral for an EUS so we will arrange this as an outpatient to determine whether or not the stricture was secondary to stones versus some sort of tumor given that his CA 19-9 was elevated. The patient will be following up with Dr. Jack Jackson within the next several weeks.
2. Cardiology. On January 12, 2011, the patient had 5 defibrillator shocks secondary to a short run of V-tach and Cardiology was reconsulted. He was started on Betapace and had no further instances of V-tach throughout the remainder of his hospital stay. His electrolytes were also repleted to prevent further arrhythmias. By January 19, 2011, the patient was feeling much improved. His obstructive jaundice had improved as well and he was determined to be ready for discharge with followup with Dr. Jackson.

DISCHARGE MEDICATIONS:
1. Hytrin 2 mg p.o. q.h.s.
2. MiraLAX as needed.
3. Potassium chloride 20 mEq daily.
4. Lisinopril 20 mg daily.

5. Magnesium oxide 400 mg p.o. t.i.d.
6. Flomax 0.4 mg daily.
7. Coreg 25 mg p.o. twice daily.
8. Sotalol 80 mg p.o. q.12 hours.
9. Digoxin 0.25 mg daily.
10. Mobic as needed.
11. Zyrtec as needed.
12. Lasix 20 mg q.Monday, Wednesday, and Friday.

The patient is to eat a salt restricted cardiac prudent diet.

TOM LEWIS, MD

This document is electronically signed by: Tom Lewis MD on 01/20/2011 at 7:09:31 AM (CST)
Verification: 420122552011012007093 1 .

Print CC:
Fax CC: Daniel Jackson, MD
D Date / Time: 01/19/2011 01:24 PM CT
T Date / Time: 01/19/2011 02:17 PM CT
S Job #: FH42012255
D Job #: 1046575
MT: 787732