Patient Name: XXXX DOB: MM/DD/YYYY

Narrative Summary

On 12/08/2015, Mr. XXXX had an emergency department note with Dr. XXXX at XXXX Medical Center for shortness of breath (SOB) and pain on the right lower chest after getting a procedure done to drain fluid around the right lung. He was presents with difficulty breathing. He had SOB X1 week. He had states that 1 week ago he had fluid drained from lining of right lung by pulmonologist and pulmonologist told to him to come to ED for possible collapsed lung. He had states that took a pain pill this morning. A review of system revealed shortness of breath. There was differential diagnosis pneumonia, bronchitis, congestive heart failure. On impression, He was diagnosed with atypical chest pain, SOB, recurrent right pleural effusion.

On 12/08/2015, He presented to the emergency room and evaluated by Dr. XXXX for some right sided chest pain and shortness of breath, which has been on-going since he had a Thoracentesis for fluid by his pulmonologist a few week ago, seems to be worsening. He does have diminished lung sounds on the right. X-ray shows recurrent pleural effusion. He was admitted in stable condition.

On 12/08/2015, Mr. XXXX had a history and physical examination with Dr. XXXX for shortness of breath. He has stated symptoms first began about a month and half ago. He was underwent a thoracentesis on 1st December with 1 L of fluid removed. His symptoms worsened again, he became short of breath and had dry cough. He had very severe pleuritic pain and was unable to sleep. His past medical history was hypertension and gout. His past surgical history was appendectomy. On assessment, he was acute respiratory distress, right pleural effusion, hypertension, gout. He was advised to continue blood pressure medications as needed.

On 12/08/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed large right pleural effusion. No mediastinal shift.

On 12/08/2015, CT guided needle placement biopsy was performed by Dr. XXXX. The CT guided needle placement revealed status post successful CT guided placement of 10 French pigtail catheter in the right pleural space. Fluid was sent to the laboratory for testing.

On 12/10/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed right pleural effusion is much smaller. Infiltrate in the right lower lung.

On the same day, Mr. XXXX had consultation with Dr. XXXX for evaluation of acute kidney injury. He had a history of hypertension and gout and complaints of shortness of breath. He was diagnosed with pleural effusion, underwent thoracentesis. He has been on follow up with Dr. XXXX from pulmonary care. He apparently had a CT scan outside with possible pulmonary mass and lymph nodes. He had a chest x-ray with right sided pleural effusion and infiltrate in the right lower lung. On assessment, acute kidney injury likely prerenal being on ACE inhibitors, Hyponatremia, mild likely volume depletion, recurrent pleural effusion status post right sided chest tube placement, hypertension, currently controlled, history of gout. He was recommended o continue in IV hydration with normal saline and will hold off on ACE inhibitors. He is being scheduled for CT with oral contrast for further evaluation of pleural effusion and lung mass. He was recommended to continue to follow.

On the same day, CT of chest, abdomen/pelvis was performed by Dr. XXXX. The CT revealed small bilateral pleural effusions, right greater than left. A right chest tube loops within the right pleural space. There is nodular soft tissue in the right pleural space, worrisome for metastatic disease. He was recommended biopsy. Minimal ascites enlarged prostate, fecal loading, no evidence of bowel obstruction, small pericardial effusion.

On 12/11/2015, CT guided needle placement biopsy right pleural mass was performed by Dr. XXXX. The CT biopsy revealed biopsy of the anterior pleural based nodule measuring 2.4 x 3.1 cm. No bleeding or other complication.

On 12/13/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed mild interval increase in the right pleural effusion. A pigtail catheter is again seen in the right side of the chest.

On 12/15/2015, Mr. XXXX had consultation with Dr. XXXX for shortness of breath. He had significant right effusion, being drained thoracentesis with 1 L. He also had a biopsy nothing has been indicative regarding cytology or pain. On assessment, He has definite recurrent pleural effusion. I think the working diagnosis here obviously is malignancy and given his questionable mesothelioma exposure with pleural based tumor os most likely mesothelioma. He was understood the risk and benefits of surgery and agreed to proceed, scheduled for tomorrow morning.

On 12/16/2015, operation was performed by Dr. XXXX. Mediastinoscopy with multiple biopsies procedure performed. Mr. XXXX tolerated the procedure well and taken to recovery room in stable condition.

On the same day, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed interval increase in the opacity in the right upper lobe near the apex. Status post pigtail catheter placement in the right lower hemithorax. The increasing opacity could be due to effusion.

On the same day, Mr. XXXX had a history and physical examination with Dr. XXXX for status post Mediastinoscopy. He has a history of smoking one pack of cigarettes per day for 25 years, quitting over 25 years ago in the 1980s. He was admitting to some minor chest pain. On assessment, status post mediastinosopy per Dr. XXXX with mediastinal biopsy, results of which are pending, recurrent right pleural effusion, status post tube thoracostomy, pulmonary mass, suspicious for carcinoma, history of dyspnea for one to two months, small left pleural effusion exists, as well as a small pericardial effusion, remote history of smoking 25-pack years, quitting in the 1980s, possible asbestos exposure-worked on ships in Navy, possible radiation exposure-worked at the Nevada Test Site, hypertension, gout, status post appendectomy. He was recommended home medications resumed in the morning.

On 12/17/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed no significant interval changes. The right pleural effusion is unchanged. No pneumothorax is seen. The widened superior mediastinum is likely related to the right thoracic inlet adenopathy imaged on CT.

On 12/18/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed no significant interval changes.

On the same day, CT of chest abdomen/pelvis was performed by Dr. XXXX. The CT revealed right pleural nodules up to 2.4 cm thickness compatible with mesothelioma. Right pleural effusion may be malignant. There are also abnormally enlarged bilateral mediastinal lymph nodes and a right supraclavicular lymph node. There is some increased attenuation of the mesentery that could be related to early metastasis and there is trace ascites. A pericardial effusion is unchanged and could also be malignant in nature. Circumferential thickening of the gallbladder is probably from underlying background illness rather than primary or metastatic gallbladder disease. Large renal cysts. One of contains a thin septation and a small nodule compatible with a Bosniak category 2F cystic lesion. Follow-up in 6 months is recommended.

On the same day, Mr. XXXX had a consultation with Dr. XXXX for possible mesothelioma. He had a history of smoking. He was found to have pleural effusion, had thoracentesis, as well as lymphadenopathy. On assessment, possible mesothelioma, pleural effusion, possible asbestos exposure, history of tobacco abuse. He was recommended follow-up on pathology.

On 12/19/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed no significant interval changes.

On 12/20/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed no acute radiographic abnormalities in the chest.

On 12/21/2015, X-ray of chest 1 view was performed by Dr. XXXX. The x-ray of chest revealed relatively stable chest radiographic appearance. Persistent right pleural effusion.

On 12/22/2015, Tunneled chest drainage catheter placement under fluoroscopic guidance was performed by Dr. XXXX.

On 12/23/2015, Mr. XXXX had a discharge summary with Dr. XXXX for malignant right pleural effusion, suspected mesothelioma, acute respiratory distress, hypertension, history of gout, acute kidney injury-resolved. He was recommended to follow-up with Dr. XXXX as well as Dr. XXXX for final pathology results and possible palliative chemo.

On 03/01/2016, X-ray of chest 2 views was performed by Dr. XXXX. The x-ray of chest revealed moderate right pleural effusion. Right pleural catheter is within the posterior pleural space. This patient may benefits from CT scan for better assessment of the right basilar process.

On the same day, Mr. XXXX had an emergency department note with Dr. XXXX for shortness of breath. He was present with difficulty breathing. His past medical history was gout, HTN, mesothelioma of lung. His past surgical history was appendectomy and thoracentesis. On assessment, symptomatic pleural effusion, shortness of breath. He was recommended follow-up.

On the same day, Mr. XXXX had an emergency document report with Dr. XXXX for symptomatic pleural effusion, history of mesothelioma, shortness of breath, anemia. He was history of a recent PleurX catheter to right chest wall for history of malignant pleural effusion secondary to mesothelioma. He was provided discharge instructions in details and all the questions answered.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

DOCUMENT NAME: ED Physician Notes
RECEIVED DATE/TIME: 12/8/2015 11:38 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] DO (12/8/2015 11:39 PST)
SIGN INFORMATION: [redacted] DO (12/8/2015 14:41 PST)

SOB - Shortness of breath

Patient: [redacted] MRN: [redacted] FIN: 62315692
Age: 74 years Sex: M DOB: [redacted]
Associated Diagnoses: None
Author: [redacted] DO

Basic Information
Time seen: Provider Initial Contact Time
12/08/2015 11:38.
History source: Patient, significant other.
Arrival mode: Private vehicle.
History limitation: None.
Additional information: Patient's physician(s): [redacted] DO (pulmonologist), Clark, Edward (pcp), Chief Complaint (ST)
Chief Complaint ED: i have SOB and pain on the right lower chest after getting a procedure done to drain fluid around the right lung. 12/08/15 11:34,
ED Triage Assessment: the pt is relaxed and calm. breathing is regular and unlabored. 12/08/15 11:34

History of Present Illness
The patient presents with difficulty breathing. The onset was 1 weeks ago and gradual. The course/duration of symptoms is constant. Degree at present moderate. The Exacerbating factors is none. The Relieving factors is none. Risk factors consist of not chronic obstructive pulmonary disease and not pneumonia. Associated symptoms: denies fever and denies chills. Pt presents with SOB x1 week. Pt states that 1 week ago he had fluid drained from lining of right lung by pulmonologist. Pt states that they called pulmonologist today and he told pt to come to ED for possible collapsed lung. Pt states that he is scheduled to have CT at SWM tomorrow to look and find cause of fluid build-up in lung. Pt states that he took a pain pill this morning.

Review of Systems
Constitutional symptoms: No fever, no chills.
Respiratory symptoms: Shortness of breath, No cough,
Cardiovascular symptoms: No chest pain,
Gastrointestinal symptoms: No abdominal pain, no nausea, no vomiting.
Additional review of systems information: All other systems reviewed and otherwise negative, other than the above noted.

Health Status
Allergies:
Allergic Reactions (Selected)
NKA.
Medications: None, Per nurse's notes.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

Past Medical/ Family/ Social History
Medical history: Negative, Per nurse's notes.
Surgical history:
No active procedure history items have been selected or recorded..
Social history: Unknown.

Physical Examination

Vital Signs
Vital-Signs

12/08/2015 11:34		
	Temperature PO	36.5 deg C
	Heart Rate	85 bpm
	NIBP Systolic	134 mm Hg
	NIBP Diastolic	85 mm Hg
	Resp Rate (Monitor)	16 Breaths/Min
	SPO2	92 %
	Oxygen Amount	Room air

Per nurse's notes.
General: Alert.
Skin: Warm, dry.
Head: Normocephalic, atraumatic.
Neck: Supple.
Eye: Pupils are equal, round and reactive to light, extraocular movements are intact.
Ears, nose, mouth and throat: Oral mucosa moist.
Cardiovascular: Regular rate and rhythm, No murmur, No edema, No Gallops, No click, , Arterial pulses: All distal pulses are 2+ and symmetric.
Respiratory: Breath sounds are equal, Breath sounds: Right, middle lobe, base(s), diminished, no rales present, no rhonchi present, no wheezes present, Retractions: None.
Gastrointestinal: Soft, Nontender, Non distended, Guarding: Negative, Rebound: Negative.
Back: Nontender, No costovertebral angle tenderness,
Musculoskeletal: Normal ROM, no swelling, no deformity, No cyanosis or clubbing.
Neurological: No focal neurological deficit observed, normal sensory observed, normal motor observed, normal speech observed, Cognitive function: Oriented x 3, to person, to place, to time.
Lymphatics: No lymphadenopathy.
Psychiatric: Cooperative.

Medical Decision Making
Differential Diagnosis: Pneumonia, bronchitis, congestive heart failure, pulmonary embolism, chronic obstructive pulmonary disease, asthma, pulmonary edema, pleural effusion, acute myocardial infarction, pneumothorax, cancer.
Rationale: Please refer to dictation for MDM# 499065

Documents reviewed: Emergency department nurses' notes, emergency department records (Pt has no old records).

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

Orders Launch Order Profile (Selected)

Inpatient Orders

Ordered

Sodium Chloride 0.9% 1000 mL: 1,000 mL/hr, IV, Stop: 12/08/15 13:38:00.

Cardiac monitor: Time 12/08/15 12:01:00, Rate 75, normal sinus rhythm, interpreted contemporaneously by me, no Premature Atrial Contraction (PAC).

Electrocardiogram: Time 12/08/15 12:01:00, rate 75, normal sinus rhythm, No ST-T changes, no ectopy, EP Interp, The Axis is normal. , QRS interval low voltage, Previous EKG available None available, EKG interpreted contemporaneously by me.

Results review: Lab results : Laboratory

12/08/2015 12:38

WBC	8.7 K/uL
RBC	5.32 M/uL
Hgb	16.2 gm/dL
Hct	**51.1 % H**
Plt	288 K/uL
MCV	96.0 fL
MCH	30.5 pg
MCHC	**31.7 gm/dL L**
RDW	13.1 %
MPV	8.8 fL
Neut%	74.9 %
Lymph%	**10.8 % L**
Mono%	9.3 %
Eos%	4.1 %
Baso%	0.9 %
PT	**12.8 sec H**
INR	**1.17 ratio H**
PTT	**38.3 sec H**
Sodium	138 mmol/L
Potassium	**4.7 mmol/L H**
Chloride	101 mmol/L
CO2	25 mmol/L
Anion Gap	12 NA
Glucose Level	89 mg/dL
BUN	19 mg/dL
Creatinine	1.18 mg/dL
BUN/Cr Ratio	16.1 NA
eGFR Afr/Am	>60
eGFR NonAfr/Am	60
Calcium	10.0 mg/dL
Protein, Total	7.7 gm/dL
Albumin	3.6 gm/dL
Globulin	4.1 NA
A/G Ratio	0.9 NA
Bili Total	1.0 mg/dL

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

ALT	36 Units/L
AST	**38 Units/L H**
Alkphos	91 Units/L
Lipase	31 Units/L
B-Natriuretic Peptide	**116 pg/mL H**
CK	154 Units/L
Troponin I	0.006 ng/mL

Radiology results: Reviewed radiologist's report, Radiologist's interpretation
Report : XR Chest 1 View
IMPRESSION: 1. Large right pleural effusion. No mediastinal shift.
++ .

Reexamination/ Reevaluation
Time: 12/08/15 13:43:00 .
Vital signs
results included from flowsheet : Vital-Signs

12/08/2015 13:00	
Heart Rate	77 bpm
NIBP Systolic	113 mm Hg
NIBP Diastolic	71 mm Hg
NIBP Mean	85 mm Hg
Resp Rate (Monitor)	**24 Breaths/Min H**
SPO2	94 %
Oxygen Amount	2 L/min

per nurse's notes

Impression and Plan
Diagnosis
Atypical chest pain (ICD10-CM R07.89, Admitting, Medical)
SOB (shortness of breath) (ICD10-CM R06.02, Admitting, Medical)
Recurrent right pleural effusion (ICD10-CM J90, Admitting, Medical)

Calls-Consults
- 12/08/15 13:08:00 [redacted] DO, Pulmonology, phone call, consult, Call returned: 1321 . Will follow. Will send Dr. Akbarullah to see pt. Would like IR-guided indwelling thoracocentesis.

Plan
Condition: Stable.
Disposition: Admit: Time 12/08/15 13:37:00, to Observation Unit (MS), [redacted] DO, Pt's insurance is Senior Dimensions which obligates an admission to Platinum admitting group. Dr. Abella is covering for this group.
Talked with in-person at 1346.
Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.
Notes: Jennifer Allen, (12/08/2015 at 1138) scribing for and in the presence of [redacted] DO.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

I personally performed the services described in the documentation, reviewed and edited the documentation which was dictated to the scribe in my presence, and it accurately records my words and actions. [redacted] DO.

Electronically Signed By:
[redacted] *DO*

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Emergency Documentation - MD

DOCUMENT NAME: Admit ER Report
RECEIVED DATE/TIME: 12/8/2015 13:35 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] DO (12/8/2015 13:35 PST)
SIGN INFORMATION: [redacted] DO (12/8/2015 16:23 PST)

Admit Emergency Room Report
DATE OF SERVICE: 12/08/2015

The patient presents with some right-sided chest pain and shortness of breath, which has been ongoing since he had a thoracentesis for fluid by his pulmonologist a few weeks ago, seems to be worsening. When he talks or exerts himself, his oxygen comes down to about 90%; at rest, he is about 93 to 94%. The patient does have diminished lung sounds on the right. X-ray shows recurrent pleural effusion, but no pneumothorax. The patient does not need an emergent thoracentesis or chest tube. However, I talked with his pulmonologist, who would like an indwelling catheter placed that was ordered via IR. Pulmonology will see him here. He is stable, awake, alert, oriented. No pneumonia. Vital signs are otherwise within normal limits. The cause of the fluid is yet to be determined as his doctor is undergoing testing of the prior fluid sample to determine an etiology. Please see electronic medical record for a full ED course. He was admitted in stable condition.

[redacted] DO

NT / MedQ
D: 12/08/2015 13:35:40
T: 12/08/2015 15:14:07
Job #: 499065

Electronically Signed By:
[redacted] *DO*
On 12/08/15 16:23
Co Signature By:
Modified Signature By:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

DOCUMENT NAME: History and Physical
RECEIVED DATE/TIME: 12/8/2015 21:03 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] DO (12/8/2015 21:03 PST)
SIGN INFORMATION: DO (12/18/2015 10:09 PST)

History and Physical
DATE OF ADMISSION: 12/08/2015

CHIEF COMPLAINT: Shortness of breath.

HISTORY OF PRESENT ILLNESS: Mr. Rothwell is a very pleasant 74-year-old Caucasian male, who presents to the hospital complaining of shortness of breath. The patient states symptoms first began about a month and a half ago. He states he went to the urgent care a little over week ago because his symptoms had progressed to the point where he felt awful. At urgent care, they noticed that he had fluid on his lung and then they arranged for drainage. The patient underwent a thoracentesis on December 1st, with 1 L of fluid removed. The following day, he had a follow up appointment with the Pulmonology, with Dr. Tsui. Arrangements were made for a CT scan of the chest, which was supposed to be done tomorrow; however, the patient's symptoms worsened again, he became short of breath and had a dry cough, he had a very severe pleuritic pain and was unable to sleep. The patient states he called his pulmonologist, who advised him to come in to the emergency room. He denies any recent fevers, chills, flu-like symptoms. No weight loss. No history of cardiac problems in the past. He denies any other recent changes in his health.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Gout.

HOME MEDICATIONS:
1. Lisinopril/hydrochlorothiazide.
2. Allopurinol.

ALLERGIES TO MEDICATIONS: None.

PAST SURGICAL HISTORY: Appendectomy.

SOCIAL HISTORY: The patient has a distant history of tobacco use, smoked for approximately 25 years ago. Socially, drinks alcohol. No recreational drugs. Currently, lives at home with his wife.

[redacted]

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MRN: [redacted]
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Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

FAMILY HISTORY: Includes mother with cervical cancer. Father with heart attack at age 77.

REVIEW OF SYSTEMS: As per HPI. A 12-point review of systems is otherwise negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 36.5 degrees Celsius, heart rate 85, blood pressure 134/85, respiratory rate 16, O2 sats 92% on room air.
GENERAL: The patient appears to be in mild distress. He is awake, alert, and oriented x3. Appears well nourished. Good hygiene. Looks stated age.
HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light. Extraocular muscles intact. Conjunctivae clear. Nares clear. Oral mucosa moist.
NECK: Supple. No masses.
CARDIOVASCULAR: Tachycardic. Regular S1, S2. No murmurs, rubs, or gallops.
LUNGS: Bilateral rales.
ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds. No rebound. No guarding. No masses.
EXTREMITIES: No cyanosis, clubbing, or edema. Pulses intact.
SKIN: No rashes, lesions, or bruising.
NEUROLOGIC: Cranial nerves II through XII grossly intact. No focal deficits.

LABORATORY DATA: White blood cell count 8.7, hemoglobin 16.2, hematocrit 51.1, platelets 288. Sodium 138, potassium 4.7, chloride 101, bicarb 25, BUN is 19, creatinine 1.18, glucose 89.

IMAGING: Chest x-ray showing large right pleural effusion.

ASSESSMENT:
1. Acute respiratory distress.
2. Right pleural effusion.
3. Hypertension.
4. Gout.

PLAN:
1. The patient will be admitted for estimated length of stay greater than 2 midnights for evaluation and treatment of his respiratory distress and pleural effusion.
2. The patient has just undergone CT-guided chest tube placement. Chest tube currently intact. We will continue to monitor. Pulmonology has been consulted to the case. We will continue with recommendations. Initial fluid studies consistent with exudative process. We will follow culture results and cytology.
3. Check echocardiogram.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

4. Continue the patient's home blood pressure medications as needed.
5. P.r.n. pain and symptom control.
6. SVNs p.r.n. shortness of breath or wheeze.
7. Lovenox for DVT prophylaxis, and Protonix for GI prophylaxis.

[redacted] DO

VJA / MedQ
D: 12/08/2015 21:03:59
T: 12/08/2015 23:10:27
Job #: 478542

Electronically Signed By:
[redacted] *DO*
On 12/18/15 10:09
Co Signature By:
Modified Signature By:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-508374	12/8/2015 12:22 PST	Auth (Verified)	[redacted] DO

Reason For Exam
(XR Chest 1 View) Chest Pain

Report
EXAM: XR Chest 1 View 12/8/2015 12:28 PM

HISTORY: Chest Pain

COMPARISON: 8/27/2011.

TECHNIQUE: XR Chest 1 View

FINDINGS: There is a large right pleural effusion. Any underlying parenchymal pathology cannot be excluded. The left lung is clear. The heart is borderline in size with an uncoiled and partly calcified aorta. The trachea is midline. No destructive bony lesions.

IMPRESSION: 1. Large right pleural effusion. No mediastinal shift.

Report generated on workstation: SRMPACS052

FINAL*

Dictated by: [redacted] MD, Physician
Electronically signed by: [redacted] MD
Transcribed by: IP, T: 12/08/2015 12:29, S: 12/08/2015 12:29

****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Guided Needle Placement Bx/Asp/Inj	12-CT-15-234796	12/8/2015 16:02 PST	Auth (Verified)	[redacted] DO

Reason For Exam
(CT Guided Needle Placement Bx/Asp/Inj) recurrent pleural effusion CHEST TUBE/PIGTAIL, PER TRANCHELL/PULMONOLOGIST

Report
EXAM: CT Guided Needle Placement Bx/Asp/Inj 12/8/2015 4:16 PM

HISTORY: recurrent pleural effusion CHEST TUBE/PIGTAIL, PER TRANCHELL/PULMONOLOGIST

PROCEDURE:
The nature of the procedure with its benefits and potential complications including but not limited to infection, hemorrhage, pneumothorax, etc., were explained to the patient and the patient's questions were answered. Patient was then placed on the CT table in supine position. A timeout was called to confirm patient's identity and the procedure being performed.

Conscious sedation:Was not performed.
Medications:N/A
Conscious sedation length: N/A minutes of intra-service time.

An appropriate spot was marked on the right mid axillary line under CT guidance. This area was prepped and draped using maximum sterile barrier technique. Under CT guidance, a trocar needle system was used to gain access to the right pleural space. A guidewire was then placed into the right pleural cavity. The coaxial needle system was removed and the entry site was dilated with 6, 8, and 10 French dilators. At this time, a 10 French pigtail catheter was inserted into the right pleural space. It was secured to the skin and connected to a Pleur-evac suction system. Small volume of the aspirated fluid was sent to the laboratory for testing.. Images were stored for documentation purposes. Patient tolerated the procedure well and left the procedure area in stable condition.

IMPRESSION:
Status post successful CT-guided placement of 10 French pigtail catheter in the right pleural space. Fluid was sent to the laboratory for testing.

Report generated on workstation: SRSPACS019

FINAL*
Dictated by: [redacted] *MD, MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/08/2015 16:20, S: 12/08/2015 16:20
****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-512476	12/10/2015 14:23 PST	Auth (Verified)	[redacted] MD

Reason For Exam
(XR Chest 1 View) effusion

Report
EXAM: XR Chest 1 View 12/10/2015 2:31 PM

AGE: 74 years. DOB: [redacted] GENDER: Male.

HISTORY: effusion.

The right lung base is opaque but there is no layering pleural effusion. There may be a small subpulmonic pleural effusion. There is atelectasis or small pneumonia at the right base. The left lung is clear. No left pleural effusion. No CHF. Normal heart size. Tortuous aorta. Comparison with 12/8/2015.

IMPRESSION:
1. The right pleural effusion is much smaller.
2. Infiltrate in the right lower lung.

Report generated on workstation: SRSDDIM033

****F I N A L****

Dictated by: [redacted] MD, MD
Electronically signed by: [redacted]
Transcribed by: IP, T: 12/10/2015 14:32, S: 12/10/2015 14:32

****F I N A L****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

DOCUMENT NAME: Consultation
RECEIVED DATE/TIME: 12/10/2015 15:53 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] MD (12/10/2015 15:53 PST)
SIGN INFORMATION: [redacted] MD (12/11/2015 09:10 PST)

Consultation

DATE OF CONSULTATION: 12/10/2015

REFERRING PHYSICIAN: [redacted] DO

NEPHROLOGY CONSULT NOTE

DATE OF BIRTH: [redacted]

REASON FOR CONSULT: Evaluation of acute kidney injury.

HISTORY OF PRESENTING ILLNESS: Mr. Rothwell is a very pleasant 74-year-old Caucasian man with a history of hypertension and gout, who presented to hospital with complaints of shortness of breath. His symptoms started about a month and a half ago and he went to urgent care. The patient was diagnosed with pleural effusion, underwent thoracentesis. Outpatient, he has been on follow up with Dr. Tsui from Pulmonary Care. Patient apparently had a CT scan outside with possible pulmonary mass and lymph nodes. The patient had a chest x-ray with right-sided pleural effusion and infiltrate in the right lower lung. He underwent a CT-guided right-sided pigtail catheter placement for pleural effusion.

Nephrology now has been asked for evaluation of worsening kidney function. Creatinine on admission is 1.1. Current creatinine is 1.2 with a BUN of 30. The patient has been on ACE inhibitors. Does not report a recent NSAID intake. He does not report a prior history of acute kidney injury/chronic kidney disease. His blood pressure, the patient is hemodynamically stable with no significant hypotensive episode.

PAST MEDICAL HISTORY: Hypertension, gout, recent history of thoracentesis for pleural effusion.

MEDICATIONS: Home medications have been reviewed including lisinopril, hydrochlorothiazide, allopurinol.

ALLERGIES: HAVE BEEN NOTED.

PAST SURGICAL HISTORY: Appendectomy.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

SOCIAL HISTORY: Distant history of tobacco use, smoked for approximately 25 years ago. Socially, he drinks alcohol. No illicit drugs. He lives at home with his wife.

FAMILY HISTORY: Has been reviewed and noncontributory.

REVIEW OF SYSTEMS: Pertinent positives and negatives as per HPI. All other systems have been reviewed and are negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature is 36.4, pulse is 84, blood pressure is 134/85, respiratory rate is 20, and saturation 92% on 2 L.
HEENT: Head is atraumatic and normocephalic. Eyes, mild anemia. Extraocular movements intact.
NECK: Supple. No JVD. No masses.
CHEST: Decreased breath sounds at bases.
CVS: S1, S2 audible. No murmur, rub, or gallop.
ABDOMEN: Soft, nontender. No organomegaly.
NEURO: No focal deficits.
MUSCULOSKELETAL: No clubbing or cyanosis.
SKIN: There is no rash or ulcers.
LOWER EXTREMITIES: No lower extremity edema.

LABORATORY EVALUATION: Hemoglobin is 13.6, hematocrit 40, white count is 6.6, platelets 230, INR is 1.1. Sodium is 133, potassium 4, chloride 103, CO2 of 27, BUN is 30, creatinine is 1.3, calcium is 8.1, mag is 2, and CPK is 154, BNP is 116.

ASSESSMENT:
1. Acute kidney injury, likely prerenal being on ACE inhibitors. The patient with elevated BUN and creatinine ratio.
2. Hyponatremia, mild, likely volume depletion. We will rule out syndrome of inappropriate antidiuretic hormone secretion.
3. Recurrent pleural effusion status post right-sided chest tube placement. The patient with recent diagnosis of pulmonary mass and lung nodule.
4. Hypertension, currently controlled.
5. History of gout.

PLAN: I agree to continue on IV hydration with normal saline. We will hold off on ACE inhibitors. We will get a renal ultrasound to rule out obstruction. Check urine electrolytes/FENa and urine osmolality.

I expect the renal function to improve with hydration. The patient is being scheduled for a CT with oral contrast for further evaluation of pleural

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

effusion and lung mass.

Medications to be adjusted with GFR.

To avoid nephrotoxic medication and contrast agents.

We will replace electrolytes as needed.

We will continue to follow. Further management will depend on the results of ongoing testing and studies.

Once again, I would like to thank you, Dr. Abela for letting me participate in his care. Should you have any questions, please do not hesitate to contact.

[redacted] M.D.

IS / MedQ
D: 12/10/2015 15:53:13
T: 12/10/2015 20:39:21
Job #: 505013

Electronically Signed By:
[redacted]
On 12/11/15 09:10
Co Signature By:
Modified Signature By:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Chest+Abd/Pelv wo Con - EXP	12-CT-15-236421	12/10/2015 19:35 PST	Modified	[redacted] MD

Reason For Exam
(CT Chest+Abd/Pelv wo Con - EXP) mediastinal nodes/mass?

Addendum
There is a 3 cm soft tissue attenuation mass at the right aspect of the thoracic inlet, likely representing an enlarged lymph node.

Report generated on workstation: SRSDDIM033

****A D D E N D U M****
Addendum Dictated by: [redacted] *MD on 12/17/2015 01:24*

Electronic Signature: [redacted] *MD*
Transcribed By: IP, T: 12/17/2015 01:24, S: 12/17/2015 01:24
****A D D E N D U M****

Report
CT the chest, abdomen, and pelvis without contrast.

History: Short of breath.

Technique: Axial images were obtained from the lung apices to the lung bases without intravenous contrast. Oral contrast was administered

Findings:

No prior studies are available for comparison.

The heart is normal size, there is a mild pericardial effusion. The thoracic aorta is normal in caliber. The lungs are fully expanded demonstrating nodular consolidations in the right lower lobe, mild bilateral pleural effusions and basilar atelectasis. A right chest tube terminates in the pleural space adjacent to the base. There is nodular soft tissue in the right pleural space. There is significant mediastinal, hilar, adenopathy.

The liver, gallbladder, spleen, pancreas, and adrenal glands are unremarkable. The kidneys are normal in size and demonstrate no hydronephrosis or stone. There are multiple bilateral renal cysts, there is a large septated partially calcified cyst exophytic from the upper pole of the left kidney measuring 9 x 8 x 9.5 cm. The abdominal aorta is normal in caliber. The bowel is normal in caliber, the colon is filled with stool. The appendix is not visualized. The bladder is unremarkable, the prostate is enlarged. There is a tiny amount of free fluid in the abdomen and pelvis, no free air is seen in the abdomen and pelvis. The osseous structures are grossly intact and unremarkable.

Impression:
1. There are small bilateral pleural effusions, right greater than left. A right chest tube loops within the right pleural space. There is

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Chest+Abd/Pelv wo Con - EXP	12-CT-15-236421	12/10/2015 19:35 PST	Modified	AKBARULLAH,SYED MD

Report

nodular soft tissue in the right pleural space, worrisome for metastatic disease. Recommend biopsy.
2. Minimal ascites.
3. Enlarged prostate.
4. Fecal loading, no evidence of bowel obstruction.
5. Small pericardial effusion.

Report generated on workstation: SRSDDIM034

****F I N A L****

Dictated by: [redacted] *MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/10/2015 20:42, S: 12/10/2015 20:42

****F I N A L****

Report last revised on 12/17/2015 01:24 PST by [redacted] MD

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Guided Needle Placement Bx/Asp/Inj	12-CT-15-237255	12/11/2015 17:26 PST	Auth (Verified)	[redacted] MD

Reason For Exam
(CT Guided Needle Placement Bx/Asp/Inj) ct core biopsy right pleural mass.

Report
HISTORY: Right side Pleural based masses.

Procedure: I discussed in detail with the patient the procedure of the lung biopsy, including the possibility of bleeding and pneumothorax. Understood this and was agreeable to proceed. Timeout was completed. The patient was brought into the CT room, and scout images were taken. On the right side there is significant fluid remaining, although there is a drainage catheter in place. Towards the anterior portion of the lung in the lower right lung there is a nodular density, measuring 2.4 x 3.1 cm, and just adjacent to the anterior liver there is another location which is also mostly behind the rib. The first approach was for the larger process anterior to the liver, but the needle could not be placed adequately. The smaller nodule just posterior to a anterior rib was next targeted, and with a compound angulation approach a 22-gauge Chiba needle was placed in the midportion of the nodule, and 3 aspirations were done, with 4 slides and material in Cytolite. There is no bleeding from the area, and the last images showed no pneumothorax. No other abnormalities are seen. All of this material was brought to the pathology department for diagnosis.

IMPRESSION:
1. Biopsy of the anterior pleural-based nodule measuring 2.4 x 3.1 cm as detailed above.
2. No bleeding or other complication.

Report generated on workstation: SRSDDIM035

FINAL*

Dictated by: [redacted] MD, MD
Electronically signed by: [redacted] MD
Transcribed by: IP, T: 12/11/2015 18:00, S: 12/11/2015 18:00

****FINAL****

[redacted]

Name: [redacted]
MRN: 00805856
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-516100	12/13/2015 08:50 PST	Auth (Verified)	[redacted] MD

Reason For Exam
(XR Chest 1 View) effusion

Report
EXAM: XR Chest 1 View 12/13/2015 9:11 AM

COMPARISON: December 10, 2015

HISTORY: effusion

FINDINGS:
Interval increase in the volume of effusion in the right side. A small pigtail catheter is again seen in the right hemithorax. Left lung remains clear. No edema. Heart size is normal. Visualized osseous structures are unremarkable.

IMPRESSION:
1. Mild interval increase in right pleural effusion. A pigtail catheter is again seen in the right side of the chest.

Report generated on workstation: SRDDDIM029

FINAL*
Dictated by: [redacted] *MD, MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/13/2015 09:15, S: 12/13/2015 09:15
****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

DOCUMENT NAME: Consultation
RECEIVED DATE/TIME: 12/15/2015 16:58 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] MD (12/15/2015 16:58 PST)
SIGN INFORMATION: [redacted] MD (1/4/2016 16:08 PST)

Consultation

DATE OF CONSULTATION: 12/15/2015

CONSULTATION NOTE

DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: The patient is a 74-year-old gentleman who comes in here complaining of shortness of breath. He had significant right effusion, being drained thoracentesis with 1 L. He also had a biopsy, nothing has been indicative regarding his cytology or pain. However, CAT scan, although with noncontrast shows suspicious pleural based nodule lesions and also significant mediastinal adenopathy.

PAST MEDICAL HISTORY: Remarkable for hypertension, gout, and also tobacco use. He was a smoker until 1980, although has quit.

PAST SURGICAL HISTORY: Appendectomy.

ALLERGIES: TO MEDICATION IS NONE.

MEDICATIONS: Prior include lisinopril, allopurinol, hydrochlorothiazide.

SOCIAL HISTORY: He is in the Navy for a while, has worked on many ships. Smoker until 1980s. However, he has quit for more than 25 years. No drugs.

FAMILY HISTORY: Mother with cervical cancer. Father with heart attack.

REVIEW OF SYSTEMS: Denies any weight loss, although he says he lost weight in the hospital, most notably for right-sided pleural type chest wall pain and trouble breathing.

PHYSICAL EXAMINATION:
GENERAL: He is a white male, in somewhat moderate distress from respiratory standpoint.
HEAD: Atraumatic.
NECK: Supple.

[redacted]

Name: [redacted]
MRN: 00805856
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

LUNGS: His breath sounds are markedly diminished on the right side.
HEART: Appears to be regular.
ABDOMEN: Soft, nontender.
EXTREMITIES: Warm.
SKIN: Warm and dry.
NEUROLOGIC: Nonfocal.

ASSESSMENT AND PLAN: He has definite recurrent pleural effusion. I think the working diagnosis here obviously is malignancy and given his questionable mesothelioma exposure with pleural-based tumor os most likely mesothelioma. He has got two things I think to go after. I think at this point, easiest thing to do and probably the best _ would be mediastinoscopy. I think even if he had positive pleural based biopsy, we will have to do for complete staging. At this point, I would not like to do any any pleurodesis at this point, but we will work on diagnosis and finding a treatment plan before we talk about palliation or what not. We will plan for surgery_ tomorrow. I explained the risks, benefits, and necessity of surgery to him in detail. He understands and agrees to proceed, scheduled for tomorrow morning.

Thank you for this consult.

[redacted] M.D.

ND / MedQ
D: 12/15/2015 16:58:46
T: 12/15/2015 22:15:00
Job #: 515660

Electronically Signed By:
[redacted] *MD*
On 01/04/16 16:08
Co Signature By:
Modified Signature By:
[redacted] *MD*
On 01/04/16 16:08

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Operative/Procedure Reports

DOCUMENT NAME: Operative Report
RECEIVED DATE/TIME: 12/16/2015 11:52 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] MD (12/16/2015 11:52 PST)
SIGN INFORMATION: [redacted] MD (1/13/2016 19:37 PST)

Operative Report

DATE OF OPERATION: 12/16/2015

SURGEON: [redacted] M.D.

PREOPERATIVE DIAGNOSIS: Mediastinal adenopathy and right pleural-based mass.

POSTOPERATIVE DIAGNOSIS: Mediastinal adenopathy and right pleural-based mass.

PROCEDURE PERFORMED: Mediastinoscopy with multiple biopsies.

FIRST ASSISTANT: Jane Burger, (CST).

ANESTHESIA: General endotracheal anesthesia.

ANESTHESIOLOGIST: Alina Grigore, M.D.

COMPLICATIONS: None.

FINDINGS:
1. The patient with a large right paratracheal mass, whitish and firm in consistency.
2. Preliminary path favoring some type of malignancy, although origin and type yet to be determined.

ESTIMATED BLOOD LOSS: Less than 10 cc.

COMPLICATIONS: None.

STATEMENT OF MEDICAL INDICATION: The patient is a 74-year-old gentleman, who has recurrent right effusion with pleural-based masses, favoring possible metastatic spread and also large lymphadenopathy in his mediastinum, presents now in need of MED. He understands the risks, benefits, and necessities of surgery and agrees to proceed.

DESCRIPTION OF OPERATION: The patient was taken to the OR and placed in supine position after which lines and monitors were placed by the Anesthesia.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Operative/Procedure Reports

He underwent endotracheal intubation, after which he was prepped and draped in the usual normal sterile fashion for this procedure. Next, we made an incision one fingerbreadth above the jugular notch. We got into the plane. He had some crossing veins coming from his lower thyroid divided between clips. Once we got into the plane, we easily developed it bluntly. We could feel a hard mass, we put the mediastinoscope. We went all the way down to the carina then came back up corresponding to an area of a large mass. Once it was done, we could see a hard white mass poking out that was clearly very abnormal, clearly represented possible malignancy based on the gross appearance. We took multiple biopsies. We actually scored it with a knife, we cracked the harder outer coat and once we did, we took good representative biopsies, it was whitish and very firm. We had adequate tissue and definitely had the tissue in origin. This was the mass that represented on CAT scan. There is no other significant adenopathy that we could see grossly with this hard white mass and probably something even lower; however, this was the easiest one to get to. Once we were done with the biopsies, we had good hemostasis. We used fibrillar and held pressure, we saw no bleeding whatsoever. We closed the wound after local was given with layers of Vicryl subcu stitch for skin. In the meantime, I scrubbed out, looked at the films with the pathologist. There was no question that represented tissue favoring malignancy, maybe even gastric type and there were some large cells. She was not quite sure what she was looking at with the other stains, and we went ahead and sent the rest of it afresh. The patient was then extubated, and taken to recovery room in stable condition.

Neel Dhudshia, M.D.

ND / MedQ
D: 12/16/2015 11:52:02
T: 12/16/2015 23:10:13
Job #: 496146

Electronically Signed By:
[redacted] *MD*
On 01/13/16 19:37
Co Signature By:
Modified Signature By:
[redacted] *MD*
On 01/13/16 19:37

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Operative/Procedure Reports

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-522282	12/16/2015 12:00 PST	Auth (Verified)	[redacted] MD

Reason For Exam
(XR Chest 1 View) s/p thoracotomy

Report
EXAM: XR Chest 1 View 12/16/2015 12:04 PM

COMPARISON: 12/13/15

HISTORY: s/p thoracotomy

FINDINGS:
Pigtail catheter in the right lower hemithorax is again noted. Opacification of the right hemithorax with opacity in the right apex due to effusion. Minimal linear platelike atelectasis in the left midlung. Heart size is normal. Widening of the superior mediastinum is unchanged. No pneumothorax.

IMPRESSION:
Interval increase in the opacity in the right upper lobe near the apex. Status post pigtail catheter placement in the right lower hemithorax. The increasing opacity could be due to effusion.

Report generated on workstation: SRMDDIM032

FINAL*
Dictated by: [redacted] *MD, MD*
Electronically signed by: [redacted]
Transcribed by: IP, T: 12/16/2015 12:05, S: 12/16/2015 12:05
****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

DOCUMENT NAME: ICU History and Physical
RECEIVED DATE/TIME: 12/16/2015 22:41 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] MD (12/16/2015 22:41 PST)
SIGN INFORMATION: [redacted] MD (12/22/2015 22:11 PST)

ICU Admission History and Physical

DATE OF ADMISSION: 12/08/2015

REASON FOR ADMISSION: Status post mediastinoscopy.

HISTORY OF PRESENT ILLNESS: This 74-year-old white male has a history of smoking one pack of cigarettes per day for 25 years, quitting over 25 years ago in the 1980s. He worked on board ships in the Navy. He also worked on the Nevada Test Site as a procurer. The patient has one to two-month history of dyspnea on exertion. He saw a pulmonologist as an outpatient and apparently had a pleural effusion, status post thoracocentesis. He also had a pulmonary nodule that was undergoing workup, as well as lymphadenopathy. He was admitted on 12/08, after he had a thoracentesis on December 1, with 1 L fluid remaining. Because of his worsening shortness of breath, the patient was admitted for further workup. The patient had a pigtail catheter placed per IR on 12/08. On 12/10, he had CT scan of the chest, abdomen, and pelvis, which shows small bilateral pleural effusions, right chest tube looped within the right pleural space with nodular soft tissue density in the right pleural space worrisome for metastatic disease. There was an enlarged prostate. Note was made of multiple bilateral renal cysts with a large septated partially calcified cyst, exophytic from the upper pole of left kidney measuring 9 x 8 x 9.5 cm. No comment is made about this cyst and the radiologist comments.

The patient admits to some minor chest pain. He states his wife spoke with Dr. Dhudshia and he is unaware of any results back yet.

PAST MEDICAL HISTORY: He has a history of hypertension, history of gout.

PAST SURGICAL HISTORY: He is status post appendectomy.

ALLERGIES: HE HAS NO KNOWN ALLERGIES.

HOME MEDICATIONS: Include the following, lisinopril.

SOCIAL HISTORY: The patient has been married for 52 years, has three children. He served time in the service. After he exited the service, he went to college, and worked as a procurement person. He helped build

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

compounds for living in Sudan. He worked on the Nevada Test Site for some time. In the Navy, he was aboard ships frequently.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Positive for increasing shortness of breath recently. No headache, vision changes. The rest of the review of systems is unremarkable.

PHYSICAL EXAMINATION:
GENERAL: Reveals a well-developed, well-nourished, gentleman who is alert and oriented x3, no acute distress.
VITAL SIGNS: Blood pressure is 142/86, heart rate is 80, oxygen saturation is 95%, his breathing rate of 22.
HEENT: EOMI, PERRLA. Oropharynx is clear.
NECK: Supple. No lymphadenopathy. He is status post mediastinoscopy with a dressing located in his lower portion of his neck. There is no neck swelling. There is no crepitus. There is no hematoma.
LUNGS: Clear bilaterally. He does have a chest tube placed in his right pleural space to suction.
HEART: Regular rhythm. Normal S1 and S2. No murmurs, gallops, or rubs.
ABDOMEN: Soft, nontender. There is no hepatosplenomegaly. Bowel sounds are active.
EXTREMITIES: No cyanosis, clubbing, or edema.
NEUROLOGIC: Nonfocal.

LABORATORY DATA: Labs were reviewed and white blood count is 11.3, hemoglobin 14.7, platelet count is 285,000. Sodium 133, potassium 4.7, chloride is 100, bicarb 27, BUN 18, creatinine 0.91, glucose 101, total protein 5.7, albumin 2.1.

IMAGING DATA: Chest x-ray shows interval increase in opacity in the right upper lobe near the apex, status post pigtail catheter placement in the right lower hemithorax. Possibly, this could be due to effusion.

IMPRESSION:
1. Status post mediastinoscopy per Dr. Dhudshia with mediastinal biopsy, results of which are pending.
2. Recurrent right pleural effusion, status post tube thoracostomy.
3. Pulmonary mass, suspicious for carcinoma.
4. History of dyspnea for one to two months.
5. Small left pleural effusion exists, as well as a small pericardial effusion.
6. Remote history of smoking, 25-pack years, quitting in the 1980s.
7. Possible asbestos exposure - the patient worked on ships in Navy.
8. Possible radiation exposure - the patient worked at the Nevada Test Site.

[redacted]

Name: [redacted]
MRN: 00805856
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

History and Physical

9. Hypertension.
10.Gout.
11.Status post appendectomy.

PLAN: Plan is to admit the patient to ICU for further monitoring purposes overnight. Chest tube will remain in place. I do not anticipate a prolonged hospital stay. DVT prophylaxis will be SCD. GI prophylaxis will be Pepcid. Analgesia will be ordered. His home medications were resumed in the morning.

[redacted] MD

WGH / MedQ
D: 12/16/2015 22:41:30
T: 12/16/2015 23:09:51
Job #: 497573

CC: [redacted] MD

Electronically Signed By:
[redacted] *MD*
On 12/22/15 22:11
Co Signature By:
Modified Signature By:
[redacted] *MD*
On 12/22/15 22:11

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-522283	12/17/2015 01:15 PST	Auth (Verified)	[redacted] MD

Reason For Exam
(XR Chest 1 View) s/p thoracotomy

Report
EXAM: XR Chest 1 View 12/17/2015 1:18 AM

COMPARISON: December 16, 2015.

HISTORY: s/p thoracotomy

FINDINGS: The heart is normal size, the superior mediastinum remains widened. The lungs are fully expanded demonstrating stable right pleural effusion, no pneumothorax is seen.

IMPRESSION:
No significant interval change. The right pleural effusion is unchanged. No pneumothorax is seen. The widened superior mediastinum is likely related to right thoracic inlet adenopathy imaged on CT.

Report generated on workstation: SRSDDIM033

FINAL*

Dictated by: [redacted] *MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/17/2015 01:23, S: 12/17/2015 01:23

****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-524060	12/18/2015 05:51 PST	Auth (Verified)	[redacted]

Reason For Exam
(XR Chest 1 View) pleural effusion

Report
EXAM: XR Chest 1 View 12/18/2015 6:14 AM

COMPARISON: December 17, 2015.

HISTORY: pleural effusion

FINDINGS: The right chest tube is unchanged. The heart remains upper limits of normal in size, the superior mediastinum remains widened. The lungs are underinflated demonstrating a stable right pleural effusion. No pneumothorax is seen.

IMPRESSION:
No significant interval change.

Report generated on workstation: SRSDDIM033

F I N A L

Dictated by: [redacted] *MD*
Electronically signed by: [redacted]
Transcribed by: IP, T: 12/18/2015 06:15, S: 12/18/2015 06:15

F I N A L

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Chest+Abd/Pelv w Con - EXP	12-CT-15-242052	12/18/2015 17:08 PST	Auth (Verified)	[redacted] DO

Reason For Exam
(CT Chest+Abd/Pelv w Con - EXP) IV contrast only. Hx pleural mass w/ initial path c/w mesothelioma , eval for disease extent/mets

Report
EXAM: CT Chest+Abd/Pelv w Con - EXP 12/18/2015 5:23 PM

TECHNIQUE: Helical CT acquisition of the thorax, abdomen, and pelvis was done with IV contrast. Multiplanar reformats were done.

COMPARISON: Unenhanced CT chest, abdomen, pelvis from 8 days ago.

HISTORY: Staging mesothelioma.

FINDINGS:
CT thorax:
Pleural fluid and nodular pleural thickening is redemonstrated. The pleural thickening is up to 2.4 cm thickness in the anterior costophrenic angle. A mild pericardial effusion is redemonstrated. There is thoracic lymph node enlargement with right lower paratracheal lymph nodes up to 16 mm short axis diameter there is an AP window lymph node that is up to 11 mm short axis diameter. A right supraclavicular nodal conglomerate is partially imaged and measures up to 4.2 x 2 cm. The degree of right pleural effusion has increased. Pigtail catheter remains in place. There is positional atelectasis without discrete lung nodule/mass. Is there are no acute osseous findings.

Heart size is normal. There is coronary artery atherosclerosis. The central pulmonary arteries and thoracic aorta are of normal caliber.

CT abdomen:
There is some increased soft tissue attenuation involving the omentum and there is a tiny volume of ascites. There is no focal liver mass. There is generalized thickening of the gallbladder wall. Several cystic lesions are in the kidney bilaterally. One of these on the left has a small septation and also a 11 mm nodule. This largest lesion measures up to 9.3 x 7.8 cm.

There are no dilated or thickened bowel loops. Sigmoid diverticulosis without diverticulitis. No acute findings of the pancreas, spleen, or adrenal glands. Abdominal aortic caliber is normal.

CT pelvis:
The prostate is enlarged. New gas in the nondependent portion of the bladder probably from recent Foley catheterization. No acute osseous findings.

IMPRESSION:
1. Right pleural nodules up to 2.4 cm thickness compatible with mesothelioma. Right pleural effusion may be malignant. There are also abnormally enlarged bilateral mediastinal lymph nodes and a right supraclavicular lymph node. There is some increased

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Computerized Tomography

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
CT Chest+Abd/Pelv w Con - EXP	12-CT-15-242052	12/18/2015 17:08 PST	Auth (Verified)	[redacted]

Report

attenuation of the mesentery that could be related to early metastasis and there is trace ascites. A pericardial effusion is unchanged and could also be malignant in nature.
2. Circumferential thickening of the gallbladder is probably from underlying background illness rather than primary or metastatic gallbladder disease.
3. Large renal cysts. One of contains a thin septation and a small nodule compatible with a Bosniak category 2F cystic lesion.. Followup in 6 months is recommended.

Report generated on workstation: SRSDDIM034

****F I N A L****

Dictated by: [redacted] *MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/18/2015 17:38, S: 12/18/2015 17:38

****F I N A L****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

DOCUMENT NAME: Consultation
RECEIVED DATE/TIME: 12/18/2015 18:10 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] MD (12/18/2015 18:10 PST)
SIGN INFORMATION: MD (12/19/2015 08:17 PST)

Consultation
DATE OF CONSULTATION:

CHIEF COMPLAINT: The patient is a 74-year-old gentleman with possible mesothelioma.

HISTORY OF PRESENT ILLNESS: The patient has a 25-pack-year history of smoking. He has also worked aboard ships in the Navy back in the 1960s. The patient was found to have a pleural effusion, had thoracentesis, as well as lymphadenopathy. He was found to have atypical cells on FNA taken on 12/14 and the cells immunostained with CK7. The pathology will be sent to a tertiary center. On CAT scan of the chest from 12/18, the patient is noted to have right pleural nodules up to 2.4 cm in thickness compatible with mesothelial and also right pleural effusion.

The patient did have a pigtail catheter placed prior 12/08/2015 and it continues to worsen. The patient has been noted to have a large cyst in the upper pole of left kidney exophytic 9 x 8 x 9.5 cm.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Gout.

PAST SURGICAL HISTORY: Appendectomy.

ALLERGIES: NKDA.

MEDICATIONS: Lisinopril.

SOCIAL HISTORY: The patient is married for 52 years. He has worked in the service. He has lived in Sudan, worked on the Nevada Test Site.

REVIEW OF SYSTEMS: The patient has increasing shortness of breath. Chest tube is in place. Denies any nausea, vomiting, fevers, chills, or diarrhea at this time.

PHYSICAL EXAMINATION:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Consultation

VITAL SIGNS: Temperature 36.7, pulse 88, respirations 18, and blood pressure 113/73.
HEENT: NA.
NECK: No adenopathy.
CHEST: Clear to auscultation on the left. Right, chest tube is in place.
ABDOMEN: Benign.
EXTREMITIES: No edema.

LABORATORY STUDIES: White blood cell count noted for white count 12, hemoglobin 14.4, hematocrit 42.3, and platelet count is 290. Sodium is 131.

IMPRESSION:
1. Possible mesothelioma.
2. Pleural effusion.
3. Possible asbestos exposure.
4. History of tobacco abuse.

PLAN:
1. Follow up on pathology.
2. If the patient does have a mesothelioma, possibilities include surgery like decortication or extrapleural pneumonectomy versus experimental therapy versus a standard which will be cisplatin and Alimta. Navelbine is another alternative for this gentleman. This was thoroughly discussed with the patient.

[redacted] M.D.

RPG / MedQ
D: 12/18/2015 18:10:44
T: 12/18/2015 21:18:28
Job #: 502690

Electronically Signed By:
[redacted] *MD*
On 12/19/15 08:17
Co Signature By:
Modified Signature By:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-525447	12/19/2015 03:07 PST	Auth (Verified)	Lee,Audie PA

Reason For Exam
(XR Chest 1 View) pleural effusion

Report
EXAM: XR Chest 1 View 12/19/2015 3:18 AM

COMPARISON: December 18, 2015.

HISTORY: pleural effusion

FINDINGS: The heart remains slightly enlarged, the superior mediastinum is widened. The lungs are underinflated demonstrating stable vascular congestion and right pleural effusion. The right chest tube is unchanged.

Impression: No significant interval change.

Report generated on workstation: SRSDDIM033

****F I N A L****

Dictated by: [redacted] *MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/19/2015 03:18, S: 12/19/2015 03:18

****F I N A L****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-527155	12/20/2015 03:39 PST	Auth (Verified)	Lee,Audie PA

Reason For Exam
(XR Chest 1 View) pleural effusion

Report
EXAM: XR Chest 1 View 12/20/2015 3:45 AM

COMPARISON: December 19, 2015.

HISTORY: pleural effusion

FINDINGS: The heart remains slightly enlarged, the superior mediastinum remains widened. The right pleural effusion has increased in size. No pneumothorax. The right chest tube is unchanged in position. Impression: Increased right pleural effusion.

IMPRESSION:
No acute radiographic abnormalities in the chest.

Report generated on workstation: SRSDDIM033

****F I N A L****

Dictated by: [redacted] *MD*
Electronically signed by: [redacted] *MD*
Transcribed by: IP, T: 12/20/2015 03:47, S: 12/20/2015 03:47

****F I N A L****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 1 View	12-XR-15-530128	12/21/2015 10:56 PST	Auth (Verified)	[redacted] DO

Reason For Exam
(XR Chest 1 View) R pleural effusion

Report
EXAM: Chest 1 view

HISTORY: R pleural effusion

TECHNIQUE: AP Chest

COMPARISON: Chest x-ray 12/20/2015.

FINDINGS: Heart size appears stable. Previous right pleural effusion appears similar to the prior exam. Right-sided chest tube remains in similar position. No evidence for pneumothorax.

IMPRESSION:

Relatively stable chest radiographic appearance. Persistent right pleural effusion.

Report generated on workstation: SRMDDIM033

FINAL*

Dictated by: [redacted] *DO*
Electronically signed by: [redacted] *DO*
Transcribed by: IP, T: 12/21/2015 11:55, S: 12/21/2015 11:55

****FINAL****

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Interventional Radiology

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
IR Ins Cath Pleural w Imaging	12-IR-15-026532	12/22/2015 11:41 PST	Modified	[redacted] DO

Reason For Exam
(IR Ins Cath Pleural w Imaging) please remove current chest tube and place PleurX catheter for malignant RIGHT pleural effusion

Addendum
Medications:

No IV antibiotics.

0.5 mg IV Versed, and 50 mcg of fentanyl

Conscious sedation was administered by an independent interventional radiology Department nurse using a combination of IV Versed and IV fentanyl for duration of approximately 35 minutes.. Continuous cardiac, respiratory, and blood pressure monitoring was performed.

Report generated on workstation: SRMDDIM032

****A D D E N D U M****
Addendum Dictated by: [redacted] *MD MD3501 on 12/22/2015 15:54*

Electronic Signature: [redacted] *MDMD3501*
Transcribed By: IP, T: 12/22/2015 15:54, S: 12/22/2015 15:54
****A D D E N D U M****

Report
Exam: Tunneled chest drainage catheter placement under fluoroscopic guidance,

History: Pleural effusion.

Medications: IV 1 g Ancef

Fluoroscopy time: 3.8 minutes.

Procedure: A timeout was called first. Informed consent was obtained. The patient was placed on the angiography table in a supine position. The right lateral chest wall was prepped and draped in a routine sterile manner. 10 cc 1% lidocaine was provided for local anesthesia. The height lower pleural space was then accessed with a 5 French Yueh centesis needle. 10 cc 1% lidocaine with epinephrine was used for local anesthesia. Subsequently, a subcutaneous tunnel was created. The 15.5 French pleural catheter was brought through the tunnel. Over a stiff guidewire, the Yueh centesis needle was then exchanged for dilators for serial dilatation. A peel-away sheath was placed. Through this sheath, the tunneled chest catheter was advanced into the left pleural space under direct fluoroscopic guidance. The catheter was then hooked up to a vacuum bottle. Approximately 500 cc pleural fluid was removed. The patient tolerated the procedure well without any adverse reactions.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Interventional Radiology

PROCEDURE	ACCESSION	EXAM DATE/TIME	STATUS	ORDERING PROVIDER
IR Ins Cath Pleural w Imaging	12-IR-15-026532	12/22/2015 11:41 PST	Modified	[redacted] DO

Report
Conclusions:
1. A tunneled chest drainage catheter was placed as described above.

This procedure was performed by Adrian ream, RPA, under my direct supervision. I was present for all key elements of this procedure

Report generated on workstation: SRMDDIM032

****F I N A L****

Dictated by: [redacted] MD, MD3501
Electronically signed by: [redacted] MD
Transcribed by: IP, T: 12/22/2015 12:31, S: 12/22/2015 12:31

****F I N A L****

Report last revised on 12/22/2015 15:54 PST by [redacted] MD

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Discharge Summary

DOCUMENT NAME: Discharge Summary
RECEIVED DATE/TIME: 12/23/2015 11:36 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] DO (12/23/2015 11:36 PST)
SIGN INFORMATION: [redacted] DO (1/2/2016 09:08 PST)

Discharge Summary
DATE OF ADMISSION: 12/08/2015
DATE OF DISCHARGE: 12/23/2015
REFERRING PHYSICIAN: [redacted] MD

DISCHARGE DIAGNOSES:
1. Malignant right pleural effusion.
2. Suspected mesothelioma.
3. Acute respiratory distress.
4. Hypertension.
5. History of gout.
6. Acute kidney injury-resolved.

PROCEDURES: Mediastinoscope with multiple biopsies done on 12/16/2015 by Dr. Neel Dhudshia.

CONSULTATIONS:
1. Pulmonology, [redacted]
2. Nephrology,
3. Oncology,
4. CVT Surgery,

DIAGNOSTIC DATA:
1. Chest x-ray done on 12/08 showing large right pleural effusion. No mediastinal shift.
2. CT chest, abdomen, and pelvis without contrast done on 12/10 showing 3 cm soft tissue attenuation mass, right aspect of the thoracic inlet, likely enlarged lymph nodes, small bilateral pleural effusions, right greater than left, right chest tube loops within the right pleural space, nodular soft tissue in right pleural space, worrisome for metastatic disease, enlarged prostate.
3. CT chest, abdomen, and pelvis with IV contrast on 12/18 showing right pleural nodules up to 2.4 cm thickness compatible with left mesothelioma, right pleural effusion may be malignant, enlarged bilateral mediastinal lymph nodes and/or right supraclavicular lymph node. Increased attenuation of the mesentery that could be related to early metastasis and trace ascites. Pericardial effusion, unchanged. Large renal cyst.
4. Chest x-ray done 12/23 showing right-sided chest tube seen with the tip at apex, small right pleural effusion, and mild underlying vascular

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Discharge Summary

congestion.

HOSPITAL COURSE: Mr. Rothwell is a 74-year-old male, who presents to hospital complaining of shortness of breath. The patient was admitted for further evaluation and treatment. Initial laboratory work was fairly unremarkable including CBC and CMP. The patient had imaging done showing a large right pleural effusion. The patient recently had outpatient thoracentesis done. Pulmonology was consulted to the case due to the recurrent effusion, a decision was made for chest tube placement, this was done on 12/08/2015. Initial cultures and cytology from effusion were negative. The patient had a CT then done showing pleural mass and enlarged lymph nodes. This problem concern for malignancy and a malignant pleural effusion. Initially, a CT-guided biopsy was done; however, that result was inconclusive, therefore a CVT surgery was consulted and a mediastinoscopy was done with multiple biopsies. Pathology from the mediastinoscopy showed findings consistent with mesothelioma. The patient with a known history of working with Navy on ships. Pathology results were then sent to a tertiary center with final confirmation still pending at this point. After the initial path results came back, Oncology was consulted to the case. As the fusion appeared to be malignant, decision was made to place a PleurX catheter. This was done on 12/22/2015. The patient tolerated the procedure well. His hospital course was otherwise fairly unremarkable. The breathing remained stable. He is currently on 4 L nasal cannula. Plan is for discharge home with home health care. The patient is to follow up with Dr. Tsui, his pulmonologist, as well as with Dr. Gollard for final pathology results and possible palliative chemo. The patient agreeable and understanding of discharge plan.

DISCHARGE MEDICATIONS:
1. DuoNeb q.6 hours p.r.n., shortness of breath or wheeze.
2. Percocet 5/325 mg one to two tabs p.o. q.4 hours p.r.n. pain.
3. Lisinopril 20 mg p.o. daily.
4. Colace 100 mg p.o. at bedtime p.r.n. constipation.
5. Home oxygen 4 L.

[redacted]

VJA / MedQ
D: 12/23/2015 11:36:51
T: 12/24/2015 01:06:32
Job #: 532705

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS DIMC; 4424; P

DOB: [redacted] Age: 74 years Sex:M
Admit Date: 12/8/2015
Disch Date: 12/23/2015
Physician: [redacted] MD
PCP: Non Staff,Physician

Discharge Summary

Electronically Signed By:
[redacted] *DO*
On 01/02/16 09:08
Co Signature By:
Modified Signature By:

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex:M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted]
PCP: Non Staff,Physician

General Radiology

PROCEDURE	ACCESSION	EXAM DATE	STATUS	ORDERING PROVIDER
XR Chest 2 Views	12-XR-16-113583	3/1/2016 16:07 PST	Auth (Verified)	Reed,Harrison PAC

Reason For Exam
(XR Chest 2 Views) right pleural effusion 2/2 mesothelioma; now with clogged pleural drain

Report
EXAM: XR Chest 2 Views 3/1/2016 4:18 PM

HISTORY: right pleural effusion 2/2 mesothelioma; now with clogged pleural drain

COMPARISON: 12/23/2015.

TECHNIQUE: XR Chest 2 Views

FINDINGS: There is a moderate right pleural effusion. Any underlying parenchymal pathology cannot be excluded. A pleural catheter is seen within the right lower hemithorax. No pneumothorax is evident.

The left lung is clear. Left costophrenic angle is sharp.

The heart is borderline in size. The thoracic aorta is uncoiled and partly calcified. Widening of the superior mediastinum is felt to be related to tortuous great vessels.

No destructive bony lesions.

IMPRESSION: 1. Moderate right pleural effusion. Right pleural catheter is within the posterior pleural space. This patient may benefit from a CT scan for better assessment of the right basilar process.

Report generated on workstation: SRMDDIM032

*** F I N A L ***
Dictated by: [redacted] *Physician*
Electronically signed by: [redacted]
Transcribed by: IP, T: 03/01/2016 16:19, S: 03/01/2016 16:19
*** F I N A L ***

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex:M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted] DO
PCP: Non Staff,Physician

Emergency Documentation - MD

DOCUMENT NAME: ED Physician Notes
RECEIVED DATE/TIME: 3/1/2016 17:12 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: [redacted] DO (3/1/2016 17:32 PST)
SIGN INFORMATION: [redacted] DO (3/2/2016 16:26 PST)

Shortness of breath

Patient: [redacted] MRN: [redacted] FIN: 62574405
Age: **75 years** Sex: **M** DOB: [redacted]
Associated Diagnoses: **None**
Author: **Gowhari, Daniel DO**

Basic Information

Time seen: Provider Initial Contact Time
03/01/2016 14:55.
History source: Patient.
Arrival mode: Private vehicle.
History limitation: None.
Additional information: Chief Complaint (ST)
Chief Complaint ED: sob 03/01/16 15:13,
ED Triage Assessment: pleural vac is blocked, has not drained in 3 days. increased sob with same. denies cp. on intermittent home O2 03/01/16 15:13.

History of Present Illness

The patient presents with difficulty breathing. The onset was 2 days ago and gradual. The course/duration of symptoms is constant. The Exacerbating factors is exertion. The Relieving factors is none. Risk factors consist of hypertension, immunocompromised patient and not diabetes mellitus. Associated symptoms: denies fever. Hx mesothelioma s/p pleurx catheter in December 2015. Right chest drain last 3 days ago. Catheter non-functioning x 2 days. Here with shortness of breath with exertion. +Immunosuppression, currently on chemo. No fevers or diabetes. No sputum production and no hemoptysis. No bloodthinners.

Review of Systems

Constitutional symptoms: No fever, no chills.
Respiratory symptoms: Shortness of breath, no cough, no hemoptysis.
Cardiovascular symptoms: No chest pain, no palpitations.
Gastrointestinal symptoms: No hematemesis, No hematochezia, no abdominal pain, no nausea, no vomiting, no diarrhea.
Neurologic symptoms: No headache,
Additional review of systems information: All other systems reviewed and otherwise negative, Ten point review of system was conducted and otherwise negative, please see the HPI and MDM for any other questions.

Health Status

Allergies:
Allergic Reactions (Selected)
NKA.

[redacted] [redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex:M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted] DO
PCP: Non Staff,Physician

Emergency Documentation - MD

Medications: Include documented meds (Selected)

Prescriptions

Prescribed

albuterol-ipratropium NEB: 3 mL, NEB - inhalation, q6hr, 360 mL, PRN: Shortness of breath or wheezing

Documented Medications

Documented

allopurinol 300 mg oral tablet: 1 Tab, PO, qDay, 30 Tab, 0 Refill(s)
furosemide 20 mg oral tablet: 1 Tab, PO, qDay, 30 Tab, 0 Refill(s)
lisinopril 20 mg oral tablet: 1 Tab, PO, Daily
ondansetron 8 mg oral tablet: 1 Tab, PO, once, 10 Tab, 0 Refill(s)
prochlorperazine 10 mg oral tablet: 1 Tab, PO, TID, for 10 Day, 30 Tab, 0 Refill(s).

Past Medical/ Family/ Social History

Medical history:

All Problems (Selected)

Gout / 150085018 / Confirmed
HTN (hypertension) / 1215744012 / Confirmed
Mesothelioma of lung / 133183019 / Confirmed.

Surgical history:

Appendectomy (132967011).
Thoracentesis (151758012)..

Social history: Reviewed as documented in chart, Alcohol use: Occasionally, Tobacco use: former, Drug use: Denies.

Physical Examination

Vital Signs

Vital-Signs

03/01/2016 15:13	Temperature PO	36.8 deg C
	Heart Rate	90 bpm
	NIBP Systolic	123 mm Hg
	NIBP Diastolic	55 mm Hg
	Resp Rate (Monitor)	16 Breaths/Min
	SPO2	97 %
	Oxygen Amount	2 L/min
	Oxygen Method	Nasal cannula

Per nurse's notes.

General: Alert, no acute distress, awake and oriented, appropriate and non-toxic appearing.
Skin: Warm, dry, pink, no rashes or lesions.
Head: Normocephalic, atraumatic.
Eye: Pupils are equal, round and reactive to light, extraocular movements are intact.
Cardiovascular: Regular rate and rhythm, S1, S2, faint systolic murmur.

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex:M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted] DO
PCP: Non Staff,Physician

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Respiratory: good air movement, Respirations: no respiratory distress, Breath sounds: crackles left lung, diminshed right lung.
Chest wall: On exam: catheter site, clean, dry, no signs of infection, minimal debris in catheter.
Back: No costovertebral angle tenderness,
Musculoskeletal: Normal ROM, no swelling.
Gastrointestinal: Soft, Nontender (benign abdomen), Guarding: Negative, Rebound: Negative.
Neurological: No focal neurological deficit observed.
Psychiatric: appropriate mentation and thought processing.

Medical Decision Making

Documents reviewed: Emergency department nurses' notes, emergency department records, Patient was last seen in ED on 12/08/2015 and diagnosed with: 1. Atypical chest pain 2. SOB (shortness of breath) 3. Recurrent right pleural effusion.

Results review: Lab results : Laboratory

03/01/2016 16:10		
	WBC	11.0 K/uL
	RBC	4.02 M/uL
	Hgb	**12.0 gm/dL L**
	Hct	37.3 %
	Plt	**531 K/uL H**
	MCV	92.7 fL
	MCH	29.8 pg
	MCHC	32.1 gm/dL
	RDW	14.6 %
	MPV	7.9 fL
	Neut%	**82.0 % H**
	Lymph%	**7.9 % L**
	Mono%	8.4 %
	Eos%	0.8 %
	Baso%	0.9 %
	PT	**13.1 sec H**
	INR	**1.20 ratio H**
	PTT	35.1 sec

Radiology results: Reviewed radiologist's report, Radiologist's interpretation

Report : XR Chest 2 Views
IMPRESSION: 1. Moderate right pleural effusion. Right pleural catheter is within the posterior pleural space. This patient may benefit from a CT scan for better assessment of the right basilar process.

Notes: Please see dictation note for MDM.

[redacted]

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Reexamination/ Reevaluation
Vital signs
results included from flowsheet : Vital-Signs

03/01/2016 18:00	Temperature PO	36.8 deg C
	Heart Rate	78 bpm
	NIBP Systolic	108 mm Hg
	NIBP Diastolic	66 mm Hg
	Resp Rate (Monitor)	16 Breaths/Min
	SPO2	98 %
	Oxygen Amount	Room air

per nurse's notes
Time: 03/01/16 19:13:00 .
Vital signs
results included from flowsheet : Vital-Signs

03/01/2016 19:37	Temperature PO	37.1 deg C
	Heart Rate	84 bpm
	NIBP Systolic	116 mm Hg
	NIBP Diastolic	64 mm Hg
	Resp Rate (Monitor)	18 Breaths/Min
	SPO2	95 %
	Oxygen Amount	Room air

per nurse's notes
Course: improving, pt feels much better, would like to go home, refuses admission.

Procedure
Critical care note
Total time: 35 minutes spent engaged in work directly related to patient care and/ or available for direct patient care.
Critical condition(s) addressed for impending deterioration include: airway, respiratory.
Associated risk factors: hypoxia.
Management: bedside assessment.
Performed by: self.

Impression and Plan
Diagnosis
Symptomatic pleural effusion (ICD10-CM J90, Discharge, Medical)
Shortness of breath (ICD10-CM R06.02, Discharge, Medical)
Plan
Condition: Improved, Stable.
Disposition: Discharged: to home.
Patient was given the following educational materials: Pleural Effusion, Shortness of Breath, Easy-to-Read.

[redacted]

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Follow up with: St. Rose Interventional Radiology Within 1 to 3 days Call (702) 616-5585 to make appointment with interventional radiology to replace pleurx catheter.
Return if symptoms worsen or for any complaints. Take all medications as prescribed. Call for follow up appointment; Edward Clark Within 1 to 3 days Please follow up with primary care.
Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.
Notes: Sabryna Stasiewski (03/01/2016 at 17:12) scribing for and in the presence of [redacted] DO

I personally performed the services described in the documentation, reviewed and edited the documentation which was dictated to the scribe in my presence, and it accurately records my words and actions.

[redacted] DO.

Electronically Signed By:
[redacted]
On 03/02/16 16:26
Co Signature By:
Modified Signature By:
[redacted]
On 03/01/16 18:54

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex:M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted] DO
PCP: Non Staff,Physician

Emergency Documentation - MD

DOCUMENT NAME:	ED Report
RECEIVED DATE/TIME:	3/1/2016 19:48 PST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	[redacted] DO (3/1/2016 19:48 PST)
SIGN INFORMATION:	[redacted] DO (3/3/2016 06:26 PST)

Emergency Room Report
DATE OF SERVICE:

BRIEF HISTORY AND MEDICAL DECISION MAKING: This is a 75-year-old male with a history of a recent PleurX catheter to his right chest wall for history of malignant pleural effusion secondary to mesothelioma. For the last 3 days, it has not been draining well and has not functioned at all for the last 2 days and he is getting increasingly short of breath with dyspnea on exertion. He only endorses mild orthopnea. He is on chemo, but denies any sputum production, hemoptysis, or recent fevers. Chest x-ray does show a large pleural effusion. We were not able to make the PleurX catheter cap work, but we were able to drain it. He wants to go to chemo tomorrow and was given a number for Interventional Radiology for replacement of the PleurX catheter and agrees to return should the symptoms get worse. All of his symptoms resolved after the PleurX catheter was drained, 750 cc of fluid were removed. There is no evidence of a cardiopulmonary, cardiovascular, thrombotic, or infectious emergency, and he refuses admission to the hospital. He has the capacity to refuse admission and he is lucid and appropriate here with no evidence of distress or hypoxia. Discharge instructions provided in detail by myself to both the patient and patient's wife. All the questions answered.

DISCHARGE DIAGNOSES:
1. Symptomatic pleural effusion.
2. History of mesothelioma.
3. Shortness of breath (secondary to above).
4. Anemia (chronic).

[redacted] DO

DG / MedQ

Legend:	C=Corrected	*=Comment	H=High	L=Low

Lab Legend:	C=Critical	@=Corrected	*=Abnormal	H=High	L=Low	$=Interpretive Data	f=Footnotes

Laboratory Medical Director: [redacted] MD

Date/Time Printed: 7/1/2016 15:56 PDT

[redacted]

Name: [redacted]
MRN: [redacted]
Acct #: [redacted]
Pt loc: SRS ER2

DOB: [redacted] Age: 75 years Sex: M
Admit Date: 3/1/2016
Disch Date: 3/1/2016
Physician: [redacted]
PCP: Non Staff,Physician

Emergency Documentation - MD

D: 03/01/2016 19:48:44
T: 03/02/2016 03:34:55
Job #: 672714

Electronically Signed By:
[redacted]
On 03/03/16 06:26
Co Signature By:
Modified Signature By: