

Age: 79Y Sex: M
Attn: ~~St. Vincent Medical~~ R, MD
Loctn: IP/561A

St. Vincent Medical Center
2131 West Third Street
Los Angeles, CA 90057
Telephone (213) 484-7111

Complete Blood Count

Requested By: Diner, Elise L, PA

Test Date: 11/13/2018 05:53

Tue, 13 Nov 0553 Complete Blood Count

Status: supplemental

Collection Time : 13 Nov 18 0553
Specimen : Bld EDTA(4965640)

CPR Specimen # : Spec #4965640: 13 Nov 18 0553
White Blood Cells : 9.28 (3.5 - 10.5) K/UL
Red Blood Cells : 3.10 (4.32 - 5.72) M/UL
Hemoglobin : 9.4 (13.5 - 17.5) g/dL
Hematocrit : 28.9 (38.8 - 50.0) %
MCV : 93.4 (81.2 - 95.1) FL
MCH : 30.3 (27 - 31) PG
MCHC : 32.5 (32 - 36) g/dL
Platelet Count : 316 (150 - 450) K/UL
RDW : 13.9 (11.8 - 15.6) %
MPV : 7.5 FL
Neut (%) : 74.2 (50.0 - 70.0) %
Lymph (%) : 15.7 (20.0 - 40.0) %
Mono (%) : 6.4 (0.0 - 13.0) %
Eos (%) : 3.5 (0.0 - 5.0) %
Baso (%) : 0.2 (0.0 - 2.0) %
Absolute Neutrophil : 6.89 (1.7 - 8.0) K/UL
Absolute Lymphocyte : 1.45 (1.0 - 5.1) K/UL
Absolute Monocyte : 0.59 (0.0 - 0.8) K/UL
Absolute Eosinophil : 0.33 (0.0 - 0.5) K/UL
Absolute Basophil : 0.02 (0.0 - 0.2) K/UL
Diff Type : AUTOMATED

(13 Nov 18 061

Age: 79Y Sex: M
Attn: ~~St. Vincent Medical Center~~ R, MD
Loctn: IP/561A

St. Vincent Medical Center
2131 West Third Street
Los Angeles, CA 90057
Telephone (213) 484-7111

Comprehensive Metabolic Panel

Requested By: Diner, Elise L, PA

Test Date: 11/13/2018 05:53

Tue, 13 Nov 0553 Comprehensive Metabolic Panel

Status: complete

Collection Time	:	13 Nov 18	0553
Specimen	:	BldLiHep(4965641)	
Calcium	:	<u>7.1</u>	(8.4 - 10.2) mg/dL
Total Bilirubin	:	<u>1.0</u>	(0.2 - 1.2) mg/dL
Albumin	:	<u>1.8</u>	(3.0 - 4.5) g/dL
Total Protein	:	<u>5.1</u>	(6.2 - 8.2) g/dL
Alk Phos	:	59	(45 - 117) U/L
AST (SGOT)	:	25	(20 - 57) IU/L
Sodium	:	130	(130 - 145) mmol/L
Potassium	:	3.9	(3.5 - 5.5) mmol/L
Chloride	:	96	(98 - 107) mmol/L
Carbon Dioxide	:	27	(22 - 31) mmol/L
Creatinine	:	0.59	(0.55 - 1.30) mg/dL
BUN	:	7	(4 - 15) mg/dL
Glucose	:	<u>232</u>	(65 - 100) mg/dL
ALT (SGPT)	:	<u>20</u>	(21 - 72) IU/L
Anion Gap	:	7	(2 - 11) MMOL/L

(13 Nov 18 0643)

Age: 79Y Visit: 00082927781
Attn: ~~Stefan Michael~~ R, MD Sex: M
Loctn: IP/561A

St. Vincent Medical Center
2131 West Third Street
Los Angeles, CA 90057
Telephone (213) 484-7111

Prothrombin

Requested By: Diner, Elise L, PA

Test Date: 11/13/2018 05:53

Tue, 13 Nov 0553 Prothrombin

Status: complete

Collection Time : 13 Nov 18 0553
Specimen : Plasma(4965642)

Protime : 11.9 (9.7 - 11.7) SEC
INR : 1.2 (0.9 - 1.1) RATIO
INR :

INR NORMAL RANGE: 0.9-1.1
INR THERAPEUTIC : 2.0-3.0

(13 Nov 18 0612

Occupation Date/Time: Wed, 7 Nov 2018 1619
Report

: HISTORY OF PRESENT ILLNESS: The patient is admitted through the ER in the evening. He is admitted for a mass in the gallbladder and gallbladder fossa and gastric outlet obstruction. He is a 79-year-old man, who has chronic problems of prostatic hyperplasia, hypertension, and atrial fibrillation, managed on Vasotec, metoprolol, and flecainide, and Eliquis, Eliquis is 2.5 mg twice daily. He had been in his usual state of health. He chronically walks 3 miles a day without any exertional symptoms. He has no history of stroke or TIA or embolic events. He and his wife went on a holiday to visit family in Ireland, and about 2 weeks ago coming down the steps about 2:00 a.m. to have some tea, he lost his footing and stumbled and hit his right lateral chest wall on the edge of a cabinet. He had some pain. He saw local physician the next day, who gave him medication for nausea. There was no severe abdominal pain. The patient continued with his vacation. After a week in Ireland, went to Spain for a week with his wife, the 2 of them walked a great deal. He denied any abdominal or chest wall pain. There is no dyspnea or shortness of breath. He did have poor appetite, but no nausea or vomiting. He returned to the

Unscheduled History and Physical - Stefan, Michael R -- Cont --

States, has been having nausea and vomiting and inability to eat since his return. I saw him in office on 11/5. He was normotensive and afebrile. He had a nontender chest wall and abdomen. Liver and spleen are not palpable. Complaining of the hit that he took. He had a chest x-ray performed that was unremarkable except for borderline cardiomegaly and clear lung fields and a tortuous aorta. A rib series came back is negative for fracture. Laboratory studies were ordered and came back on the 6th showing normal liver and kidney function, normal glucose. Sodium was low at 129. He had a white count of 18000 with a left shift, hemoglobin 13.1, hematocrit 36.2, platelets were 397,000. The patient was informed of the findings of the x-ray and the labs. He still is having problems with keeping down any food or liquids. He was advised to come to the emergency room, so we could do imaging of his abdomen. He was seen by the ER staff. CT of the abdomen showed a complex mass and right gallbladder fossa involving the gallbladder with distention. There were no frank stones. There is questionable free air versus gas in the gallbladder wall. There is also distended stomach with fluid. He had a white count of 14000 with a slight anemia and hyponatremia. He has normal renal function and liver enzymes. Lipase was normal as well. The patient had placement of a nasogastric tube with 900

Scheduled History and Physical - Steran, Michael R -- continued
mL of fluid return. He was given IV Invanz and fluids.
He had a normal
lactate level. He was admitted to the telemetry unit
because of PVCs and
PACs, which is chronic. He has chronic atrial
fibrillation that was found
incidentally. He converted to sinus rhythm with beta
blockers. He has
been kept in sinus rhythm with use of flecainide along
with metoprolol,
Vasotec for hypertension, and Eliquis for stroke
prevention. He uses
Eliquis 2.5 mg twice daily. Last dose of Eliquis was on
the morning of
11/06/2018. The patient is admitted for the
abnormalities. He denies
abdominal pain or any GI symptoms prior to his trip and
his stumble and
hitting his chest. He has no history of gastrointestinal
diseases. Denies
prior to this admission fever, chills, jaundice, or
icteric urine.

ALLERGIES: None.

MEDICATIONS: Eliquis as mentioned 2.5 mg twice daily,
metoprolol twice
daily, Vasotec twice daily, finasteride daily, and
tamsulosin daily,
flecainide 50 mg twice daily, 2 tablets, 100 mg therefore.

PAST HISTORY: Negative for surgery or trauma or medical
admits.

SOCIAL AND FAMILY HISTORY: Married with a number of
children.

SYSTEM REVIEW: CONSTITUTIONAL: He has been in generally
good ongoing

health. No change in his status until the above-mentioned injury. Tobacco use is none. Ethanol use is rare.

HEAD: Denies headaches.

EYES: No visual impairment. No diplopia or glaucoma.

EARS: Negative for hearing loss, dizziness, or tinnitus.

NOSE: Negative for epistaxis or obstruction.

THROAT: Negative for hoarseness or dysphagia.

PULMONARY: Negative for lung disease, cough, wheezing, sputum production, or orthopnea.

CARDIAC: He has hypertension for many years. He was found to have atrial fibrillation on a routine office exam. Denies any problem with chest pain or palpitations. Echocardiogram in 2016 showed left ventricular hypertrophy, ejection fraction 60%, and mild left and right atrial enlargement. He has no exertional dyspnea. No complaint of orthopnea, leg edema, or palpitations. No history of stroke or TIA or embolic events. No history of MI or CHF or rheumatic fever or heart murmurs.

GI: As above with no history of disease.

GU: He has prostatic hyperplasia, elevated PSA. He has had prostate biopsy in the past. He has nocturia once or twice. Negative for kidney stones, blood in urine, or recurrent infections.

ENDOCRINE: Negative for diabetes or thyroid disease.

HEMATOLOGIC: Denies bleeding, bruising, anemia, transfusion, or thrombotic events.

NEURO: Negative for tremors, strokes, seizures, syncope, or transient ischemic attack. There is no disorder of speech and no weakness or paralysis of extremities.

PSYCH: Negative for confusion, memory loss, anxiety, depression.

MUSCULOSKELETAL: He has osteoarthritis. He had a swelling of the right wrist and hand in late 2017 that resolved. X-rays are negative for fracture.

PHYSICAL EXAM

VITAL SIGNS: In the ER, blood pressure was in the 170s, heart rate was 88, respirations are 18, O2 saturation is 98%. He is afebrile

GENERAL: He is a well-developed, well-nourished man, awake, alert, responsive, lying in bed, in no distress. Denies any problems with abdominal pain, chest pain, shortness of breath. He does have anorexia and nausea.

HEENT: Head is normal in shape and contour. Eyes are clear. Sclerae clear. Anicteric. Pupils equal, round, and reactive to light. EOMs are intact. Mouth and throat are clear. Pharynx is clear. Uvula and tongue midline. The mucosa is clear, and voice is strong.

NECK: Without venous distention, adenopathy, or thyromegaly. There are no bruits or neck vein distention. Carotid pulses are strong.

THORAX: Nontender without deformity.

LUNGS: Clear bilaterally.

CARDIAC: Shows a regular rhythm with premature beats without murmurs or gallops.

ABDOMEN: Soft, nontender. Bowel sounds are present. Liver and spleen are

Unscheduled History and Physical - Stefan, Michael R. - 11/5/11
not palpable. There are no masses or bruits.
GU: Normal external male.
EXTREMITIES: Warm without edema, deformities, or
varicosities. Pulses are
2+ in both upper and lower extremities distally. There
are no
varicosities.
NEUROLOGIC: Awake, alert, responsive. Speech is fluent.
Cranial nerves
are grossly intact 2 through 12. Grip is strong
bilaterally without
rigidity, tremor, dysmetria noted. On 11/5, gait was
within normal limits.

SKIN: Pale, clear, warm, and dry.

IMPRESSION AND PLAN: The impression at this time is
complex mass in the
right gallbladder fossa with distended gallbladder with
some thickening.
No frank stones. There is air suggesting emphysematous
cholecystitis
versus free air. He has a distended stomach with gastric
outlet
obstruction possibly. The patient will have NG tube
placed for
decompression of the stomach. Surgical consultation has
been requested.
He will continue n.p.o. and IV fluids and IV antibiotics
pending further
evaluation. The patient will be admitted. He will have
medications for
pain and nausea and ice chips only by mouth.

DIAGNOSIS: Mass in the gallbladder fossa, gastric outlet
obstruction,
hypertension, prostatic hyperplasia, chronic atrial
fibrillation, chronic
anticoagulant use. The patient and wife and attendant

- Scheduled History and Physical - Stefan, Michael R -- continued

family have been
advised of this finding, early diagnosis, and possible
course of action,
which may include surgical intervention. Of note, EKG
performed on 11/5
with a sinus rhythm with an intraventricular conduction
delay and
occasional PVCs, left axis deviation, which is unchanged
from prior EKG.

[Back](#)

Cautions: No Known Medication Allergy , No Known Other Allergy , No Known Latex Allergy , No Known Food Allergy
Code Status: Full Code

Admit Diagnosis	VT	HT (cm)	Adm WT (kg)	WT (kg)	Attending	LOS
PERFORATION , ACUTE CHOLECYSTITIS	IP	165.10	63.3	63.3	Steran, Michael R. MD	7

Electrocardiogram

11/08/2018 SUPPLEMENTAL
05:04

Test Reason : cardiac evaluation
Blood Pressure : ***/*** mmHG
Vent. Rate : 058 BPM Atrial Rate : 056 BPM
P-R Int : 154 ms QRS Dur : 130 ms
QT Int : 446 ms P-R-T Axes : 013 -54 091 degrees
QTc Int : 437 ms

Sinus bradycardia with Premature supraventricular complexes

Left bundle branch block

Abnormal ECG

When compared with ECG of 07-NOV-2018 12:27, (unconfirmed)

Left bundle branch block is now Present

Minimal criteria for Septal infarct are no longer Present

Cautions: No Known Medication Allergy , No Known Other Allergy , No Known Latex Allergy , No Known Food Allergy

Code Status: Full Code

Admit Diagnosis	VT	HT (cm)	Adm WT (kg)	WT (kg)	Attending	LOS
PERFORATION , ACUTE CHOLECYSTITIS	IP	165.10	63.3	63.3	Stacy, Michael, MD	7

Home Flow Medication Addn'l Lab Radiology Diag/Rpts Orders
Sheets

*History and Physical - ~~Stacy, Michael, MD~~ ER

Event Time	2018-11-07 16:19
Status	COMPLETE
Dictated By	Michael, Stacy, MD
Dictation Date/Time	Wed, 07 Nov 2018 1619
Report	HISTORY OF PRESENT ILLNESS: The patient is admitted through the ER in the evening. He is admitted for a mass in the gallbladder and gallbladder fossa and gastric outlet obstruction. He is a 79-year-old man, who has chronic problems of prostatic hyperplasia, hypertension, and atrial fibrillation, managed on Vasotec, metoprolol, and flecainide, and Eliquis, Eliquis is 2.5 mg twice daily. He had been in his usual state of health. He chronically walks 3 miles a day without any exertional symptoms. He has no history of stroke or TIA or embolic events. He and his wife went on a holiday to visit family in Ireland, and about 2 weeks ago coming down the steps about 2:00 a.m. to have some tea, he lost his footing and stumbled and hit his right lateral chest wall on the edge of a cabinet. He had some pain. He saw local physician the next day, who gave him medication for nausea. There was no severe abdominal pain. The patient continued with his vacation. After a week in Ireland, went to Spain for a week with his wife, the 2 of them walked a great deal. He denied any abdominal or chest wall pain. There is no dyspnea or shortness of breath. He did have poor appetite, but no nausea or vomiting. He returned to the States, has been having nausea and vomiting and inability to eat since his return. I saw him in office on 11/5. He was normotensive and afebrile. He had a nontender chest wall and abdomen. Liver and spleen are not palpable. Complaining of the hit that he took. He had a chest x-ray performed that was unremarkable except for borderline cardiomegaly and clear lung fields and a tortuous aorta. A rib series came back is negative for fracture. Laboratory studies were ordered and came back on the 6th showing normal liver and kidney function, normal glucose. Sodium was low at 129. He had a white count of 18000 with a left shift, hemoglobin 13.1, hematocrit 36.2, platelets were 397,000. The patient was informed of the findings of the x-ray and the labs. He still is having problems with keeping down any food or liquids. He was advised to come to the emergency room, so we could do imaging of his abdomen. He was seen by the ER staff. CT of the abdomen showed a complex mass and right gallbladder fossa involving the gallbladder with distention. There were no frank stones. There is questionable free air versus gas in the gallbladder wall. There is also distended stomach with fluid. He had a white count of 14000 with a slight anemia and hyponatremia. He has normal renal function and liver enzymes. Lipase was normal as well. The patient had placement of a nasogastric tube with 900 mL of fluid return. He was given IV Invanz and fluids. He had a normal lactate level. He was admitted to the telemetry unit because of PVCs and PACs, which is chronic. He has chronic atrial fibrillation that was found incidentally. He converted to sinus rhythm with beta blockers. He has been kept in sinus rhythm with use of flecainide along with metoprolol, Vasotec for hypertension, and Eliquis for stroke prevention. He uses Eliquis 2.5 mg twice daily. Last dose of Eliquis was on the morning of 11/06/2018. The patient is admitted for the abnormalities. He denies abdominal pain or any GI symptoms prior to his trip and his stumble and hitting

his chest. He has no history of gastrointestinal diseases. Denies prior to this admission fever, chills, jaundice, or icteric urine.

ALLERGIES: None.

MEDICATIONS: Eliquis as mentioned 2.5 mg twice daily, metoprolol twice daily, Vasotec twice daily, finasteride daily, and tamsulosin daily, flecainide 50 mg twice daily, 2 tablets, 100 mg therefore.

PAST HISTORY: Negative for surgery or trauma or medical admits.

SOCIAL AND FAMILY HISTORY: Married with a number of children.

SYSTEM REVIEW: CONSTITUTIONAL: He has been in generally good ongoing health. No change in his status until the above-mentioned injury. Tobacco use is none. Ethanol use is rare. **HEAD:** Denies headaches. **EYES:** No visual impairment. No diplopia or glaucoma. **EARS:** Negative for hearing loss, dizziness, or tinnitus. **NOSE:** Negative for epistaxis or obstruction. **THROAT:** Negative for hoarseness or dysphagia. **PULMONARY:** Negative for lung disease, cough, wheezing, sputum production, or orthopnea. **CARDIAC:** He has hypertension for many years. He was found to have atrial fibrillation on a routine office exam. Denies any problem with chest pain or palpitations. Echocardiogram in 2016 showed left ventricular hypertrophy, ejection fraction 60%, and mild left and right atrial enlargement. He has no exertional dyspnea. No complaint of orthopnea, leg edema, or palpitations. No history of stroke or TIA or embolic events. No history of MI or CHF or rheumatic fever or heart murmurs. **GI:** As above with no history of disease. **GU:** He has prostatic hyperplasia, elevated PSA. He has had prostate biopsy in the past. He has nocturia once or twice. Negative for kidney stones, blood in urine, or recurrent infections. **ENDOCRINE:** Negative for diabetes or thyroid disease. **HEMATOLOGIC:** Denies bleeding, bruising, anemia, transfusion, or thrombotic events. **NEURO:** Negative for tremors, strokes, seizures, syncope, or transient ischemic attack. There is no disorder of speech and no weakness or paralysis of extremities. **PSYCH:** Negative for confusion, memory loss, anxiety, depression. **MUSCULOSKELETAL:** He has osteoarthritis. He had a swelling of the right wrist and hand in late 2017 that resolved. X-rays are negative for fracture.

PHYSICAL EXAM

VITAL SIGNS: In the ER, blood pressure was in the 170s, heart rate was 88, respirations are 18, O2 saturation is 98%. He is afebrile. **GENERAL:** He is a well-developed, well-nourished man, awake, alert, responsive, lying in bed, in no distress. Denies any problems with abdominal pain, chest pain, shortness of breath. He does have anorexia and nausea. **HEENT:** Head is normal in shape and contour. Eyes are clear. Sclerae clear. Anicteric. Pupils equal, round, and reactive to light. EOMs are intact. Mouth and throat are clear. Pharynx is clear. Uvula and tongue midline. The mucosa is clear, and voice is strong. **NECK:** Without venous distention, adenopathy, or thyromegaly. There are no bruits or neck vein distention. Carotid pulses are strong. **THORAX:** Nontender without deformity. **LUNGS:** Clear bilaterally. **CARDIAC:** Shows a regular rhythm with premature beats without murmurs or gallops. **ABDOMEN:** Soft, nontender. Bowel sounds are present. Liver and spleen are not palpable. There are no masses or bruits. **GU:** Normal external male. **EXTREMITIES:** Warm without edema, deformities, or varicosities. Pulses are 2+ in both upper and lower extremities distally. There are no varicosities. **NEUROLOGIC:** Awake, alert, responsive. Speech is fluent. Cranial nerves are grossly intact 2 through 12. Grip is strong bilaterally without rigidity, tremor, dysmetria noted. On 11/5, gait was within normal limits.

SKIN: Pale, clear, warm, and dry.

IMPRESSION AND PLAN: The impression at this time is complex mass in the right gallbladder fossa with distended gallbladder with some thickening. No frank stones. There is air suggesting emphysematous cholecystitis versus free air. He has a distended stomach with gastric outlet obstruction possibly. The patient will have NG tube placed for decompression of the stomach. Surgical consultation has been requested. He will continue n.p.o. and IV fluids and IV antibiotics pending further evaluation. The patient will be admitted. He will have medications for pain and nausea and ice chips only by mouth.

DIAGNOSIS: Mass in the gallbladder fossa, gastric outlet obstruction, hypertension, prostatic hyperplasia, chronic atrial fibrillation, chronic anticoagulant use. The patient and wife and attendant family have been advised of this finding, early diagnosis, and possible course of action, which may include surgical intervention. Of note, EKG performed on 11/5 with a sinus rhythm with an intraventricular conduction delay and occasional PVCs, left axis deviation, which is unchanged from prior EKG.

CHART REVIEW FROM 10/1/17

* Abnormal

** Critical

Loc Patient Name Pt Number Visit Number Sex Age Attending
 [REDACTED] [REDACTED] [REDACTED] [REDACTED] M 79Y [REDACTED]

Date and Time	WBC	RBC	Hgb	Hct	MCV	MCH	MCHC	Plt	RDW	MPV	Neut %	Lymph%
30Oct2017 1550	8.00	4.02*	13.7	39.0	96.9*	34.2	35.3	234	12.8	7.9	69.7	20.6
06Nov2018 1840	14.34*	4.39	13.9	41.1	93.7	31.6	33.7	416	12.7	7.7*	81.7*	10.9*
07Nov2018 0519	14.64*	3.94*	11.9	37.0	93.8	30.0	32.0	368	12.7	7.8*	80.2*	11.1*
07Nov2018 2040	13.77*	3.36*	10.4	32.1	95.5*	31.0	32.5	323	12.9	8.1*	90.9*	3.8*
08Nov2018 0530	16.88*	3.33*	10.3	31.7	95.1	30.8	32.4	325	13.4	7.9	85.1*	8.4*
09Nov2018 0420	17.37*	3.26*	10.0	31.5	96.6*	30.8	31.9	325	13.4	7.5	89.3*	6.2*
10Nov2018 0600	13.21*	3.45*	10.6	33.2	96.1*	30.8	32.1	320	13.4	7.8	82.6*	10.3*
11Nov2018 0500	12.81*	3.31*	10.1	31.5	95.1	30.4	32.0	323	13.7	7.5	82.6*	10.3*
12Nov2018 0415	10.81*	3.38*	10.3	31.4	93.1	30.6	32.9	314	13.7	7.5	80.0*	12.6*
13Nov2018 0553	9.28	3.10*	9.4*	28.9	93.4	30.3	32.5	316	13.9	7.5	74.2*	15.7*

Chart Review Trend Report

* Abnormal

** Critical

Loc

Patient Name

Pt Number

Visit Number

Sex

Age

Attending

Date and Time	Mono	Eos	Baso	Abs	Abs	Abs	Abs	Abs
30Oct2017 1550	5.0	3.8	0.9					
06Nov2018 1840	6.5	0.7	0.3	11.	1.5	0.9	0.0	0.0
07Nov2018 0519	8.2	0.1	0.4	11.	1.6	1.1	0.0	0.0
07Nov2018 2040	4.8	0.2	0.3	12.	0.5	0.6	0.0	0.0
08Nov2018 0530	6.0	0.4	0.1	14.	1.4	1.0	0.0	0.0
09Nov2018 0420	4.0	0.3	0.2	15.	1.1	0.6	0.0	0.0
10Nov2018 0600	4.4	2.5	0.3	10.	1.3	0.5	0.3	0.0
11Nov2018 0500	5.3	1.6	0.3	10.	1.3	0.6	0.2	0.0
12Nov2018 0415	5.1	2.0	0.2	8.6	1.3	0.5	0.2	0.0
13Nov2018 0553	6.4	3.5	0.2	6.8	1.4	0.5	0.3	0.0