# Introduction to Medical Transcription Solutions

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**Exercise 1.1**

1. F Medical language specialist is synonymous with medical transcriptionist.
2. F The AAMT Code of Ethics contains standards of conduct and professionalism to guide the medical transcriptionist.
3. T
4. F An electronic medical record can be used simultaneously by more than one person.
5. F The job description by Hay Management Consultants identified three distinct professional levels for medical transcriptionists.
6. T
7. T
8. F Words can be added to medical speller software.
9. T
10. F The certification exam for medical transcriptionists can be taken after 2 years of acute care medical transcription experience.
11. F Quality of medical transcription is more important than quantity standards.
12. T
13. F The AAMT represents and advances the medical transcription profession.
14. T
15. T
Chapter 2
Solutions
## Answers to Review Exercises

### Exercise 2.1

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### Exercise 2.3

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Exercise 2.4
1. extension
2. flexion
3. Rotation
4. symmetric
5. supine
6. prone
7. recumbent
8. anterior
9. posterior
10. Abduction
11. Adduction
12. proximal
13. medial
14. distal
15. lateral
16. dorsal
17. ventral
18. eversion
19. inversion
20. inferior
21. superior
22. horizontal
23. vertical

Exercise 2.5
1. centimeter
2. millimeter
3. microgram
4. milligram
5. gram
6. kilogram
7. milliliter
8. before food
9. grain
10. milliequivalents
11. every hour
12. every 2 hours
13. twice a day
14. 4 times a day
15. 3 times a day
16. immediately
17. as desired
18. intramuscular
19. intravenous
20. subcutaneous
21. by mouth/orally
22. nothing by mouth

Exercise 2.6
1. access
2. radiology
3. excess
4. assess
5. vial
6. pleasant, thin
7. re-examined
8. 3-cm
9. long, interesting
10. 20-month-old, well-nourished
11. 5
12. adduction
13. pain
14. antipyretic
15. antidote
16. addiction
17. self-help
18. palpitations
19. pane
20. palpitation
CHART NOTE

Carl Adams
2, 20--

CHIEF COMPLAINT
Suture removal. Patient returns for removal of stitches placed about 8 days ago due to injury sustained when he hit the edge of the coffee table.

OBJECTIVE
Wound at the lateral aspect of the left eye looks well healed. Three 5-0 nylon sutures were removed without difficulty.

ASSESSMENT
Laceration, healed.

PLAN
I advised the mother to use vitamin E for scar prophylaxis.

John Blackburn, MD

JB:XX

D: 4/2/20—
T:
Chapter 2, Item 2

CHART NOTE

Cecelia Wert          April
2, 20--

SUBJECTIVE
Patient has been having spotting for the past few days. She had a baby 2 months ago and has not had a period since then. Her home pregnancy test was positive.

OBJECTIVE
There is minor tenderness of the pelvic region. Pelvic examination was not done.

ASSESSMENT
Spontaneous abortion.

PLAN
Refer to obstetrics for possible curettage.

John Blackburn, MD

JB:XX

D: 4/2/20—
T:
CHART NOTE

David Mendez
2, 20--

CHIEF COMPLAINT
Patient presents after having been in a motor vehicle accident.

HISTORY OF PRESENT ILLNESS
Patient states it was a low-speed, side collision. He was seat belted. There was no loss of consciousness. The patient complains of pain in his left shoulder at the joint area.

PAST MEDICAL HISTORY
Recently had reconstructive surgery of right ear.
ALLERGIC TO PENICILLIN.

PHYSICAL EXAMINATION
Vital signs are stable; afebrile. Primary survey was done with the patient on a backboard.
HEENT: Normal. Chest was nontender with good excursion. Lungs were clear. Abdomen was soft and nontender. Range of motion of all extremities was full. There was some tenderness of the left shoulder at the joint. Neurologic exam was within normal limits.

LABORATORY DATA
Cervical spine film was negative. Shoulder film shows a first-degree joint separation.

DIAGNOSIS
Motor vehicle accident resulting in left shoulder joint separation.

TREATMENT
Ice to shoulder. Patient is placed in shoulder immobilizer. Recheck in 3 days.

John Blackburn, MD
JB:XX
D: 4/2/20—
T: 
Chapter 2, Item 4

X-RAY REPORT

David Mendez
2, 20--

LEFT SHOULDER X-RAY
There is separation of the AC joint of the left shoulder. No displacement of structures. There are no abnormalities noted of the humerus. No fractures are identified.

John Blackburn, MD

JB:XX

D: 4/2/20—
T:
April 2, 20--

Ms. Mabel Ryerson  
13949 Adams Circle  
Denver, CO 80241-3820

Dear Ms. Ryerson

The mammogram you had on March 24 to monitor your fibrocystic breast disease was essentially unchanged. 

As we discussed it is recommended that you have a repeat mammogram in 1 year. 

If you have any questions, please do not hesitate to call my office and ask for my nurse.

Sincerely

John Blackburn, MD

JB:XX
HISTORY AND PHYSICAL EXAMINATION

Alison Beckman

2, 20--

CHIEF COMPLAINT
Routine health maintenance.

HISTORY
Patient is a 62-year-old, married, white female who was here for a yearly exam. She states she has been feeling well and has no specific concerns. Social history: She is currently not working out of the house.

PAST MEDICAL HISTORY
ALLERGIC TO PENICILLIN.
Nonsmoker. Denies any major illnesses. She has had a hysterectomy. Family history: Maternal grandmother had diabetes; mother had breast cancer.

REVIEW OF SYSTEMS
No complaints.

PHYSICAL EXAMINATION
HEENT: Negative. Thyroid is normal.
HEART, LUNGS, AND ABDOMEN: Within normal limits.
BREASTS: Soft bilaterally; no masses are felt. She states she does monthly breast self-exams.
PELVIC EXAMINATION: External genitalia are normal. Vagina is clear. Cervix is negative. Pap smear was not done.

IMPRESSION
Normal exam.

PLAN
1. Discussed diet and exercise.
2. Given lab requests for screening labs to be done fasting on April 6.
3. Mammogram to be scheduled.
4. Return to clinic 1 year, sooner PRN.

John Blackburn, MD

JB:XX

D: 4/2/20—
T:
Michael Weysik          April
2, 20--

SUBJECTIVE
Michael comes in today for a 15-month examination. Mother has no complaints. He is
feeding himself and putting 2 words together when talking. He is actually in motor and
growth development in the 22-month level.

He is above the 95th percentile for height and at the 95th percentile for weight.

OBJECTIVE
Head is normal. Ears are clear. Eyes are clear. Pupils are equal, round and reactive to
light and accommodation. Throat is clear. Nose is clear. Neck has good range of motion
without nodes. Lungs are clear. Heart has regular rate and rhythm. Abdomen is soft
without masses. Testicles are descended. Back is straight. He is walking well. He has
good muscle tone. See developmental forms in chart.

LABORATORY
Hemoglobin 12.5.

ASSESSMENT
Normal well-baby examination.

PLAN
Continue present diet and advance as tolerated. Immunizations were given; see form.
Recheck in
3 months, sooner if needed.

John Blackburn, MD

JB:XX

D: 4/2/xx
T: 
Chapter 2, Item 8

CHART NOTE

Reis Olsson

April

2, 20--

SUBJECTIVE
Reis came in for suture removal from a left knee wound. He is doing well.

OBJECTIVE
Wound appears dry and clean; there are no signs of infection.

ASSESSMENT
Suture removal.

PLAN
All 5 sutures were removed. Bandage was applied.

John Blackburn, MD

JB:XX

D: 4/2/20—

T:
April 2, 20--

Ms. Susan Yee Yang  
124 South River Court  
Denver, CO 80239-7250

Dear Ms. Yang

I am happy to report to you that the lab work you had performed on March 24 has returned and is normal.

As explained to you at your last visit to our office, you will need to continue having this monitored by blood tests every 2 weeks. Please stop in our office and pick up the lab request form on the way to the laboratory next time.

You are to continue your medications on the schedule that we discussed. If you have any questions about this schedule, please call my office to speak with my nurse.

Sincerely

John Blackburn, MD

JB:XX
April 2, 20--

Mr. Andrew Frank
ABC Construction Company
750 South Fillmore Street
Denver, CO 80209-5072

Dear Mr. Frank

RE: Warren Thomas  Social Security Number: 555-30-2930

Mr. Thomas was recently treated by me at Wilson Hospital. At that time I placed him on a disability leave. I felt his condition was such that he could not return to work until his symptoms had resolved.

Mr. Thomas was last seen by me on April 2. On re-evaluation it is apparent that he would be able to return to work on the 15th of next month. This is sooner than I anticipated, but it also reflects his positive progress.

If there are any other questions, please contact my office.

Sincerely

John Blackburn, MD

JB:XX
Chapter 3
Solutions
Exercise 3.1

Part 1
1. cold
2. skin
3. blue
4. skin
5. red
6. sweat
7. keratin
8. fat
9. black
10. pus
11. hair
12. within
13. under, below
14. inflammation
15. study of
16. tumor
17. condition of
18. disease
19. (surgical) repair
20. examination

Part 2
1. bluish color to skin
2. repair of the skin
3. inflammation of the skin
4. (specialty) study of the skin
5. sweating: perspiring
6. within the skin
7. condition of keratin layer
8. fatty tumor
9. black tumor
10. under the skin
11. disease of the hair
12. examination of the hair

Exercise 3.2
1. m
2. h
3. i
4. k
5. d
6. b
7. n
8. o
9. f
10. c
11. a
12. g
13. j
14. l
15. e
16. laceration
17. abrasion
18. erythema
19. ecchymosis
20. blister
21. eruption
22. macules
23. papules
24. vesicles
25. pustules
26. comedos
27. indurated
28. nodules
29. pruritus
30. antibiotics
31. analgesics
32. excoriation
33. fissure
34. purulent
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<td>3. h</td>
<td>3. mucus</td>
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<td>9. 2- x 3-inch</td>
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<td>10. d</td>
<td>10. Dr. LeToure</td>
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<td>17. Caucasian</td>
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<td>18. Sliverlike</td>
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<td>19. soared</td>
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SUBJECTIVE
Patient presents with blisterlike eruption around the corners of her mouth, present for 3 to 4 days.

OBJECTIVE
Erythematous, slightly scaly, papular lesions with a few small vesicles at the corners of the mouth. No pustules; no fissures.

ASSESSMENT
Herpes simplex; rule out impetigo.

PLAN
Patient placed on acyclovir 5% ointment to apply sparingly to rash. Recheck if not improving.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
April 5, 20--

Alan McDonald, MD  
6500 Eagle Street  
Denver, CO 80239-1287  

Dear Dr. McDonald  

RE: Patricia Smith-Wright  

Patricia Smith-Wright is being referred to you for treatment of a lesion on her upper chest. She states it is not painful or itchy and has not changed in size or color. She is concerned because it is unsightly.  

On examination the lesion is a 1-cm mole, uniform brown in color with irregular borders.  

My impression is that of a nevus, but we want to rule out basal cell carcinoma.  

It was recommended to her that she make an appointment at your office at her earliest convenience for treatment.  

Thank you for seeing and treating this patient.  

Sincerely  

John Blackburn, MD  
JB:XX
SUBJECTIVE
Mother brought 5-week-old baby in because of rash on his face and scalp which began about 2 weeks ago and has spread to his chest.

OBJECTIVE
He has some scaling of the scalp and oily crusting behind both ears and in scalp. He has a macular rash on cheeks and upper chest. There are no excoriated areas.

ASSESSMENT
1. Seborrheic dermatitis.

PLAN
Suggested warm mineral oil on scalp before shampooing. May use 1% hydrocortisone cream on face and chest once a day. Recheck at 3-month well-baby exam or p.r.n.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
Chapter 3, Item 4

CHART NOTE

Ronald Glazier

5, 20--

SUBJECTIVE
Patient is a 15-year-old male with increasing acne over the last 1 to 2 years. He has been using soap and Oxy 10 without improvement.

OBJECTIVE
On the face, neck, and upper back, there is mild to moderate acne. Lesions consist of maculae, papules, mild oily comedos, and an occasional nodule but no cysts or boils.

ASSESSMENT
Acne vulgaris, mild to moderate.

PLAN
Oxy 10. Retin-A 0.25-mg cream applied sparingly to facial lesions. E.E.S. 400 mg t.i.d. for 3 months. Recheck in 3 months.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
April 5, 20--

Alan McDonald, MD  
6500 Eagle Street  
Denver, CO 80239-1287

Dear Dr. McDonald

RE: Lee Yang

In the near future you will be seeing a patient of mine, Lee Yang. He has been seen by me several times for treatment of verruca on his hands. They have been resistant to liquid nitrogen treatment.

On examination of his hands, there is an approximate 4-mm growth over the dorsum of the proximal phalanx of index finger and a small lesion on the dorsum of middle finger, right hand. He also has a 3-mm verrucous growth on the left index finger near the nail.

Mr. Yang has agreed to see you and to follow your recommendations for this problem.

Thank you for assisting in the care of this patient.

Sincerely

John Blackburn, MD

JB:XX
Chapter 3, Item 6

CHART NOTE

Elizabeth Norbak                                      April
5, 20--

SUBJECTIVE
Patient presents with a "sliverlike" spot on the bottom of her right heel. She does not recall any injury. It has been present for some time and is beginning to cause pain with walking.

OBJECTIVE
There is an 8-mm black speck on the plantar aspect, right heel. There is no evidence of infection. It is somewhat tender.

ASSESSMENT
Plantar wart.

PLAN
The area was trimmed with a #15 blade and frozen with liquid nitrogen. Recheck in 3 weeks; cryotherapy may need to be repeated.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
PROCEDURE NOTE

Summer Raintree         April
5, 20--

CHIEF COMPLAINT
Patient noticed a red swollen lump on left neck. She denies fever, chills, or sweats.

EXAMINATION
On examination there is a cystic lesion with erythematous overlying skin measuring 3 x 4 cm in the left side of neck. The mass is fluctuant and slightly tender to touch. There is no enlargement of neck glands.

After explanation of the condition, including alternative treatment, the patient agreed to the procedure.

PROCEDURE
The area was steriley prepped and then injected with 1% lidocaine. A #11 blade was used to incise the cyst. A copious amount of purulent material and sebum were extracted. The wound was irrigated with sterile saline solution, packed with ¼-inch gauze, and sterile dressing applied. The sebaceous material was sent for culture.

DIAGNOSIS
Sebaceous cyst, infected, left neck.

PLAN
Keflex 250 mg q.i.d. for 10 days. Return in 2 days for recheck.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
PROCEDURE NOTE

Hank Rice
5, 20--

CHIEF COMPLAINT
Yesterday patient noticed a red swollen lump on his medial thigh. Today it is reddened and painful. He wonders if this is an ingrown hair.

OBJECTIVE
There is an indurated area measuring 3 cm in diameter in the proximal medial right thigh. In the center is a darker area of erythema with a small pustule. There is a wider area of erythema surrounding this, consistent with a cellulitis. There are no red streaks going up toward the groin.

Explanation of the process was given to the patient, and he agreed to having the procedure performed.

PROCEDURE
The abscessed area was cleansed with Betadine and anesthetized with 1% Xylocaine. An incision and drainage were done with a #11 blade. Scant pus was obtained. A pocket was curetted out and then packed with Iodoform gauze.

DIAGNOSIS
Abscess with cellulitis.

PLAN
Patient was given Ancef 1 gm IM. Tomorrow he is to start Keflex 500 mg q.i.d., #40 capsules. He was given Tylenol #3 for pain, 10 tablets. He is to remove the packing tomorrow and start warm soaks 3 times a day, 10 minutes each time. Signs of infection were discussed with him. He was told to return immediately if he notices any of these signs; otherwise, recheck in about 5 days.

John Blackburn, MD

JB:XX
D: 4/5/20—
T:
Chapter 3, Item 9

CHART NOTE

Nancy Hurr
5, 20--

SUBJECTIVE
Patient bumped her leg on metal shelving in the garage, sustaining a laceration. Bleeding has been controlled with pressure. Patient takes 1 aspirin per day for anticoagulant effect; she was on Coumadin but stopped it due to ecchymosis and bruising. Tetanus immunization is up to date.

OBJECTIVE
Examination of right leg reveals a deep V-shaped laceration with total length of 10 cm. It is oozing blood. No other abrasions or contusions are noted.

ASSESSMENT
Laceration, right leg.

PLAN
Wound was prepped in usual fashion. One bleeder was ligated with 4-0 Vicryl; smaller bleeders were cauterized. Subcutaneous closure was with 4-0 Vicryl; skin, with 5-0 nylon. Bacitracin, dressing, and Ace bandage were applied. Patient is advised to keep dressing clean and dry. Patient is to return for suture removal in 7 days.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
Chapter 3, Item 10

CHART NOTE

Teresa Bixby
5, 20--

SUBJECTIVE
This 16-year-old female presents with rash over her body. She was told in the past that this was scabies and was treated with antibiotic.

OBJECTIVE
Examination of extremities and abdomen shows nodularity and excoriations with scarring secondary to pruritus and scratching. There appear to be some linear tracks in the abdomen. Keloids have formed in a few places on legs secondary to chronic excoriation.

ASSESSMENT
Chronic scabies with excoriation.

PLAN
Prescription for Kwell to be applied to affected areas and left on overnight, then washed off in morning. Good hygiene was emphasized. All bedding and clothes need to be laundered. Recheck in 1 week.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
Chapter 3, Item 11

CHART NOTE

Lucas Everson
April 5, 20--

SUBJECTIVE
Child is 5 years old. His mother brings him in because he has an infected right big toe. Apparently she noticed redness, swelling, and some streaking on the dorsum of his right big toe last night. No fever.

OBJECTIVE
Temperature 98°. Examination of right foot indicates the presence of a small area of infection on the medial aspect of the toe adjacent to the toenail. This area is inflamed. He has slight streaking on the dorsum of the toe towards dorsum of foot medially. Mother states last night some purulent material came out.

ASSESSMENT
Paronychia, right big toe.

PLAN
Warm moist compresses 3 to 4 times per day in the next few days. Bacitracin to be applied. Keflex 250 mg/teaspoon, three-fourths teaspoon t.i.d. for 10 days. Recheck if not improved in 72 hours.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
Chapter 3, Item 12

CHART NOTE

Janet Grossman
5, 20-

SUBJECTIVE
Patient has a classmate who had lice. Note was sent from school. She has started to scratch her scalp.

OBJECTIVE
Scalp was examined. No definite head lice were identified. Several hairs were suspicious for eggs. There were also several areas of excoriation in the upper neck where she had been scratching.

ASSESSMENT
Pediculosis.

PLAN
Kwell shampoo with instructions. Wash bedding and anything else that was in contact with her head, such as caps. Return if further problems.

John Blackburn, MD

JB:XX

D: 4/5/20—
T:
Chapter 4
Solutions
Answers to Review Exercises

Exercise 4.1

1. w 14. r
2. f 15. v
3. x 16. m
4. t 17. g
5. l 18. j
6. y 19. q
7. o 20. p
8. i 21. c
9. s 22. k
10. b 23. h
11. u 24. e
12. d 25. a
13. n

Exercise 4.2

1. f 6. i
2. h 7. j
3. c 8. b
4. a 9. e
5. d 10. g

Exercise 4.3

1. nares 8. alveoli
2. pharynx 9. paranasal sinuses
3. larynx 10. eustachian tube
4. trachea 11. adenoids
5. thorax 12. tonsils
6. bronch 13. pleura
7. bronchioles

Exercise 4.4

1. bronchitis 6. sinusitis
2. bronchoscopy 7. pleuritis
3. laryngitis 8. pneumonitis/pulmonitis
4. laryngectomy 9. pneumonectomy/pulmonectomy
5. laryngoscopy
Exercise 4.5

1. followup
2. shoddy
3. 130-170 over 70-100
4. dysphasia
5. WBCs
6. follow through
7. 70 plus
8. course
9. supple
10. pleural
11. x3
12. 98.6°F
13. Coarse
14. plural
15. dysphagia
16. subtle
17. A+
18. palate
19. check up
20. doubly
21. 160/180
22. steriley
23. CO2
24. workup
25. shotty
Ronald Myers
April 10, 20--

SUBJECTIVE
Patient has a 2- to 3-day history of typical upper respiratory infection symptoms with hoarseness and mild sore throat.

OBJECTIVE
External auditory canals and tympanic membranes are clear. Oropharynx is not injected. Neck has no nodes. Chest is clear.

ASSESSMENT
Viral upper respiratory tract infection.

PLAN
Symptomatic therapy. Recheck if not improving.

Debra Litman, MD

DL:XX
D: 4/10/20--
T: 4/10/20--
Chapter 4, Item 2

CHART NOTE

Andrea Sandstrom        April 10, 20--

SUBJECTIVE
Patient complains of sore throat, stuffy nose, and low-grade fever.

OBJECTIVE
She has tenderness over both maxillary sinuses and injected nasal mucosa with swollen turbinates. Throat has postnasal drip. Neck is supple without lymphadenopathy. Lungs are clear without rales, rhonchi, friction rubs, or wheezes.

LABORATORY
Quick strep test is negative. White count normal at 8200.

ASSESSMENT
1. Sinusitis.
2. Nonstrep pharyngitis.

PLAN
Augmentin 250 mg t.i.d. Follow up p.r.n.

Debra Litman, MD

DL:XX

D: 4/10/20—
T:
Chapter 4, Item 3

CHART NOTE

Jordan Adams            April
10, 20--

SUBJECTIVE
Patient is a 5-year-old boy who is complaining of sore throat, dysphagia, fever, and chills this morning. He has had 2 documented strep throats this year.

OBJECTIVE
Temperature is 100.2°. Ears are clear. Throat is deeply injected with 4+ cryptic hypertrophic tonsils with exudate. Neck has marked tender cervical lymphadenopathy and submandibular adenopathy.

LABORATORY
Quick strep is positive for strep.

ASSESSMENT
Acute suppurative streptococcal tonsillitis and pharyngitis.

PLAN
He was given 1.2 CR Bicillin IM. He was observed for 20 minutes and discharged in satisfactory condition. He is to drink lots of fluids, rest for the next 24 hours, and use Tylenol p.r.n. Recheck in 5 days if not improved, sooner p.r.n.

Debra Litman, MD

DL:XX

D: 4/10/20—
T:
Dear Dr. Freeman,

RE: Anthony Walters

As we discussed in our telephone conversation this morning, I am referring Anthony Walters, a 7-year-old child, to you for management of his sore throat. His mother brought him in to the clinic today because of difficulty swallowing, sore throat, and inability to open his mouth.

On examination his temperature was 99.2°. He was in no distress except that he was not able to open his mouth beyond three-quarters of an inch. Eardrums were clear although he does have some scar tissue bilaterally (has had PE tubes x3). His oropharynx showed the right pretonsillar area is quite inflamed. The left side appeared normal. There was no exudate. Soft palate adjacent to the tonsillar area on the right side was inflamed and prominent. Submandibular lymph nodes were not enlarged, but there was minimal tenderness on the right side. No generalized lymphadenopathy.

LABORATORY: Hemoglobin 14.3; WBC 12,900 with 78% PMNs, 13% lymphocytes, and 9% monocytes. Mono test was negative. Rapid screen for group A beta strep was positive.

My assessment was right peritonsillar abscess associated with streptococcal infection.

He was started on Keflex 250 mg, 2 capsules t.i.d. for 10 days. I recommended that he use saline gargles 2 to 3 times a day for the next few days until they can get an appointment with you. If his condition worsens, his mother was told to take him to urgent care. The seriousness of this situation was discussed with his mother, and she will make an appointment for Anthony to be seen in your office as soon as possible.

Sincerely,
Janet Sullivan, MD  
Department of Pulmonary Medicine  
6500 Eagle Street, Suite 525  
Denver, CO 80239-1020

Dear Dr. Sullivan

RE: Jack Manly

In the near future you will be seeing Mr. Manly for evaluation of his lung condition. He is an elderly gentleman with a long history of chronic smoking. He presented today with complaints of cough productive of yellowish-green phlegm. He has been a pack-per-day smoker since his late teenage years. He states that over the last 3 days he has had fevers, shortness of breath, and dyspnea on exertion after walking 30 feet. He has noticed 1 time per night paroxysmal nocturnal dyspnea. His orthopnea is unchanged (uses 2 pillows). He is using his nebulizer every 4 hours.

On examination today his temperature was 99.0°; pulse 108; respirations 28. In general he is a thin male with mild tachypnea but no intercostal muscle retraction. HEENT: Ears are clear. Nasopharynx is congested with purulent discharge. CHEST: Increased AP diameter with increased sounds on percussion, decreased air sounds throughout the lungs with some diffuse scattered expiratory wheezing; no crackles were noted.

My diagnosis is bronchitis in a smoker with a history of emphysema.

He was placed on Bactrim and prednisone. We had a discussion regarding smoking cessation; he was strongly urged to quit.
I advised him to make an appointment in your office in the next few days. As I anticipate that you will perform pulmonary function evaluations, including spirometry, these were not done in my office at this time. Mr. Manly has agreed to follow your plan of treatment and will follow up with me as you dictate.

Sincerely

Debra Litman, MD

DL:XX
Chapter 4, Item 6

CHART NOTE

Claudia Stein
April 10, 20--

SUBJECTIVE
This is a 4-year-old female with about 6 days of nasal congestion and cough. She had been running intermittent low-grade fevers. Cough is becoming worse; it is congested. Coughs both day and night. Appetite and energy levels have decreased.

OBJECTIVE
Cooperative, but subdued. Ears and eyes are clear. There is mild audible nasal congestion. Throat is clear. Neck is supple without adenopathy. Lungs have good air entry bilaterally, but there are coarse rales in the right bases posteriorly and laterally. No wheezes, grunting, or retraction. Heart is normal. Abdomen is benign.

LABORATORY
Chest x-ray shows consolidation in the right middle lobe and infiltrates in the right lower lobe.

ASSESSMENT
Right middle and lower lobe pneumonia.

PLAN
Augmentin 250 mg chewable, 1 t.i.d. for 10 days. Push fluids for fever control. Recheck at end of treatment. Repeat chest x-ray in 6 weeks to verify clearing.

Debra Litman, MD

DL:XX

D: 4/10/20--
T:
Chapter 4, Item 7

CHART NOTE

Leonard Reichart          April
10, 20--

SUBJECTIVE
This 56-year-old male with emphysema is here today because of shortness of breath and increasing weakness. For the last 1½ months, he has had up to 3 times per night paroxysmal nocturnal dyspnea but denies problems of orthopnea. He is not smoking. He states he uses an albuterol inhaler for asthma and use of this seems to relieve the symptoms. He has also had a cough with some white sputum. No fevers or chills. No lower extremity edema.

OBJECTIVE
Thin, gaunt gentleman appearing older than his stated age. BP 150/62. Pulse 92. Respiration 30. Heart has regular rhythm; barrel chested. Lungs have fair to good air movement with diffuse expiratory wheezing and prolongation of the expiratory phase. Extremities are without edema.

LABORATORY
PA and lateral chest films reveal flattened diaphragms, increased AP diameter, and box-car lung shapes consistent with severe emphysema.

TREATMENT
Pulmonary function testing before and after albuterol treatment reveals severe obstructive changes with no improvement following treatment.

ASSESSMENT
Shortness of breath secondary to chronic obstructive pulmonary disease exacerbation.

PLAN
Refer to Janet Sullivan, Department of Pulmonary Medicine.

Debra Litman, MD

DL:XX

D: 4/10/20--
T:
Chapter 4, Item 8

CHART NOTE

Michael Hite
April 10, 20--

SUBJECTIVE
Patient presents with general malaise, fever to 103°, and cough occasionally productive of blood-tinged sputum for 1 day. He denies nausea or vomiting.

OBJECTIVE
Temperature 102.7°. He is in mild distress. HEENT: Nares are patent. Pharynx is markedly erythematous without exudates or ulcerations. Neck is supple with shotty anterior cervical lymphadenopathy bilaterally. Chest examination reveals rare scattered rhonchi which clear with cough.

X-RAY
There are mild fibrotic changes at both lung bases, over the right lung apex, and along the right chest wall laterally. Since the previous study of February 4, the increased markings at the right lung base are consistent with some early pneumonia, superimposed upon the underlying fibrotic changes described above. There is some deformity to the right rib cage, apparently reflecting several old, healed rib fractures. The heart size is normal.

ASSESSMENT
1. Viral syndrome.
2. Bronchitis with bronchospasm.

PLAN
Push fluids. Tylenol for fever. E.E.S. 400 mg q.i.d. for 10 days. Robitussin DM p.r.n. cough. Follow up in 3 days if symptoms do not improve.

Debra Litman, MD
DL:XX
D: 4/10/20—
T:
Chapter 4, Item 9

CHART NOTE

Duane Lofgren
10, 20--

April

SUBJECTIVE
This 8-year-old male has a cough that started last night and sounded quite croupy and a sore throat. No documented fever.

OBJECTIVE
Alert, well hydrated; in no acute distress. Afebrile. Ears: Both tympanic membranes are clear. Nose and throat: Very mild injection; no exudate; no enlarged tonsils. Neck is supple without adenopathy. Lungs are clear; no wheezing, rhonchi, or rales. Heart is without murmur.

ASSESSMENT
Croup.

PLAN
Suggested using a vaporizer, elevating his head, and pushing fluids. Robitussin DM at bedtime only. Return in 2 to 3 days if not showing signs of improvement. Discussed the normal course of croup. Parents were told to take the child to an urgent care facility if symptoms worsen, he has difficulty getting his breath, or he turns dusky colored.

Debra Litman, MD

DL:XX

D: 4/10/20---
T:
April 10, 20--

Tomas Berez, MD
3499 Dexter Street
Denver, CO 80207-2312

Dear Dr. Berez

RE: Charles Jefferson  Chart No. 128933

Mr. Jefferson will be making an appointment to see you in the very near future. He is a 57-year-old gentleman who has had emphysema for many years, and it has become progressively more severe. At this time he presents with complaints of increasing weakness, particularly with minimal exertion. This is undoubtedly related to his severe emphysema.

I have not instituted any change in his therapy as he plans to see you within the week, and he will follow your recommendations.

I am enclosing my office notes for your review. Please don't hesitate to contact me if you need further information.

Sincerely

Debra Litman, MD
DL:XX
Enclosure
Chapter 5
Solutions
Answers to Review Exercises

Exercise 5.1

1. hematology
2. angiocardiography
3. arrhythmia or dysrhythmia
4. arteriogram
5. echocardiogram
6. septicemia
7. hematocyte
8. hematoma
9. leukocytosis
10. cardiomegaly
11. leucopenia
12. arteriosclerosis
13. hemostasis
14. phlebotomy, venotomy
15. vasodilator
16. cardiomyopathy
17. splenectomy
18. cytologist
19. leukemia

Exercise 5.2

1. h
2. b
3. g
4. c
5. o
6. a
7. n
8. k
9. i
10. m
11. l
12. c
13. j
14. d
15. f

Exercise 5.3

1. electrocardiogram
2. complete blood count
3. myocardial infarction
4. red blood (cell) count
5. white blood (cell) count
6. blood pressure

Exercise 5.4

1. e
2. a
3. d
4. c
5. b

Exercise 5.5

1. e
2. f
3. a
4. j
5. i
6. h
7. e
8. b
9. d
10. g
Exercise 5.6
1. 4,500-10,500
2. anemia
3. pancreatitis
4. potassium
5. sodium
6. prothrombin
7. around 2

Exercise 5.7
1. regimen
2. and/or
3. 4 p.m.
4. II and III
5. cul-de-sac
6. erythema
7. sight
8. q.i.d.
9. infection
10. cited
11. iliac
12. arthrosclerosis
13. QS-wave
14. n.p.o.
15. arrhythmia
16. q.8.h.
17. grade 1/6 to 2/6
18. T-wave
19. arthrosclerosis
20. p.r.n.
SUBJECTIVE
Patient is still complaining of swelling, edema, and tenderness of her left lower leg since her injury to her leg in February. Patient was diagnosed with possible vascular insufficiency. She had her leg x-rayed twice, and it was negative. Patient's main complaint is the swelling.

OBJECTIVE
She has 2+ pedal edema and slight tenderness over the edema itself. She has good dorsalis pedis pulse. The ankle is clear. She has superficial varicose veins on the leg.

ASSESSMENT
Pedal edema, could be secondary to varicose veins or vascular insufficiency.

PLAN
Since symptoms are not improving, venous Doppler ultrasound will be scheduled to evaluate for DVT. She was informed that she might have to use TED stockings for the rest of her life.

Lynn Solinski, MD
LS:XX
D: 4/12/20—
T:
HISTORY AND PHYSICAL EXAMINATION

Marietta Henley
12, 20--

CHIEF COMPLAINT
Severe headache.

HISTORY OF PRESENT ILLNESS
This is a 35-year-old black female with known sickle cell disease. She developed a severe headache and was tremulous tonight. She has been sleeping poorly and is quite nervous.

PAST MEDICAL HISTORY
ALLERGIC TO PENICILLIN.
She notes her hemoglobin runs about 8 g%, and she requires transfusions when it is 6 or lower. She has had gallbladder surgery. She has had no recent infections.

PHYSICAL EXAMINATION
GENERAL: Patient is alert and oriented. BP 132/68; pulse 100; respirations 24; temperature 98.4°. She is quite nervous and has a fine tremor.
SKIN: Mild jaundice.
HEENT: Pupils are equal and reactive; fundi appear normal.
NECK: Supple.
LUNGS: Clear.
CARDIAC EXAM: Regular, but there is a grade 1/6 systolic murmur.
ABDOMEN: Soft and nontender. Spleen is not palpable. Liver is palpable about 2 fingerbreadths below the right costal margin.
EXTREMITIES: Free of edema.

LABORATORY DATA
Hemoglobin 6.9. White count 12,900.

TREATMENT
She was given Demerol 50 mg and Vistaril 25 mg IM, and her pain was markedly relieved.

DIAGNOSES
1. Headache.
2. Sickle cell anemia.

(continued)
Marietta Henley, Page 2
History and Physical Examination
April 12, 20—

RECOMMENDATION
Ativan 1 mg q.8 h. as needed for anxiety or sleep. Percocet 1 q.6 h. as needed for pain, #12. Increase fluid intake. She felt well enough to go home. She will follow up in 48 hours for recheck of CBC. She was apprised of her 6.9 hemoglobin today. She is discharged in stable condition.

Lynn Solinski, MD
LS:XX
D: 4/12/20—
T:
CHART NOTE

Renee Eckstrom
12, 20--

SUBJECTIVE
Renee is a 26-year-old female who presents with swelling, redness, and tenderness in the left lower extremity, present for the past 24 hours becoming more swollen. She has some pain with walking. It is worse after being on her feet throughout the day. She denies any direct trauma to this area. About 2 years ago, she suffered a similar problem and was told to wear support hose, which she has not done. She is on birth control pills. She is a nonsmoker.

OBJECTIVE
LEFT LOWER EXTREMITY: She has localized erythema, induration, tenderness, swelling, and obliteration of the greater saphenous vein with varicose changes noted distally and proximally. Sensation is decreased. Pulses are excellent.

ASSESSMENT
Chronic venous insufficiency of greater saphenous system with superficial thrombophlebitis; no evidence of deep venous thrombosis.

PLAN
Ibuprofen 600 mg b.i.d. with food. Warm compresses to the affected area for 30-60 minutes t.i.d. Elevate leg when sitting. Recheck in 1 to 2 weeks, sooner if no improvement.

Lynn Solinski, MD
LS:XX
D: 4/12/20—
T:
SUBJECTIVE
This 61-year-old male has a problem with nosebleeds. No history of nose trauma. Hemorrhage comes on spontaneously about every 2 weeks. He may go a couple of months without one and then gets one every day for a few weeks. The bleeding may start at rest and occasionally with exertion. Previously he has been able to stop the bleeding with pressure on the nose. He has no other bleeding problems. He states he has been on antihypertensive medications in the past but is not currently taking anything.

OBJECTIVE
BP 174/70; pulse 80. He has some dried blood in the right nostril. There is no active bleeding at this time, but there is a small clot over the anterior midseptum which may be the bleeding site.

ASSESSMENT
1. Hypertension.
2. Recurrent epistaxis.

PLAN
Patient was given Procardia sublingually with blood pressure dropping to 140/70. Vaseline jelly was applied to the right nostril anteriorly. Patient was instructed in treatment of nosebleeds if they recur. He is to start Procardia XL 1 daily. Patient will need to have his blood pressure monitored with daily checks at home and recheck in the office in 5 days. If epistaxis continues he may need to be referred to an otolaryngologist.

Lynn Solinski, MD
LS:XX
D: 4/12/20—
T:
CHART NOTE

Bryant Andres
12, 20--

SUBJECTIVE
This is a 42-year-old male with 4 days of swelling and pain in the rectal area. He had a hemorrhoid incised a year ago.

OBJECTIVE
There is a 3-cm edematous, thrombosed hemorrhoid at about 9 o'clock position. Marcaine and 1% lidocaine were infiltrated into the area with immediate relief. A small incision was made and clot expressed. Packing was then placed.

ASSESSMENT
Thrombosed hemorrhoid.

PLAN
Patient to change dressing, cleanse area, use Americaine ointment. He is to use Advil for pain and, if needed, Tylenol with codeine which he states he has at home. Return if swelling does not continue to improve and/or he has prolonged bleeding.

Lynn Solinski, MD
LS:XX
D: 4/12/20—
T:
April 12, 20--

Merlin Williams, MD  
300 Central Avenue  
Lakewood, CO 80134  

Dear Dr. Williams  

RE: Alyssa Babcock  
DOB: 11/25/--

Thank you again for referring Ms. Babcock to us. She is being discharged from the hospital today and will return to your care. I will briefly summarize her care and hospitalization.

As you recall Ms. Babcock is an 82-year-old white female who came to our office for consultation of her coronary artery disease.

PAST MEDICAL HISTORY: She was status post 3-vessel CABG 7 years ago. Over the past several months, she has noted increasing angina. When I saw her in the office on April 1, she was complaining of fatigue and increasing episodes of substernal aching pressure with minimal physical exertion. The symptoms were temporarily relieved by rest and taking nitroglycerin tablets. She has a history of hypertension and 3-pillow orthopnea. Her last cholesterol was 293.

MEDICATIONS: Digoxin 0.125 mg p.o. daily and nitroglycerin 0.4 mg p.r.n. for anginal attacks.

Family history: Positive for arteriosclerotic heart disease, congestive heart failure, and vascular insufficiency.

PHYSICAL EXAMINATION: My initial examination in the office showed the patient to be a well-developed, well-nourished, elderly female in acute distress due to chest pain. VITAL SIGNS: Weight 181. BP 160/94; pulse 92; respirations 26 and regular. HEENT: Within normal limits. CHEST: Clear bilaterally.
HEART: Regular rhythm with a normal S1 and S2 and a 2/6 late systolic ejection murmur. There were no other murmurs or gallops. There was no jugular venous distention.
ABDOMEN: Soft and nontender with normal bowel sounds. Negative for abdominal masses.
EXTREMITIES: Peripheral pulses were palpable, but decreased with 1+ edema.
LABORATORY: ECG shows acute myocardial infarction with peaked Ts laterally as well. There is reciprocal depression in leads I and II. The chest x-ray is negative. Mediastinum looks normal size. WBC 20.1; hemoglobin 13.8.

She was admitted urgently for evaluation of her angina and scheduled for cardiac catheterization. She was administered oxygen and medication for pain relief. A cardiac angiogram was performed on April 1. She was noted to have a thrombosed graft to her left anterior descending artery. The graft to her left circumflex was patent. She was seen by the cardiac surgeon, Dr. Selkirk, and scheduled for coronary artery bypass to her left anterior descending artery on April 2.

Following surgery the patient did quite well. Her chest tubes were pulled, and she was transferred from cardiac intensive care to the cardiac unit. She did not suffer any postoperative complications. She was discharged from the hospital on the fifth postop day.


DISCHARGE MEDICATIONS: Digoxin 0.125 mg p.o. daily; Coumadin 2.5 mg on even days and 5 mg on odd days; and Advil or ibuprofen 1-2 tablets q.4 h. p.r.n. pain.

FOLLOW-UP CARE: She is to return to your office for continuing care. She will need a lipid profile to monitor her hypercholesterolemia, prothrombin times for monitoring her Coumadin, a digoxin level, and electrolyte check.

Thank you for your referral of this interesting patient. She has done well, and I anticipate no difficulties related to this procedure.

Sincerely

Lee W. Kim, MD, Consultant

LWK:XX
April 12, 20--

Margaret Downing, MD
6500 Eagle Street, Suite 700
Denver, CO 80239-1700

Dear Dr. Downing

RE: Derek Wood

This letter is to inform you that your patient, Derek Wood, has returned to our office. As you may recall, he was referred by you in January for a persistent tachycardia.

He was seen in our office on January 13 and failed to return for followup after his Holter monitor had been completed. He states he continues to have problems with palpitations on almost a daily basis, but all of these episodes are short-lived. He has never had problems with associated chest pain, shortness of breath, or loss of consciousness with any of these episodes.

For the last 2 months, he has been having some fleeting left arm pain which occurs 3 to 4 times per day but only lasts 1 to 2 seconds. He knows of no alleviating or aggravating factors. He has not tried any modalities to prevent or relieve his symptoms.

Today on examination his blood pressure is 136/70, and pulse is 120.

Holter monitor had revealed basic sinus rhythm. Heart rates were generally 62-98. Sinus tachycardia was seen rarely with rates as high as 132/minute. Sinus bradycardia was seen rarely with rates as low as 48/minute. Supraventricular ectopics were seen 62 times. Paroxysmal atrial tachycardia was seen once lasting 11 beats at 161/minute. Ventricular ectopics were seen 0 to 1 time/hour. Symptomatic episode of “funny heart beat” seen with PAT. Lightheadedness was seen with no unusual ECG changes.

His diagnosis remains paroxysmal atrial tachycardia. He was given a prescription for Atenolol 25 mg by mouth every day. He is to follow up with me in 2 weeks, sooner p.r.n. At a future visit, his anxiety and stress disorder need to be addressed.

Sincerely

Lee W. Kim, MD, Consultant

LWK:XX
HISTORY AND PHYSICAL

Trent Wilson            April
12, 20--

CHIEF COMPLAINT
Weakness.

HISTORY OF PRESENT ILLNESS
This 81-year-old male presents because of extreme and sudden weakness. He apparently was in his bathroom and had a bowel movement. He got up from the toilet and felt extreme weakness and became lightheaded and faint.

PAST MEDICAL HISTORY
History of congestive heart failure. He is on multiple medications including Cardizem, enalapril 5 mg every day, Lanoxin 0.25 mg every day, and Lasix 40 mg every day.

PHYSICAL EXAMINATION
There was no postural change in blood pressure. BP 113/60 with pulse 50, sitting. BP 111/55 with pulse 50, standing. He denies lightheadedness at this time.
HEENT: Unremarkable.
NECK: No jugular venous distension. Carotid pulses equal without bruits.
LUNGS: Clear.
HEART: S1 and S2 are normal; no systolic or diastolic murmurs; no S3, S4. No dysrhythmia.
ABDOMEN: Essentially soft with active bowel sounds. There was no particular tenderness nor mass felt.
EXTREMITIES: Unremarkable. Pulses including carotid, radial, femoral, and dorsalis pedis are strong and equal bilaterally.

LABORATORY DATA
Hemoglobin 12.3. White count 10,800. Normal electrolytes with creatinine of 1.6. ECG shows sinus bradycardia, but no other acute changes.

DIAGNOSIS
Weakness on the basis of sinus bradycardia, probably Cardizem or Lanoxin induced. However, given the normal potassium, I would doubt that his digoxin level is markedly increased.

TREATMENT
Check digoxin level, and call patient if abnormal. He was instructed to change positions slowly when going from sitting to standing, etc. Recheck p.r.n.

Lynn Solinski, MD

LS:XX
Lisa Swankoski, MD
Ivy Lane Clinic
1241 Ivy Lane
Denver, CO 80220-1872

Dear Dr. Swankoski

RE: Ali Saarken  DOB: 4/1/--

Your patient, Ali Saarken, was recently hospitalized for cardiac catheterization, which was performed without complications. The catheterization revealed left main-stem artery to be normal. There was a very mild calcification at the proximal portion of the left anterior descending with a 50% stenosis just prior to the takeoff of the first diagonal. The ostium of the first diagonal is involved with the same stenosis and represents for that artery perhaps a 70% narrowing. Left ventriculogram revealed mild hyperkinesis of the anterolateral segments suggesting the diagonal artery had been the lesion causing her myocardial infarction.

She will be returning to your office for ongoing care. Thank you for asking us to assist in the care of this interesting patient.

Sincerely

Lee W. Kim, MD, Consultant

LWK:XX
Chapter 6
Solutions
Answers to Review Exercises

Exercise 6.1
1. incision into common bile duct (gallbladder) to remove stones
2. visual exam of esophagus and stomach using an instrument
3. enlargement of the liver
4. doctor who specializes in the stomach and intestines
5. new opening into the jejunum
6. toothache
7. pertaining to the mouth
8. valve between ileum and cecum
9. prolapse of rectum
10. create new (artificial) cutaneous opening of colon
11. x-ray of bile ducts (gallbladder vessels)
12. forming permanent opening between duodenum and jejunum
13. removal of pancreas
14. incision into the abdominal wall
15. suturing the lip
16. inflammation of salivary glands
17. disease of liver
18. hemorrhage in small intestine
19. swallowing air
20. pertaining to the tongue and pharynx

Exercise 6.2
1. gastritis
2. appendicitis
3. cholecystitis
4. esophagitis
5. pharyngitis
6. pancreatitis
7. hepatitis
8. enteritis
9. stomatitis
10. colitis

Exercise 6.3
1. colitis
2. dyspepsia
3. proctoscopy
4. lapartomy
5. choledolithiasis
6. gastroscopy
7. ileostomy
8. colostomy
9. duodenum
10. gastrostomy
11. enteric-
12. pharyngitis

Exercise 6.4
1. j
2. i
3. e
4. m
5. a
6. h
7. l
8. f
9. n
10. c
11. b
12. k
13. d
14. g
Exercise 6.5
1. alkaline phosphatase
2. amylase
3. abnormal
4. within
5. transaminase

Exercise 6.6
1. reflux
2. lose
3. fecal
4. third-floor
5. liver
6. New Zealand
7. loose
8. reflex
9. asphagia
10. fecal
11. dissention
12. Dr. Bently’s and Dr. Wilson’s
13. 2 weeks’
14. Neoplasms."
15. distended
16. weekend?”
17. livor
18. slow-moving
19. midabdomen
20. hazel-green
SUBJECTIVE
Patient has been having problems with diarrhea for about 3 weeks. She had 3 loose bowel movements today. She has been feeling very tired and complains of on/off abdominal pains. She wonders if her diarrhea has anything to do with increasing her Lanoxin 0.25 mg although she has been taking that dose for about 10 days.

OBJECTIVE
Pulse 116. BP is under control.
CHEST: Clear.
HEART: Regular.
ABDOMEN: Reveals vague epigastric and lower abdominal tenderness, no muscle guarding, and no rebound.

LABORATORY
White count is down to 11,000 from 13,400. Potassium is 3.5.

ASSESSMENT
1. Gastrointestinal disturbance, possibly viral, and possibly a reaction to Lanoxin.
2. Slight hypokalemia.

PLAN
Lomotil 2.5 mg q.3 h. p.r.n., K-Dur 20 mEq b.i.d. Continue Lanoxin. Tylenol #3 for pain. She will call if she continues to have problems and may need to consider stool culture.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
Jeanne Raymond
15, 20--

CHIEF COMPLAINT
Nausea, vomiting, and abdominal pain.

HISTORY OF PRESENT ILLNESS
Patient has had 3 episodes of midepigastric colicky pain, nausea, and vomiting during the past
2 weeks. There has been some diarrhea with these episodes. Stool is normal color; patient
denies clay-colored stools.

PAST MEDICAL HISTORY
States she always has some degree of anorexia. No fatty food intolerance. No
medications.

PHYSICAL EXAMINATION
VITAL SIGNS: Normal.
SKIN: No jaundice. Mucous membranes are moist.
EYES: Clear without icterus.
LUNGS: Clear.
CARDIAC: Normal rate and rhythm.
ABDOMEN: Soft with upper right quadrant tenderness to deep palpation; no guarding,
rebound, or other tenderness.

LABORATORY DATA
White count was 14,300. Normal electrolytes. Amylase was within normal limits.
Ultrasound of the gallbladder demonstrated a 1-cm stone in the gallbladder and no
wall thickening. Ducts were not dilated.

DIAGNOSIS
Cholelithiasis.

PLAN
Case was discussed with the surgeon who will see her for possible cholecystectomy in the
near future.

Lynn Solinski, MD

LS:XX

D: 4/15/20—
T:
April 15, 20--

Lia Luez, MD
Department of Gastroenterology and Rectal Surgery
Eagle Medical Center
6450 Eagle Street
Denver, CO 80239-7251

Dear Dr. Luez

RE: Cecil Razido

This letter is in followup of our conversation on April 12. My April 10 examination included the following:

HISTORY OF PRESENT ILLNESS: This 40-year-old male has approximate 12-year history of chronic ulcerative colitis. He presents with abdominal pain over the last several weeks. He has had increasing cramps and decreasing appetite over the last week. He had an emesis x1 two days ago. Denies melena or blood in his stools. There have been no fevers, shaking chills, or other systemic symptoms.

PAST MEDICAL HISTORY: He has been treated with Metamucil and an antispasmodic in the past. He had a laparotomy years ago following a motor vehicle accident. He had a stricture in his GI tract 5 years ago secondary to ulcerative colitis, which was treated with prednisone.

EXAMINATION: Oropharynx is clear. HEENT, neck, lungs, and heart are normal. Abdomen shows positive bowel sounds without guarding or rebound. There is minimal tenderness to palpation in the LUQ; no masses are noted. Rectal exam shows a small amount of brown stool, which is guaiac negative.

LABORATORY: White count 11,500 with 60% neutrophils. Hemoglobin 15.4. Sodium 138; potassium 3.7; chloride 101; CO2 of 30; BUN 9; glucose 107; creatinine 0.9; calcium 9.7; SGOT 8; bilirubin 0.4; alkaline phosphatase 104; and amylase 34.
Flat and upright x-ray of the abdomen is within normal limits.

DIAGNOSIS: Chronic ulcerative colitis with exacerbation.
PLAN: Mr. Razido will be seeing you in the near future for your evaluation and treatment recommendations.

Thank you for assisting in the care of this patient.

Sincerely

Lynn Solinski, MD

LS:XX
CONSULTATION

Carol Gregg
15, 20--

CHIEF COMPLAINT
Nausea and “stomach pain.”

HISTORY OF PRESENT ILLNESS
Patient complains of dyspepsia, nausea, and epigastric discomfort which she describes as a constant burning for several weeks. It was initially treated successfully with Tagamet but has recurred over the last couple of weeks. She states she gets nauseated when she is around food. Tagamet relieves her symptoms somewhat. Stress, spicy foods, alcohol, and Motrin seem to exacerbate her condition. She has not consumed any chocolate, tea, or coffee.

PAST MEDICAL HISTORY
The patient has had frequent bouts of nausea on/off over the past 4 to 5 years. She has not seen a physician for this condition until now. She had appendicitis and an appendectomy at age 17.

ALLERGIES
None.

MEDICATIONS
Motrin 600 mg b.i.d. and Tagamet p.r.n.

Family history: Mother has been diagnosed with diverticulitis following gastric resection for an ulcer. Father has a hiatal hernia.

Social history: Patient is a 25-year-old female who works as a credit consultant in a local furniture market. She states that she is “always stressed out” by demands on her time. On weekends she admits to drinking 4 to 5 alcoholic beverages.

REVIEW OF SYSTEMS
GENERAL: Well-nourished, well-developed young woman with athletic-appearing build in mild distress. She states that she has frequent headaches and admits to a lot of tension at work. CARDIOVASCULAR: No chest pain or edema.
RESPIRATORY: No cough or dyspnea.
GASTROINTESTINAL: See HPI. No vomiting, melena, or hematemesis. No fever, chills, or diaphoresis.
GENITOURINARY: Negative.
MUSCULOSKELETAL: Negative.
SKIN: Negative.

PHYSICAL EXAMINATION

IMTSolutions/1007

(continued)
HEENT. Normocephalic. Eyes, clear. TMs, normal. Oropharynx, clear.
NECK: Supple without adenopathy.
LUNGS: Clear to auscultation and percussion.
HEART: Regular sinus rhythm; no murmurs, clicks, or rubs.
ABDOMEN: Soft, flat, and nontender with normal bowel sounds; no masses or organomegaly. PELVIC: Deferred.
EXTREMITIES: Peripheral pulses intact.
NEUROLOGICAL: Unremarkable.

DIAGNOSIS
Gastritis, probably exacerbated by nonsteroidal anti-inflammatory drugs and stress.

RECOMMENDATIONS
Several methods of stress reduction were discussed. She is to stop using Motrin and is to use Extra-Strength Tylenol for headaches. She was given a sample of Prilosec 20 mg every day for 1 month. She is to return to her primary physician in 1 month and may be able to switch back to Tagamet at 400 mg b.i.d.

Lynn Solinski, MD, Consultant
LS:XX
D: 4/15/20—
T:
CHART NOTE

Laura Eagan  
15, 20--  
April

SUBJECTIVE
Patient complains of a burning-type pain in her upper abdomen and chest region. This started during the last week. She denied shortness of breath or diaphoresis. She does have malaise, belching, and occasional reflux symptoms; no food intolerance, dysphagia, emesis, flatulence, diarrhea, or constipation. No other abdominal symptoms. She denied any respiratory symptoms. There is no family history of heart disease. She admits to not eating properly and being overweight. Gastroscopy has never been suggested to her.

MEDICATIONS
Patient states she has tried Maalox, Tagamet, and Zantac. They will relieve the pain for only short periods of time.

OBJECTIVE
HEENT, lungs, and heart are essentially normal. Abdomen is obese, soft, and flat without tenderness; no rigidity or rebound. Bowel sounds are normal; no masses or organomegaly.

ASSESSMENT
Probable reflux esophagitis or peptic ulcer disease.

PLAN
Prilosec 20 mg daily for 2 weeks. She is to eat small, frequent meals consisting of low-fat foods; take antacids after each meal and bedtime; and to start exercising. Recheck in 2 weeks or immediately if any episodes of chest pain.

Debra Litman, MD

DL:XX

D: 4/15/20—
T: 
CHART NOTE

Brian Bruder
15, 20--

SUBJECTIVE
This 48-year-old male has 2 complaints.

1. He states that he has had problems with throat tightness for the past 2 months. It has been gradually getting worse. He feels it is “like a claustrophobic reaction.” This seems to be worse when he is lying down; it is relieved when he has a glass of water. If he is active, he does not notice it at all. No dysphagia.

2. He had a bloody stool a couple weeks ago, showing bright red blood in the toilet bowl. His rectal area was somewhat sore, and he does have hemorrhoids. He has not noticed any change in his bowel habits. He denies problems with constipation, weight changes, or family history of colon cancer.

OBJECTIVE
GENERAL: Talkative, middle-aged gentleman in no apparent distress.
HEENT: Oral cavity is pink and moist with moderate pharyngeal erythema and postnasal drainage.
NECK: Supple without adenopathy or enlarged thyroid. There are no palpable masses.
LUNGS: Clear to auscultation.

ASSESSMENT
1. Throat tightness; this may be secondary to postnasal drainage or perhaps anxiety, etc.
2. Hematochezia. This is probably secondary to hemorrhoids; however, other etiologies cannot be excluded.

PLAN
Flexible sigmoidoscopy to evaluate hematochezia and rule out polyps, malignancy, etc. He will start chlorpheniramine 8 mg sustained release 1 b.i.d. for postnasal drainage and throat tightness.

Debra Litman, MD

DL:XX

D: 4/15/20—
T:
FLEXIBLE SIGMOIDSCOPY PROCEDURE NOTE

Brian Bruder
April 15, 20--

SUBJECTIVE
Bloody stools; rule out polyps or other lesions.

ANESTHESIA
None.

PROCEDURE
After explanation of the procedure, its indications, benefits, risks, and alternative treatment methods, the patient agreed to the procedure and signed an informed consent.

The patient was placed in the left lateral recumbent position. A digital rectal exam was done. Small internal hemorrhoids were noted. The flexible sigmoidoscope was inserted and advanced to 60 cm. There were no polyps or lesions noted. Retroflex view of the rectum was normal. The patient tolerated the procedure well.

Debra Litman, MD

DL:XX

D: 4/15/20—
T:
CHART NOTE

Harriet Myers  
April  
15, 20--

SUBJECTIVE
Harriet presents for postoperative followup. She had a cholecystectomy a month ago. Again we discussed the anatomy and that she had acute secondary pancreatitis. I diagrammed this for her and explained how she can get a stone again although this is uncommon. She is doing very well postoperatively. Only medication is hormone replacement therapy. She is off pain medication.

REVIEW OF SYSTEMS
Noncontributory.

OBJECTIVE
BP 150/80; encouraged her to continue watching this. Afebrile. No scleral icterus. Heart is regular without murmur. Lungs are clear. Abdomen has 4 small laparoscopic incisional sites showing multiple suture tags which are pulled as much as possible and cut deep to allow retraction and to dissolve. Each incision looks very good; no herniations. No tenderness, masses, organomegaly, or jaundice. No dependent edema.

ASSESSMENT
One-month post cholelithiasis and cholecystitis, secondary pancreatitis.

PLAN
Patient to return in 3 months for chem profile, especially looking at kidney function, potassium, and urinalysis. Patient to be seen earlier p.r.n.

Debra Litman, MD

DL:XX

D: 4/15/20—

T:
CHIEF COMPLAINT
Abdominal pain for 4 days.

SUBJECTIVE
Patient admits to fairly heavy drinking over the past week or so. She had several emesis originally but that has stopped, and patient is now able to keep down some fluids. Denies diarrhea. No fever or chills.

PAST MEDICAL HISTORY
She has a history of peptic ulcer disease and a bleeding duodenal ulcer. There is a past history of questionable liver damage, cirrhosis, or hepatitis secondary to alcoholism. She has not been diagnosed with pancreatitis.

OBJECTIVE
Afebrile and in no acute distress. Appears well hydrated. Lungs are clear. No costovertebral angle, back, or spine tenderness. Heart is regular rate and rhythm. Abdomen shows positive bowel sounds; no guarding or rebound; no distinct tenderness.

LABORATORY
White count 11,100. Hemoglobin 15.2. Electrolytes are normal. Glucose 158. Liver function tests elevated showing AST of 32, bilirubin 0.5, alkaline phosphatase 97, and amylase 24.

ASSESSMENT
Alcoholic gastritis.

PLAN
Patient was given Toradol 60 mg IM with some relief. She was given a GI cocktail of Maalox and lidocaine with relief of symptoms. She will take antacids at home. Bland diet is recommended for several days, then return to regular diet as tolerated. She states she will avoid alcohol, and she has promised this in the past, as well as to consider counseling for her alcoholism. Return to clinic if any problems or condition fails to respond to antacids.

Debra Litman, MD

DL:XX

D: 4/15/20—
T:
PROCEDURE NOTE

Edwina Forrester  
15, 20--

PROCEDURE
Flexible sigmoidoscopy.

INDICATIONS
Patient is a 62-year-old female here for routine screening flexible sigmoidoscopy. Stool has changed in size, but denies melena or blood in the stool. Hemoccults were negative x3. Procedure was explained, and consent was obtained.

PROCEDURE
The 60-cm scope was introduced to 40 cm and was tolerated well. A sessile, reddish, nonbleeding polyp, probably less than 1 cm, was found between 35 and 40 cm. Retroflex viewing is negative. Patient tolerated the procedure well.

DIAGNOSIS
Polyp at 35 to 40 cm on flexible sigmoidoscopy screening.

PLAN
She is referred to a gastroenterologist for colonoscopy. Discussed colonoscopy risks, benefits, and procedure.

Debra Litman, MD

DL:XX

D: 4/15/20--
T:
X-RAY REPORT

Bruce Noreen
15, 20--

INDICATIONS
Abdominal pain and constipation.

X-RAY
Flat plate of abdomen.

INTERPRETATION
The intestinal gas pattern is normal. There is no evidence for obstruction or ileus. There are no masses or abnormal calcifications identified at this time.

ASSESSMENT
Normal flat plate of abdomen.

Debra Litman, MD
DL:XX
D: 4/15/20—
T:
Chapter 7
Solutions
Answers to Review Exercises

Exercise 7.1
1. extremities
2. good; well
3. within
4. origin; beginning
5. sweet; sugar
6. breast
7. ovary
8. growth
9. nourishment
10. extremity enlargement
11. abnormal formation
12. x-raying of breast
13. pertaining to the body
14. excessive eating
15. decreased sugar in blood
16. normal thyroid
17. producing from within
18. breast discharge
19. fixation of testes
20. underdeveloped sex glands

Exercise 7.2
1. h
2. a
3. m
4. d
5. k
6. j
7. l
8. b
9. f
10. c
11. i
12. e
13. g

Exercise 7.3
1. affect
2. 80 units
3. incidence
4. callus
5. adolescents
6. cease
7. ; however,
8. convalescence
9. callus
10. effect
11. has
12. , however,
13. are
14. 20 units
15. incidents
16. however
17. seized
18. callous
19. incidence
20. have
Russell Hendricks
15, 20--

SUBJECTIVE
Russell is an 81-year-old diabetic male. He developed stasis ulcer on the ventral aspect of his left foot several months ago, and he has been treating the ulcer by daily baths and dry dressing. Today he feels there is too much callous formation around the ulcer.

MEDICATIONS
Humulin insulin 30 units NPH and 15 units regular every morning; atenolol 25 mg p.o. every day; levothyroxine 0.1 mg p.o. every day.

PLAN
Patient will continue soaking his foot and apply Neosporin and a sterile dressing daily. He is to return in 2 weeks for followup.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
CHART NOTE

Randy LaMotta
15, 20--
April

CHIEF COMPLAINT
This 20-year-old male has type 1 diabetes, which was diagnosed in 1986. Patient is here today for followup. He states he checks his glucose twice a day which runs in the 100-200 range, usually in the low 100s. He is on no medications, using dietary control only. He states he has had hyperglycemic-like symptoms of polydipsia and polyuria twice in the last month. He has had hypoglycemic symptoms consisting of weakness and inability to concentrate once in the last month. He is here now primarily because he wants to have his driver's license renewed.

OBJECTIVE
BP is 124/78; pulse 88. Eye exam is negative. Examination of his feet shows some slight callous formation on the heels bilaterally with some cracked skin; no evidence of fungal infection or ulceration. Dorsalis pedis and posterior tibial pulses are 2+ and symmetric. His mental capacity at this time appears within normal limits, and his motor skills do not appear impaired.

DIAGNOSIS
Type 1 diabetes, suboptimal control.

PLAN
Patient will have a random blood glucose and hemoglobin A1c today. The importance of good glycemic control was again discussed in detail with the patient. He was given a diary for recording his blood glucose readings. The form for his driver's license was signed. He was asked to return in 1 month for followup, and he is to bring in his glucose diary.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
CHART NOTE

Luis Diaz
15, 20--

SUBJECTIVE
This is a followup of diabetes, lipids, and urine studies. Patient acknowledges dietary laxity. He currently takes glyburide 10 mg in the a.m. and 5 mg in the p.m.

LABORATORY
Fasting glucose of 263; hemoglobin A1c of 11.5% up considerably from 2 years ago. A 24-hour urine showed proteinuria of 437 mg/day; creatinine clearance of 78; creatinine of 1.0.

OBJECTIVE
He is in good spirits. Weight is 190; BP 152/90; pulse 64.

ASSESSMENT
1. Diabetes mellitus, poor control.
2. Probably early diabetic nephropathy.
3. Hypertension.

PLAN
We talked about his diabetic condition and its impact on his general health. He will increase glyburide to 10 mg b.i.d. and try to watch his diet better. We discussed other complications including neuropathy, kidney problems, and insulin therapy as an option at some point if needed. He would like to avoid that if possible. He asked about the pump implantation. He is to begin lisinopril 10 mg p.o. every day; #15 samples were given. He is to return in 2 weeks for blood pressure check, creatinine, and potassium. His prescription for lisinopril can be filled if blood pressure is okay.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
SUBJECTIVE
This 59-year-old male returns for followup of cholesterol and diabetes. He states he checks his glucose only periodically; usually in the morning they run in the 160-220 range; in the evening they are in the 180-200 range. He works the 10:30 p.m. to 6 a.m. shift. He admits he does not count calories or follow food exchanges.

OBJECTIVE
BP 164/92, repeat 164/92. There is a small shallow ulceration on the left shin. Feet appear in good condition with no calluses, cracking, or fissures.

LABORATORY DATA
Total cholesterol 258; triglycerides 180; HDL cholesterol 68; LDL cholesterol 134.

ASSESSMENT
1. Type 2 diabetes, currently poorly controlled.
2. Hypercholesterolemia.
3. Skin ulcer.

PLAN
1. He is to use Duoderm on regular basis on the ulcer.
2. He is to monitor his glucose more closely and to keep a diary.
3. The American Diabetic Association diet was suggested, and a referral to the dietician was recommended. He should also adhere to a low-cholesterol diet in hopes of avoiding medication for his hypercholesterolemia.
4. He will increase the p.m. NPH from 26 to 28 units.
5. He is to return to the office for weekly blood pressure checks by the nurse for followup of his hypertension and return to see me in 1 week. We will check fasting sugar and hemoglobin A1c at that time.

Lynn Solinski, MD

LS:XX

D: 4/15/20—
T: 
April 15, 20--

Merlin Williams, MD
300 Central Avenue
Lakewood, CO 80134

Dear Dr. Williams

RE: Ludwig Grandquist

This letter is to keep you updated on the progress of your patient, Ludwig Grandquist.

On April 14 Mr. Grandquist had his second visit with our office. As you will recall, Mr. Grandquist is a 74-year-old Native American gentleman with diabetes mellitus. His hemoglobin A1c 2 months ago was 8.5, a considerable improvement from the previous one. He does acknowledge that his caloric intake tends to fluctuate based on his schedule. He works part time as a custodian for a local church. I reviewed his glucose diary. His sugars range from about 78 to the low- to mid-100s with an occasional number over 200.

Currently he is taking NPH 20 units in the a.m. and 18 units in the p.m. He is also on Cardizem for his hypertension, 1 aspirin daily as a prophylactic measure, Metamucil daily p.r.n., and sublingual nitroglycerin p.r.n.(which he has not had to use for several weeks).

On examination he is a spry, thin, elderly male with good hygiene. Weight 197; BP 140/90; pulse 80 and regular. The funduscopic eye exam was within normal limits. There are no reported respiratory difficulties. He has no chest pain. Heart sounds appear normal. His abdomen is negative. Extremities appear normal for age with good mobility.

The recent lab workup including fasting glucose, BUN, creatinine, and electrolytes showed good numbers.

His diabetic control overall looks good. He can decrease the frequency of Accu-Cheks, but I will make no changes.
He wishes to return to your care. He was told to get lab requests from your office within the week for a 24-hour urine collection for creatinine clearance and total protein and to have a
Merlin Williams, MD
Page 2
April 15, 20--

hemoglobin A1c 1 week prior to an appointment with you. He was instructed to follow up with you in 3 months or sooner if any problems.

Sincerely

Lynn Solinski , MD

LS:XX
Chapter 7 Solutions

Chapter 7, Item 6

CHART NOTE

Robert Bias

April 15, 20--

SUBJECTIVE
Robert is here for diabetes recheck. He rarely checks his blood sugars, 2 to 3 times in the last 2 weeks. His 2-hour postprandial was 146 on April 10. He is off all medications for blood pressure and diabetes. He had lost 6 pounds before the last visit and again has lost 7½ pounds at today's visit due to dietary changes. He does get some heartburn. Two months ago he had chest pain for a half a day with some shortness of breath which totally resolved. By history it really does not sound cardiac.

OBJECTIVE
BP 140/98. Comfortable. Funduscopic eye exam is negative. Nose, mouth, neck, and thyroid are negative. Heart is without murmurs. Good pulses. Lungs are clear. Obese abdomen; otherwise unremarkable. Feet are clear.

ECG shows nonspecific ST changes only. Random Accu-Chek 267; hemoglobin A1c, pending. Chest x-ray is unremarkable.

ASSESSMENT
1. Type 2 diabetes, suboptimal control.
2. Overweight but improving.
3. Life-style interventions.
4. Elevated blood pressure.

PLAN
Await hemoglobin A1c. Double efforts in diabetes monitoring. We discussed multiple related aspects of diabetes monitoring and life-style interventions. He is to return if his chest pains return, but no further workup at this time. Patient to return in 3 months when we will check kidney status again, earlier p.r.n.

Lynn Solinski, MD

LS:XX

D: 4/15/20—
T:
CHART NOTE

Tashia Bealka
15, 20--

April

SUBJECTIVE
Tashia comes in to recheck hyperthyroidism. She is gaining some weight.

OBJECTIVE
Blood pressure is 112/80. Weight is 138 pounds, 4 pounds heavier than last month.
HEENT still shows mild exophthalmus. Goiter is not palpable today. Lungs are clear.

ASSESSMENT
Hyperthyroidism, fair control by PTU 50 mg, 2 tablets t.i.d.

PLAN
Continue same dosage. Next month we will check thyroid function.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
Chapter 7 Solutions
Chapter 7, Item 8

CHART NOTE

Barbara Glickstein
April 15, 20--

SUBJECTIVE
Barbara has swelling of hands and legs, has been tired and cold lately, still has problems with constipation, and has had some weight gain. She has been on Synthroid 110 mcg daily and Premarin 0.625. She has no hot flashes or depression.

OBJECTIVE
BP 124/76. Weight 171 pounds which is about 5 pounds heavier than a month ago. HEENT are normal. Chest, lungs and heart are clear. Goiter is not palpable.

ASSESSMENT
Hypothyroidism.

PLAN
Will check TSH, T3, and T4. Synthroid 112 mcg every day. Recheck in 1 month.

Lynn Solinski, MD
LS:XX
D: 4/15/20—
T:
CHART NOTE

Irene Colbert        April
15, 20--

CHIEF COMPLAINT
Irene was treated with radioactive iodine for Graves disease several years ago and is now hypothyroid. On Synthroid 0.05 mg daily, her energy level is good. No constipation, diarrhea, or temperature intolerance, although perhaps slightly warmer than normal. No other symptoms of low or high thyroid at this time.

EXAMINATION
Thyroid is clear to palpation. Normal deep tendon reflexes, skin turgor, and hair texture. Clear heart and lungs. No dependent edema. No exophthalmus.

DIAGNOSIS
Hypothyroidism, status post radioactive iodine therapy for Graves disease; euthyroid now.

TREATMENT
Continue present levothyroxine 0.05 mg every day. Drawing thyroid profile today. See at least annually for thyroid, earlier p.r.n.

Lynn Solinski, MD
LS:XX
D: 4/15/20--
T: 
April 15, 20--

Roger Capser, MD
Ivy Lane Clinic
1241 Ivy Lane
Denver, CO 80220-1872

Dear Dr. Capser

RE: Tia Wytkoff

This is a followup to your referral of Tia to my office. My examination on April 10 revealed that this 53-year-old white female had thyroid disease felt to probably represent a nodular Graves thyroid with thyrotoxicosis, status post radioactive iodine therapy 2 months ago. She is on atenolol 50-75 mg every day. She presents for followup of this medication and blood pressure check.

At the present time she feels good one day and uncomfortable the next. She has episodes of spontaneous flushing without diaphoresis, headache, or tachycardia. She is not aware of her cardiac rhythm. Occasionally she does not sleep well and has some muscle aching and muscle weakness.

OBJECTIVE: Face is moderately flushed, resembling a first-degree burn such as from a sunburn; this fades during the visit. Pulse is not tachycardic. BP initially was 134/60; on my check it was 122/48 sitting, going to 128/50 with standing. Thyroid is 2 to 3 times normal volume and is hard. No discrete nodules are palpable. Consistency has become harder than on my last assessment about 5 weeks ago.

ASSESSMENT: 1. Thyrotoxicosis, partially controlled.
2. Inflamed scarred thyroid gland.
3. Normotensive on atenolol.
PLAN: I told her I felt her current dosage of atenolol, 75 mg every day, was appropriate. However, if she checks her pulse each morning, she can take 50 mg for pulse under 60 beats per
minute and 75 mg for pulse greater than 60. She agrees with this. Retreatment with radioactive iodine would be considered at her next visit. Thyroid profile will be done today.

Again thank you for this referral. I will continue to follow Tia with you.

Sincerely

Lynn Solinski, MD

LS:XX
CHART NOTE

Darla Garske

April

15, 20--

SUBJECTIVE
Patient presents for evaluation of weight gain of 5-10 pounds over the past 3 months. She had been on imipramine and switched to Zoloft about 6 weeks ago. She is followed by Dr. Rothstein for her psychiatric problem of depression. She has, otherwise, been feeling well. No sore throat, hoarseness, chronic cough, fever, sweats, chills, GI or GU symptoms, or abdominal pain. She is on Estraderm patches.

Family history: Positive for hypothyroidism in her father.

OBJECTIVE
Pleasant female in no distress. Head and neck are unremarkable. Chest is clear. Heart sounds are normal. Abdomen is benign.

ASSESSMENT
Essentially normal examination. Suspect weight gain is related to the switch in medication. Rule out hypothyroidism.

PLAN
Check thyroid screen and treat accordingly. Advised to follow up on medication with her psychiatrist.

Lynn Solinski, MD

LS:XX

D: 4/15/20—

T:
Chapter 8
Solutions
Chapter 8 Solutions

Answers to Review Exercises

Exercise 8.1

Part 1
1. bladder 9. visual exam
2. machine to record 10. above
3. increased; above 11. surgical crushing
4. stone; calculus 12. nourishment; growth
5. kidney 13. ureter
6. condition of 14. urethra
7. formation
8. kidney

Part 2
1. anuria 6. nocturia
2. glucouria 7. oliguria
3. hematuria 8. pyuria
4. proteinuria 9. polyuria
5. dysuria

Exercise 8.2
1. g 10. a
2. j 11. e
3. i 12. p
4. q 13. f
5. m 14. k
6. h 15. d
7. n 16. c
8. b 17. l
9. o

Exercise 8.3
1. costovertebral angle
2. intravenous pyelogram
3. kidney, ureter, bladder
4. urinalysis
5. urine culture
6. urinary tract infection

Exercise 8.4
1. Necrosis 10. Enuresis
2. zero 11. nephrosis
3. healthful 12. discrete
4. 1300 13. than
5. discreet 14. 0800
6. Then 15. anureis
7. x3 16. 3.4-cm
8. diagnosis 17. enuresis
9. healthy 18. continence
Lia Yen
17, 20--

SUBJECTIVE
Lia complains of frequency of urination, urgency, and burning sensation for about 3 to 5 days. She denies hematuria. She has slight suprapubic discomfort. She has been treated for bladder infection in the past. Her last menstrual period was 4 days ago.

OBJECTIVE
She has very vague tenderness over the suprapubic area. Flanks are clear.

LABORATORY
WBC 11,200. Urinalysis shows yellow, cloudy urine; specific gravity 1.015; 3-5 RBC; 80-100 WBC; and many bacteria.

ASSESSMENT
Urinary tract infection.

PLAN
Septra DS 1 b.i.d. for 10 days. Repeat urinalysis after that.

Lee W. Kim, MD
LWK:XX
D: 4/17/20—
T:
CHART NOTE

Sarah Adair
17, 20--

SUBJECTIVE
Sarah is a 16-year-old female who presents with acute onset of urinary frequency, urgency, and burning for 2 days. She has had urinary infections including pyelonephritis. She is ALLERGIC TO ERYTHROMYCIN.

OBJECTIVE
Abdomen is soft without rebound, guarding, or tenderness. There is no CVA tenderness.

LABORATORY
WBC 13,400. Urinalysis was tea-colored and hazy; specific gravity 1.020; 8-10 RBC; 40-50 WBC/HPF; and moderate bacteria.

ASSESSMENT
Urinary tract infection.

PLAN
Urine sent for culture and sensitivity. Bactrim DS b.i.d. for 10 days. Drink lots of fluids. Recheck urine in 2 weeks, sooner if no improvement.

Lee W. Kim, MD

LWK:XX

D: 4/17/20—
T:
CHART NOTE

Adella Nash
17, 20--

April

SUBJECTIVE
This 69-year-old white female with long-standing hypertension returns for a followup of test results which were done to evaluate her proteinuria.

OBJECTIVE
Initial blood pressure 148/96; repeat 130/90. Her 24-hour urine reveals creatinine clearance of 50 mL/minute; total protein 495 mg/24 hours. Renal ultrasound is unremarkable.

ASSESSMENT
1. Hypertension, fairly well controlled.
2. Low-grade proteinuria, probably secondary to long-standing hypertension.

PLAN
Patient was told her proteinuria will need to be followed periodically. She will be seen in followup for her hypertension in 2 months.

Lee W. Kim, MD
LWK:XX
D: 4/17/20--
T:
CHART NOTE

Sharon Tanaka
17, 20--

SUBJECTIVE
Patient presents with mild urgency and frequency and some lower abdominal pelvic cramping. She has no vaginal symptoms. No history of exposure to sexually transmitted disease.

OBJECTIVE
There is mild suprapubic tenderness; otherwise, exam is unremarkable.

LABORATORY
Urinalysis is negative, but quite dilute from increased fluid intake.

ASSESSMENT
Suspect urethritis.

PLAN
Placed on 3-day course of Macroantin. Recheck if not improving.

Lee W. Kim, MD

LWK:XX

D: 4/17/20— T:  
April 17, 20--

Barry Rienhardt, MD
Urology Department, Suite 302
6500 Eagle Street
Denver, CO 80239

Dear Dr. Rienhardt

RE: Quentin Thorne

As per our telephone conversation this morning, I am referring Quentin Thorne to you for evaluation and treatment.

Mr. Thorne is a 32-year-old male with no previous history of nephrolithiasis. Yesterday he began having complaints of flank pain radiating to the right testicle. The pain was colicky in nature. He did not notice any changes in urinary flow or in the color of his urine.

His past medical history is negative except for an insignificant heart murmur as a child. He is ALLERGIC TO DEMEROL.

His family history is significant in that his father is a diabetic with complications of nephropathy, kidney failure, and is currently on dialysis.

Mr. Thorne was seen in emergency last night and had an emergency IVP. This showed a 3 x 2-mm nonobstructing calculus in the proximal right ureter at the level of L3. The ureter appeared mildly narrowed, suggesting stricture or spasm. There are also several small calculi in the distal right ureter, the largest of which measures 4 x 3 mm and which cause partial obstruction. On the prevoiding film the right ureter is mildly dilated. On the postvoiding film the right ureter does drain. There was no hydronephrosis. As a side note a 2-cm gallstone was also noted.
He received IV fluids and Toradol IV in the ER with significant improvement of symptoms. He continues to have pain for which he has taken Percocet. Today he has had a couple episodes of emesis, including one episode in the office this morning. Pain persists predominantly in the right flank. He has been straining his urine, but he hasn't caught any stone fragments.
EXAMINATION: Patient is alert and oriented x3, but in obvious discomfort. Weight is 158. BP 128/70; pulse 64. HEENT: Within normal limits. Mucous membranes are moist. Chest, lungs, and heart are within normal limits. Abdomen is soft and generally nontender, but with some guarding in the right flank and some right costovertebral angle tenderness.

Patient was given 10 mg Compazine IM, 4 mg morphine sulfate IM, and 1 liter of D5 one-half strength normal saline with 10 mEq of potassium chloride over the course of about 1½ hours.

ASSESSMENT: Ureterolithiasis, partial obstruction, persistent symptoms.

PLAN: As we discussed today the size of the stones is such that he might pass them. He will use vigorous oral hydration as tolerated. For nausea he will use Compazine 25-mg suppository b.i.d. or oral Compazine 5- to 10-mg tablet q.6 h. p.r.n. and continue Percocet p.r.n. for pain. If the stones do not appear in his strained urine, or if his symptoms worsen, he is to call your office for possible lithotripsy.

Sincerely

Lee W. Kim, MD

LWK:XX
CHART NOTE

Betty Nikolai
17, 20--

SUBJECTIVE
This 4-year-old female presents with urinary frequency, oliguria, and incontinence for the last day. She has had pain on urination for the last 3 to 5 days. No blood has been noted in urine. She does not complain of back pain. She did complain that her stomach hurt, but has not been vomiting. She has had a fever to 101° for the last couple of days. She has a history of UTIs with pyuria several months ago.

A voiding cystogram 1 month ago revealed the following: The bladder is well filled with contrast material and is normal in size and configuration. During voiding the urethra appears normal. There is no evidence of ureteral reflux. Post procedure catheterization revealed the bladder to be empty. The impression was a normal voiding cystourethrogram.

The patient did not return to our office for a repeat urine.

Family history is significant for paternal grandmother who had “kidney problems” which required a nephrectomy.

OBJECTIVE
Alert, in no distress. Abdomen is soft without masses, tenderness, or hepatosplenomegaly. No CVA tenderness.

LABORATORY
Urinalysis shows 60-80 WBC and 80-100 RBC and positive nitrites.

ASSESSMENT
Recurrent urinary tract infection.

PLAN
Septra 2 teaspoons b.i.d. for 10 days. Catheterize for urine culture and sensitivities. Repeat UA and UC 2 days after treatment of antibiotics is complete. If condition does not clear, or if it recurs, she will be referred to urology.

Lee W. Kim, MD
LWK:XX
D: 4/17/20—
T:
CHART NOTE

Luisa Enright
17, 20--

SUBJECTIVE
Patient has complaints of dysuria and hematuria. This came on as she was driving home from work today. She has not had fever, chills, diaphoresis, emesis, or back pain.

OBJECTIVE
There is no CVA tenderness nor any abdominal distension.

LABORATORY
Urinalysis is cloudy showing small ketones; specific gravity 1.021; WBC 50-75; RBC packed; and moderate bacteria. WBC is 11,800.

ASSESSMENT
Acute cystitis.

PLAN
Septra DS b.i.d. for 10 days and Pyridium 200 mg t.i.d., #9. Force fluids. Recheck in 2 weeks.

Lee W. Kim, MD
LWK:XX
D: 4/17/20—
T:
CHART NOTE

Eugene Edwards
17, 20--

April

CHIEF COMPLAINT
Lethargy, loss of appetite, and anuria.

HISTORY OF PRESENT ILLNESS
Patient is brought by caregiver who states patient is not eating well, drinking only small amounts, and sleeping a lot. Condom catheter applied for urine collection yielded only 30 mL in 24 hours. Patient had positive culture for E. coli 2 weeks ago and was treated with course of Septra.

PAST MEDICAL HISTORY
Patient has cerebral palsy and mental retardation.

PHYSICAL EXAMINATION
Patient is wheelchair ridden. Skin turgor is good. No CVA tenderness. No abdominal tenderness.

LABORATORY
UA shows 10-20 WBC/HPF, 5-7 RBC/HPF, few bacteria, and few epithelial cells.

DIAGNOSIS
Cystitis, possible glomerulonephritis.

TREATMENT
Continue Septra b.i.d. for 2 weeks. Push fluids and record intake and output. Take temperature b.i.d. Caregiver to call tomorrow with progress report.

Lee W. Kim, MD
LWK:XX

D: 4/17/20—
T:
CHART NOTE

Juan Verdez            April
17, 20--

SUBJECTIVE
Father states that this 5-year-old child has a difficult time starting to void and strains to void. He had a urethral dilation 1 year ago for stenosis of the meatus, and he did well for a short time.

IVP was done and the report is as follows: The scout film showed no evidence of urinary tract calculi. The renal contours, collecting system, ureters, and bladder are radiographically normal. There was only a 2-ounce residual urine in the bladder after voiding.

EXAMINATION
Exam is essentially negative. Urine is negative.

DIAGNOSIS
Urethral stricture.

PLAN
Refer to urologist for cystoscopy and dilation.

Lee W. Kim, MD
LWK:XX
D: 4/17/20—
T:
HISTORY AND PHYSICAL

Carlos Hernandez
17, 20--

CHIEF COMPLAINT
Urinary problems.

HISTORY OF PRESENT ILLNESS
Patient complains of voiding difficulties which are gradually becoming more prominent including hesitancy of initiation of stream, reduced force of stream, frequency, dribbling, nocturia x4, and occasional incontinence. He has no complaints of urinary retention.

PAST MEDICAL HISTORY
He states he has had no serious health problems and has not had a physical examination “in many years.” He states he had the usual childhood illnesses and acne as a teenager. He has hypertension and some environmental allergies which are controlled with OTC medications. Surgeries include appendectomy at age 7, surgical repair of a fractured ankle at age 19, herniorrhaphy at age 32, and cholecystectomy at age 45.

MEDICATIONS
Enalapril 20 mg daily and aspirin 5 gr/day.

ALLERGIES
No known allergies to medications. He does have environmental allergies to dust, pollen, and cat dander.

Family history: His mother had hypertension, hypercholesterolemia, ASHD, and died at age 63 from a cerebral hemorrhage. His father became an alcoholic during his military service and suffered from hepatitis, chronic pancreatitis, and gastritis. The father died at the age of 79 from metastatic cancer.

Social history: Patient is a retired land surveyor who worked much of his life outdoors. He now spends much of his time volunteering in the community. His wife volunteers in the local library. He states he and his wife have good communications and enjoy their life together.

REVIEW OF SYSTEMS
No unusual bleeding or skin lesions. Negative for chest pain or dyspnea on exertion. No indigestion or change in weight or bowel habits.

(continued)
PHYSICAL EXAMINATION
GENERAL: The patient is a 77-year-old Hispanic male who appears his stated age. He is well groomed, and his hygiene is good. He is alert and oriented to person, place, time, and situation. He converses well and appears to be an intelligent man.
NECK: Supple, without masses or adenopathy. Full range of motion.
CHEST: Clear to auscultation and percussion. No rales, rhonchi, or wheezing.
HEART: Normal sinus rhythm without murmurs or gallops.
ABDOMEN: Soft, nontender with active bowel sounds; no masses are palpable. Liver, kidney, and spleen are not palpable. Surgical scars are faint but present.
GENITALIA: External genitalia are normal. Rectal examination reveals 3+ enlarged prostate, benign in consistency. Stool is guaiac negative.
EXTREMITIES: There is no edema. Peripheral pulses are equal.
NEUROLOGICAL: Grossly intact.

LABORATORY
Patient was catheterized for residual urine of 200 mL. Urinalysis is essentially negative.

ASSESSMENT
Prostatic hypertrophy, most probably benign.

PLAN
Mr. Hernandez will be referred to urology for cystoscopy and possible transurethral prostate resection.
HISTORY OF PRESENT ILLNESS
Patient had onset 2 hours ago of colicky right flank pain that radiates around to the right lower quadrant and into the urethra. Mara states urine seems to have blood in it. Pain becomes more severe for 1- to 10-minute periods and then eases off. When pain is severe she rates it 8 on a scale of 1 to 10. Patient denies fever, chills, nausea, vomiting, or diarrhea.

PAST MEDICAL HISTORY
Denies history of nephrolithiasis or gallstones. Denies prior similar episodes. No medications; no drug allergies.

EXAMINATION
Patient is a 52-year-old female, appearing intermittently uncomfortable. There is mild CVA tenderness. Lungs are clear. Abdomen is soft and nontender. No suprapubic tenderness. Lumbosacral spine is nontender with full range of motion. Extremities have good pulses without edema.

LABORATORY
Clean-catch UA showed large amount of blood, some bacteriuria, 0-2 white cells, and packed red cells. White count 15,000.

DIAGNOSIS
Right ureterolithiasis.

PLAN
Patient was initially almost pain free; shortly thereafter she started getting severe pain in the right flank and right lower quadrant. She was given Toradol 60 mg IM and sent for an IVP.
CHART NOTE

Anita Stokes
17, 20--

HISTORY
Patient complains of severe pain in the right lateral abdomen, around to the back. No fever or chills. She had a kidney stone in the past which required lithotripsy.

EXAMINATION
There is tenderness over the right costovertebral angle and flank area.

DIAGNOSTICS
IVP shows a small, calcified fleck in the right ureter. Urinalysis reveals 2+ red cells. White blood count is 11,900.

DIAGNOSIS
Right ureteral stone; rule out pyelonephritis.

PLAN
Urine is sent for culture and sensitivity. She is given codeine #3 for pain. Push fluids. She is to strain all urine and save any stones. Septra DS for 5 days. Call in 24 hours for culture report.

Lee W. Kim, MD

LWK:XX

D: 4/17/20--
T:
Chapter 9
Solutions
Answers to Review Exercises

Exercise 9.1
1. gland
2. pain or painful condition
3. before
4. swelling, hernia
5. neck
6. vagina
7. bad, difficult
8. within, containing
9. woman
10. uterus
11. breast
12. menses
13. uterus
14. ovary
15. testes
16. hemorrhage
17. excessive or usual discharge
18. fallopian tube
19. food or nutrition
20. duct or vessel

Exercise 9.2
1. f
2. a
3. h
4. e
5. i
6. m
7. p
8. k
9. l
10. o
11. q
12. b
13. d
14. g
15. c
16. j
17. n
18. i
19. n
20. l

Exercise 9.3
1. acquired immunodeficiency syndrome
2. Bartholin, Skene, and urethral glands
3. cesarean section
4. fetal heart tones
5. gonococcus/gonorrhea
6. human immunodeficiency virus
7. human papillomavirus
8. pelvic inflammatory disease
9. premenstrual syndrome
10. sexually transmitted disease
11. breast self-exam
12. dilatation (dilation) and curettage
13. estimated date of confinement
14. testicular self-exam
15. human chorionic gonadotropin
16. obstetrics
Exercise 9.4
1. prostrate
2. perineal
3. Fetal
4. glands
5. perfusion
6. ;
7. profusion
8. gravida 3, para 3, abortus 0
9. fatal
10. protrusion
11. perineal
12. Fetal
13. 3-0-1-2
14. protrusion
15. prostate
16. ; however,
17. Fecal
18. ;
19. profusion
20. glands
Richard Kaplan  April 19, 20--.

SUBJECTIVE
Richard is a 32-year-old male who awoke with pain in the right groin area. He does not remember any injury.

OBJECTIVE
Abdomen is clear without tenderness. Inguinal areas are clear. There is no evidence of hernia. Examination of testicles indicates he has a tender right testicle, which is soft. I could not feel any mass. Spermatic cords are clear.

ASSESSMENT
Orchitis, etiology unclear.

PLAN
Sitz baths 3-4 times daily. Keflex 500 mg t.i.d. for 5 days. Motrin 600 mg q.8 h. p.r.n. Patient will call me after 48 hours if he is still having problems with symptoms.

Debra Litman, MD

DL:XX

D: 4/19/20—
T:
April 19, 20--

Belinda Hegdahl, MD
Department of General Surgery
6500 Eagle Street, Suite 100
Denver, CO 80239

Dear Dr. Hegdahl

RE: Jared Hoffmeier

Thank you for consenting to see this patient of mine, Jared Hoffmeier, on a semiurgent basis. He is the 33-year-old male whom I described in our telephone conversation.

Mr. Hoffmeier complains of right inguinal cramping and sharp, constant pain radiating into the scrotum and right testicle. This was brought on by lifting heavy objects at work today. He works for UPS and does a lot of repetitive lifting of heavy objects. Patient is status post vasectomy.

On examination abdomen is soft and nontender with positive bowel sounds. There is fullness in the right groin area. Palpation of the inguinal canal reveals a bulge that is made worse with coughing. It is reducible and there is no question of incarceration or strangulation. Rectal examination is negative. Prostate gland is normal in size and texture. Examination of the external genitalia reveals the penis to be normal, circumcised male.

No lab work was done in my office today.

My assessment is right inguinal hernia.

Because of his financial situation, he needs to have this repaired in the very near future. This has been discussed with the patient, and he agrees to seeing you and having you perform a herniorrhaphy. Also we discussed testicular self-exam.

Thank you for seeing Mr. Hoffmeier.

Sincerely

Debra Litman, MD

DL:XX
SUBJECTIVE
Patient is complaining of vaginal discharge without pruritus. She had unprotected sexual activity but has no known exposure to AIDS. She wants testing to be sure that she is not infected. She has had vaginosis in the past.

OBJECTIVE
ABDOMEN: Soft and nontender.
PELVIC EXAMINATION: BSU are normal. Vagina is normal. There is scanty discharge. Wet prep is negative for Trichomonas, yeast, and bacteria. Cervical cultures were done for GC, Chlamydia, and herpes. Bimanual examination shows uterus to be normal. There is a small mass about 3 to 4 cm on the left side, which is tender. This could be a tubo-ovarian abscess, or she could have residual pelvic inflammatory disease.

ASSESSMENT
Pelvic mass; rule out PID or sexually transmitted disease.

PLAN
1. HIV testing was done.
2. Doxycycline 100 mg b.i.d. for 10 days.
3. Will await test results.
4. Methods for prevention of STDs as well as contraception were discussed.
April 19, 20--

Ms. Donna Hooley  
428 Upton Lane  
Lakewood, CO 80134

Dear Ms. Hooley

This is to advise you of the lab results following your recent annual exam.

The Pap smear has been reported as normal. The hormone levels were normal indicating that you are not menopausal.

Your cholesterol was 190, which is within the normal limits. I am enclosing a copy of the cardiac risk screen that you had done. I have penciled in the readings from last year. You will note that there has been considerable improvement in these readings, and your overall risk factor is a satisfactory 0.8. You should continue to follow a low-cholesterol routine and plan to have these studies repeated in one year.

Thyroid function levels that were done indicate that your thyroid gland is functioning at a lower than normal level. You should consider a thyroid medication to bring these levels back to normal. If you will call me, at your convenience, I will be happy to help you get started on this medication.

If you have any questions regarding this, please do not hesitate to call me.

Sincerely

Debra Litman, MD

DL:XX

Enclosure
SUBJECTIVE
Paula is a 43-year-old, gravida 4, para 4-0-0-4, who is being seen for an annual physical examination. She has had amenorrhea for 3 years and has a lot of trouble with hot flashes. She states she was having trouble with hot flashes about 4 years ago and was seen by Dr. Erickson and placed on some estrogen that made her very sick. She has otherwise been well. Her interval medical history is not remarkable. She has a low-back discomfort that bothers her, and I suggested she might want to follow up with that at her family practice.

GYNECOLOGICAL HISTORY
Menses began at age 14 with PMS as a teenager and young adult. She has had 2 C-sections: 1 for eclampsia and 1 for cephalopelvic disproportion.

OBJECTIVE
Normal head, eyes, ears, nose, and throat. Neck is supple; thyroid is not enlarged. Breasts are pendulous; careful examination of the breasts revealed no masses. Abdomen is soft; no organs or masses are noted. Pelvic exam shows external genitalia are normal. Vagina and cervix show mild atrophic changes, but are, otherwise, not remarkable. Uterus is in midposition and feels normal in size. No clear-cut adnexal pathology is noted. Stool is guaiac negative. Pap smear is done.

ASSESSMENT
Annual physical examination.

PLAN
Patient was advised she should schedule a mammogram and should have these done yearly. I gave her appropriate literature regarding this. Complete and careful discussion regarding hormone replacement therapy was carried out with the patient today. Patient is undecided about taking hormones at this point, and I did give her all appropriate literature. She will let me know if she thinks she wants to get involved with this. We did talk about cutting back her smoking and appropriate cholesterol levels. We will do cardiac risk screen today. Also we talked about future bone density studies.

Debra Litman, MD

DL:XX

D: 4/19/20—
T: 
HISTORY AND PHYSICAL REPORT

Soon Lee Yim          April 19, 20--

REASON FOR VISIT
Patient is a 53-year-old Asian female who presents for an annual exam.

PAST MEDICAL HISTORY
Patient has been in good health. She has 3 adult children, living and well. There were no problems with pregnancies or deliveries. Habits: Patient is a nonsmoker. She rarely drinks alcoholic beverages. At work she will take the steps rather than the elevator, but does not routinely get much other exercise. She uses the seat belt when in the car.

MEDICATIONS
Calcium supplement 400 mg b.i.d., hormone replacement therapy, and ibuprofen p.r.n. for occasional headaches.

REVIEW OF SYSTEMS
Periods are every 4 to 5 weeks with moderate flow. No dysmenorrhea. No complaints of chronic headaches; visual problems; numbness; tingling; vertigo; dyspnea; nor leg, chest, arm, or abdominal pain. Patient does breast self-exams.

Family history: Patient is 1 of 7 siblings. There is no family history of uterine, ovarian, or colon cancer; heart disease; stroke; or osteoporosis. One sister has endometriosis, one sister had a mastectomy, and one brother has ulcerative colitis.

Social history: Patient is a legal secretary, working full time. She is married and states that they have a good relationship. She has a good social support system.

PHYSICAL EXAMINATION
HEENT: Negative.
NECK: Thyroid is normal and nontender; no nodularity.
LUNGS: Clear to percussion and auscultation.
HEART: Regular rate; no murmur, rubs, or gallops.
BREASTS: Soft and pendulous without masses although mildly cystic.
ABDOMEN: Soft and nontender with good bowel sounds. Liver, kidney, and spleen are not palpated.
PELVIC EXAMINATION: External genitalia are clear. BSU are normal. Vagina is pink with rugae. Introitus is normal. Cervix is pink and firm; no eversion; no erosion. Pap was done with cytobrush. Bimanual exam showed uterus to be anteverted, normal size, mobile, and nontender. Adnexa are negative bilaterally.

(continued)
History and Physical Report
April 19, 20--

RECTOVAGINAL EXAMINATION: Confirmatory.
EXTREMITIES: No clubbing, edema, or cyanosis. Peripheral pulses are equal and full.

LABORATORY
Hemoglobin 13.6. White count 10,400. Glucose, kidney function tests, liver profile, and electrolytes were all with normal limits. Stool Hemoccults were negative.

Mammography failed to reveal any dominant mass, suspicious microcalcifications, or other distortions. The skin and subcutaneous tissues appeared normal. The impression was a radiographically normal mammogram.

IMPRESSION
1. Routine health maintenance.
2. Normal gynecological exam.

RECOMMENDATIONS
Routine labs and mammogram were discussed with patient. We reviewed the need for adequate calcium intake and weight-bearing exercises. Patient given prescription for hormone replacement for 1 year. Return in 1 year or p.r.n. for problems.

Debra Litman, MD

DL:XX
D: 4/19/20—
T:
CHART NOTE

Shelley Ellis         April 19, 20--

SUBJECTIVE
The patient is here for annual female examination. She is a gravida 3, para 2-0-1-2 with no problems or complaints. She feels well. She continues to use testosterone cream in the vulvar area and feels this is working well for her. She sees Dr. Regan for general medical care. She had a flexible sigmoidoscopy within the last several years and is aware of when to schedule colonoscopy. Her interval medical history is completely negative.

PAST MEDICAL HISTORY
One ectopic pregnancy.

OBJECTIVE
HEENT: Normal.
NECK: Supple. Thyroid is not enlarged.
BREASTS: Careful examination revealed no masses.
ABDOMEN: Soft; no organs or masses are noted.
PELVIC EXAMINATION: External genitalia are normal. There is some slight clitoromegaly consistent with testosterone application. The previously noted vulvar dystrophy appears to be stable. There has certainly been no extension of it. Vagina shows atrophic changes; otherwise, not remarkable. Support is good. Pap smear is done. Bimanual and rectovaginal examinations were completely normal.

LABORATORY
Stool is guaiac negative.

ASSESSMENT
1. Normal female examination.
2. Vulvar dystrophy, stable.

PLAN
Schedule mammogram in July and follow up with Dr. Regan or myself p.r.n.

Debra Litman, MD

DL:XX
D: 4/19/20--
T:
SUBJECTIVE
This 52-year-old patient was seen for an annual examination. She is frequently awakened at nighttime with hot sweats, and she is wondering whether these represented hot flashes related to estrogen deficiency.

PAST MEDICAL HISTORY
She is status post D&C, laparoscopy, and hysterectomy with bilateral oophorosalpingectomy for dysplasia, menorrhagia, and metrorrhagia. No complaints with reference to the vaginal area, bladder, or bowel function, etc.

MEDICATIONS
She is currently on Estraderm 0.05-mg patches. There has been no skin irritation from the Estraderm patches.

OBJECTIVE
Neck, breast, and abdominal examinations are unremarkable. Vaginal area shows normal-appearing cuff. There is no unusual discharge or redness. Rectovaginal examination is negative. The Estraderm patch area is not inflamed.

ASSESSMENT
1. Menopause.
2. Basically normal examination.

PLAN
Yearly mammography; routine fasting blood work to include glucose, liver function, basic metabolic panel, and Hemoccults. Sigmoidoscopy versus colonoscopy procedures were discussed. She will continue hormone replacement therapy with Estraderm patches. She was given samples of 0.1 mg to try for the next month. She will call me with results at the end of that time; and if improvement in symptoms, prescription will be called to her pharmacy.

Debra Litman, MD

DL:XX

D: 4/19/20—
T:
April 19, 20--

Mia Yang, MD  
Department of Gynecology and Obstetrics  
6500 Eagle Street, Suite 275  
Denver, CO 80239

Dear Dr. Yang

RE: Ann Sankaaran

In the very near future, you will be seeing my patient, Ann Sankaaran, whom I am referring to you for evaluation and management. She is a very gracious, 88-year-old lady. She was seen in my office today for the following reasons:

CHIEF COMPLAINT: Pressure and pain in pelvic area.

HISTORY OF PRESENT ILLNESS: This elderly female has had intermittent pain in lower pelvis for several months. She has been treated for recurrent bladder infections. Ann states that she is uncomfortable as her bladder fills, and she becomes comfortable when she empties her bladder. She has occasional incontinence. She also wonders if her uterus is prolapsed. Ann’s daughter noted while bathing her mother that there was a "white bulge" in the patient’s vagina.

PHYSICAL EXAMINATION: Patient is alert and in no acute distress. She appears to be well hydrated. Heart is regular sinus rhythm. No CVA tenderness. Abdomen shows positive bowel sounds; no tenderness, mass, or distention. Pelvic exam shows an atrophic vulva, normal for age. Speculum examination reveals a white atrophic vaginal mucosa. There is an apparent cystocele protruding into the vaginal vault. The uterus is not obviously prolapsed. Bimanual exam reveals no masses or tenderness. No rectocele is noted.

DIAGNOSES:  
1. Cystocele with questionable prolapsing uterus.  
2. Stress incontinence.

RECOMMENDATIONS: Patient will follow up with gynecology for evaluation and possible surgery to include cystorrhaphy and/or uterine suspension. These procedures have been explained to the patient and her daughter. Ms. Sankaaran agrees to see you and to follow your recommendations.
Sincerely

Debra Litman, MD

DL:XX
April 19, 20--

Belinda Hegdahl, MD  
Department of General Surgery  
6500 Eagle Street, Suite 100  
Denver, CO 80239

Dear Dr. Hegdahl

RE: Leah Ahmann

This is to introduce you to my patient, Leah Ahmann. She presented on April 15 with right breast pain. She states she has had a painful lump in her right breast for 3 days. She has 2 children, ages 4 and 7, and has not been breast-feeding for at least 3 years. There is no family history of breast cancer.

There is a 2 x 2-cm, tender nodule just above the areola of the right breast in the midline. There is overlying erythema. There is no indentation or orange-peel sign; no induration or discharge from the nipple. There are no tender or enlarged nodes in the right axilla. The mammography on April 15 demonstrated a 16 x 8 x 8-mm, discrete simple cyst within the 12 o’clock position of the right breast. The cyst exhibits posterior wall enhancement. The impression is a simple cyst.

This is most likely a simple cyst of the right breast, which appeared to be an infected cyst, but it should be evaluated further.

The patient is advised to apply warm compresses to the breast. Keflex 500 mg q.i.d. for 1 week. She is to make an appointment with you at your earliest available time. It is anticipated that you will arrange for biopsy if there is not a dramatic response to antibiotics.

Thank you for assisting in the care of this interesting patient.
Sincerely

Debra Litman, MD

DL::XX
HISTORY OF PRESENT ILLNESS
This is a 50 year old who is 4 days post lumpectomy for right breast cancer. She had an axillary node dissection at the time, and she has a Jackson-Pratt drain in her axilla. It has been accumulating about 150 mL/day. She was started on tamoxifen therapy.

EXAMINATION
Surgical site appears to be clean. Drain shows a fair bit of clotted material.

DIAGNOSIS
Obstruction of Jackson-Pratt drain.

TREATMENT
Jackson-Pratt drain was irrigated with sterile saline, and clots were removed. Follow up in 2 days.

Debra Litman, MD

DL:XX

D: 4/19/20—
T:
CHART NOTE

Tasha Sprague          April 19, 20--

SUBJECTIVE
This patient was seen in January and told she had a Bartholin cyst. She now feels it is beginning to bother her.

OBJECTIVE
The examination reveals no evidence of Bartholin cyst. The patient does have a vaginal cyst in the posterior vaginal wall just distal to the hymenal ring. This may represent an inclusion cyst. I indicated to the patient that we can try to drain the cyst; this might resolve the situation, although it could recur. She is willing to let us do this.

The area was prepped with Betadine, and a small amount of 1% Xylocaine was placed in the area. An 18-gauge needle was put into the cyst, and very thick, cheesy material began to come out. I did open this up more with a scalpel blade and evacuated this cyst of thick, sebaceous material. I would suspect this represents an inclusion cyst perhaps from an old stitch. It was certainly not a Bartholin cyst. The mass did disappear completely. The bleeding was controlled with silver nitrate cautery.

ASSESSMENT
Inclusion cyst.

PLAN
Once again the patient has been cautioned that this situation may recur and may require more definitive surgery. In my view that would probably require removal of the cyst under anesthesia.

Debra Litman, MD
DL:XX
D: 4/19/20—
T:
Chapter 10
Solutions
Answers to Review Exercises

Locating the Major Bones
9 calcaneus
6 carpals
11 Cervical vertebra
1 Clavicle
18 Coccyx
10 Cranium
19 Femur
22 Fibula
13 Humerus
4 Ilium
15 Lumbar vertebra
7 Metacarpals
24 Metatarsals
20 Patella
8 Phalanges
17 Radius
3 Ribs
5 Sacrum
12 Scapula
2 Sternum
23 Tarsals
14 Thoracic vertebra
21 Tibia
16 Ulna

Locating the Major Muscles
4 Abdominal
7 Anterior lower leg
5 Anterior thigh
12 Between shoulder blades
13 Buttocks
6 Calf
3 Chest
2 Inner upper arm
10 Lower back
1 Major neck muscle
9 Outer upper arm
14 Posterior thigh
8 Shoulder cap
11 Upper back, shoulder-to-shoulder and across vertebrae
### Exercise 10.1
1. t  
2. m  
3. p  
4. a  
5. q  
6. r  
7. b  
8. e  
9. h  
10. k

### Exercise 10.2
1. q  
2. n  
3. l  
4. k  
5. m  
6. r  
7. s  
8. o  
9. f  
10. c

### Exercise 10.3
#### Part 1
1. g  
2. j  
3. b  
4. d  
5. i  
6. c  
7. e  
8. h  
9. a  
10. f

#### Part 2
1. g  
2. a  
3. j  
4. i  
5. h  
6. e  
7. d  
8. f  
9. c  
10. b

### Exercise 10.4
1. heal  
2. turnover  
3. humorous  
4. log-in  
5. flanges  
6. humerus  
7. gate  
8. heel  
9. weigh-in  
10. gait  
11. blackout  
12. printout  
13. heal  
14. phalanges  
15. humorous
CHART NOTE

Joellen Ulrich                  April 22, 20--

SUBJECTIVE
This 15-year-old female suffered an injury to her left hand in gymnastics. She was splinted and sent to the office for evaluation.

OBJECTIVE
She has diffuse swelling and ecchymosis over the dorsal aspect of her right hand in the 3rd and 4th metacarpal midshaft region. She has full range of motion of her fingers. Neurosensory exam is normal. Peripheral circulation is normal.

X-ray shows evidence of nondisplaced oblique shaft fractures of metacarpals without involvement of the articulating structures.

ASSESSMENT
Right 3rd and 4th metacarpal fractures, nondisplaced.

PLAN
She was taped for immobilization and placed in a short-arm splint. She will keep the hand elevated and use Advil or aspirin. Followup will be with orthopedics in the next 3 to 7 days.

John Blackburn, MD

JB:XX

D: 4/20/20—
T:
Joseph Iverson

April 22, 20--

CHIEF COMPLAINT
Joe is a new patient who presents to the clinic with left knee pain, swelling, and weakness. He denies previous trauma to this area but has had right knee pain and arthritis in past. Recently he changed physicians because of change in health care policies.

PAST MEDICAL HISTORY
Negative.

ALLERGIES
None.

MEDICATIONS
None.

Past surgical history: Negative.

Social history: Nonsmoker. He does drink beer, 4 to 6 cans per day.

Family history: Father has degenerative disk disease; brother had herniated disk which required a laminectomy.

EXAMINATION
Weight 304 pounds. Initial BP 134/104; repeat 132/94. 
SKIN: Flushed and red.
LEFT KNEE: Exam showed the knee to be warm and swollen compared to right knee. Extension is 180 degrees; flexion is 90 degrees. Negative drawer, Apley grind, and patellar apprehension test. He has marked tenderness and crepitus in the patellar and suprapatellar ligaments on palpation.

PERIPHERAL PULSES: They are 2+/4 and symmetrical in the popliteal, posterior tibial, and dorsalis pedis areas.

X-RAY
No gross evidence of fractures or abnormalities.

LABORATORY
Nonfasting glucose 120; total cholesterol 253; uric acid 8.8.

(continued)
DIAGNOSIS
Left knee pain and swelling secondary to gouty arthritis.

PLAN
Daypro 600 mg 2 tablets daily for 1 week. Decrease alcohol consumption. Recheck in 1 week; if there is no improvement, he will start on allopurinol.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
April 22, 20--

Arthur Braun, MD
Department of Orthopedics
6500 Eagle Street, Suite 150
Denver, CO 80239

Dear Dr. Braun

RE: Tom Quam

In the near future you will be seeing my patient Tom Quam for his knee problems.

This 44-year-old male states that a month ago he twisted his knee. The pain is worse on the lateral and inferior aspect of right knee. It seems to be worse if he pivots. He occasionally notices a catch in his knee. Tom has had recurrent problems with his knee. He is not using any anti-inflammatory medicines at this time.

On exam today there is no tenderness with active or passive range of motion of the knee. There is no crepitus, warmth, erythema, or synovial swelling. There is some tenderness with palpation of the right mediocollateral ligament. There is lateral collateral ligament laxity but no mediocollateral ligament laxity. McMurray test is negative.

My diagnosis is a right lateral collateral ligament sprain, recurrent.

The plan is for him to start physical therapy and to make an appointment at your office. He may need MRI and/or arthroscopy.

Sincerely

John Blackburn, MD

JB:XX
CHART NOTE

Ben Sankaaran

SUBJECTIVE
Ben came in with a 1-month history of back pain with sudden onset from lifting heavy furniture. After 3 chiropractic adjustments, the chiropractor referred him to me because of continued complaints of pain radiating into his lower left leg to the level of the ankle. He was advised to try flexion-extension exercises, but this seemed to aggravate his complaints. He has not experienced fever, sweats, chills, difficulty with bowel or bladder, or gait complaints.

OBJECTIVE
Examination of the thoracolumbar spine reveals flexion is to 90 degrees; backward bending is 0 degrees; side bending bilaterally is 30 degrees; rotation bilaterally is 45 degrees. Range of motion of the lumbar spine is full on flexion, extension, lateral bending, and rotation with some discomfort on extension. Straight-leg raise test is negative bilaterally at 70 degrees, although the patient does have tight hamstrings. Muscle strength, bulk, tone, and light touch are intact. Deep tendon reflexes are 2+/4 and symmetric. Toes are downgoing. Patrick test is negative bilaterally. There is mild left sacroiliac joint tenderness and mild left sciatic notch tenderness. There is no tenderness to palpation or percussion over the lumbosacral spine. Good heel-and-toe walk. Gait is normal. Spring test is negative.

DIAGNOSES
1. Thoracolumbar strain.
2. Acute low back pain with radicular pain into the left leg without neurologic evidence of radiculopathy.
3. Possible chronic lumbar myositis.

PLAN
1. Bed rest with local heat for 24 hours then he may increase his activities.
2. Flexion exercises, adding extension exercises as he improves.
3. Prednisone 2 mg t.i.d. with meals.
4. Tylenol #3 if needed for pain control.
5. Discussed side effects, risks, and benefits of this treatment.
6. Patient to follow up in 1 week.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
PROCEDURE NOTE

Deann O'Connell          April 22, 20--

Deann has complaints of pain in her right hip and down the thigh laterally. She states that when she sleeps on that side, the pain intensifies.

Exam revealed tenderness over the right greater trochanter with positive Patrick test; otherwise, the exam was negative.

Diagnosis was right greater trochanteric bursitis.

PROCEDURE
The right hip was injected with 1.5 mL of triamcinolone suspension in 3.5 mL Marcaine with good partial relief of symptoms. She was placed on Naprosyn and lateral stretching exercises for the hip.

Follow up with this patient if no improvement, or p.r.n.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
CHART NOTE

Stephan Taggert

April 22, 20--

SUBJECTIVE
This 15-year-old male presents with lower left arm pain. Two days ago he was struck by a heavy log falling on his left forearm. When he uses his left hand, Stephan now has swelling and pain with pronation, supination, and gripping.

OBJECTIVE
He has mild swelling over the distal radius approximately 8 cm proximal to the radial styloid. Neurovascular is intact. He has full range of motion of his hand and phalanges.

X-ray confirms a nondisplaced fracture in the distal forearm.

ASSESSMENT
Left radial shaft fracture in good alignment.

PLAN
Plaster cast applied. Elevation with use of sling, Advil, aspirin, or Tylenol. Follow up in 10 days.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
CHART NOTE

Tianne St. John

CHIEF COMPLAINT
This patient was involved in an auto accident yesterday. She was a seat-belted passenger in a pickup truck that was hit from behind. She bumped her elbow. She has minimal pain in her left elbow and some pain in her neck. There is no pain with head movement. There was no loss of consciousness.

EXAMINATION
There is no pain to palpation of the elbow in flexion, extension, or rotation. There is no swelling or bruising. There is pain to palpation in the cervical and trapezius regions bilaterally and minimal pain over the cervical spine. There is no pain with flexion, extension, or rotation of the head. There is normal upper extremity strength and sensation.

X-RAY
C-spine films are negative. There is no evidence of fracture or dislocation of the elbow.

ASSESSMENT
Left elbow contusion and whiplash, status post motor vehicle accident.

PLAN
Apply ice to the neck region. Advil or Aleve for pain. She was informed that she will feel stiff and more uncomfortable in the next 2 days. Recheck appointment should be scheduled in 5 days, sooner if worsening symptoms.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
April 22, 20--

Arthur Braun, MD
Department of Orthopedics
6500 Eagle Street, Suite 150
Denver, CO 80239

Dear Dr. Braun

RE: Destiny Gomez

This to introduce you to Destiny Gomez whom I called you about today. Destiny fell and injured her right wrist and right knee.

On exam the right wrist is swollen with obvious deformity. There is normal sensation of fingers with normal motion of the fingers. She has pain with movement of the wrist. Right knee patella is tender to palpation. There is joint effusion of the knee. Sensation and motor distal to the injury is normal.

X-RAY: X-ray of the right wrist reveals distal radial fracture with about 20 degrees dorsal angulation and displaced about 30% from normal position. There is no ulnar fracture. Right knee x-ray shows a fracture of the patella with no displacement of the fragments.

2. Patellar fracture, right knee.

She has been placed in a leg immobilizer. She was given one crutch and instructed in crutch walking. She should bear as little weight as possible on right extremity. Posterior splint with Ace wrap was placed on forearm. She was given Tylenol #3 for pain. The appointment has been made in your office for tomorrow at 9:30 a.m. She was told to be fasting in the event that you may wish to schedule an open reduction.

Thank you for seeing this patient on an emergency basis.

Sincerely

John Blackburn, MD

JB:XX
By fax
CHART NOTE

Rudolph Zakowski

April 22, 20--

SUBJECTIVE
This 11-year-old boy had a repetitive injury to his right upper extremity 2 weeks ago while roller blading. He fell repeatedly on the point of his right elbow and now complains of soreness in shoulder. Rudy and his family are concerned because he is scheduled to play baseball.

OBJECTIVE
Full range of motion of shoulder. He has tenderness over the humeral greater tuberosity. There is negative impingement sign. He has full range of motion of his right elbow, which is nontender. He has a good grasp.

X-ray of the humerus including shoulder with comparison view of the opposite side shows no bony deformity. He has open epiphyses.

ASSESSMENT
Probable tendinitis of shoulder.

PLAN
Range of motion exercises. Advil 2 to 3 times per day. Recheck if not improving.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
Chapter 10 Solutions

Chapter 10, Item 10

CHART NOTE

Roger Gates

April 22, 20--

SUBJECTIVE
Roger came in for a recheck of bilateral wrist pain and intermittent numbness and tingling over both hands. An EMG was done and was negative.

OBJECTIVE
There is tenderness over the volar aspect of both wrists. Negative Tinel sign; negative Phalen test. Strength and sensation are normal bilaterally.

ASSESSMENT
Bilateral wrist tendinitis versus early carpal tunnel syndrome though the EMG is negative at this time.

PLAN
Limit gripping and grasping to less than 25 times per hour. Continue wrist splints. Continue Naprosyn. Physical therapy 3 times weekly for 2 weeks, then return for recheck.

John Blackburn, MD

JB:XX

D: 4/22/20—

T:
Chapter 10, Item 11

X-RAY REPORT

Luke Nguyen
April 22, 20--

NOTE
Patient was seen today by nurse practitioner; see dictated note in file.

X-RAY
Left great toe, status post joint replacement.

FINDINGS
There has been a first metatarsophalangeal joint replacement prosthesis inserted. The device is maintained in good alignment with no evidence of loosening or infection. The first metatarsal and proximal phalanx are in good alignment.

John Blackburn, MD
JB:XX
D: 4/22/20--
T:
X-RAY REPORT

Rachelle Bacella  
April 22, 20--

CLINICAL DATA
Patient was seen today by nurse practitioner; see dictated note in file. Rule out fibular fracture.

X-RAY
Left ankle.

FINDINGS
Soft tissue swelling is present over both malleoli, particularly over the lateral malleolus. There is a small ankle joint effusion. The ankle is otherwise normal. There are moderately sized posterior and plantar calcaneal spurs. There are no fractures noted.

John Blackburn, MD
JB:XX
D: 4/22/20—
T:
X-RAY REPORT

Lawrence Minick

NOTE
Patient was seen today by nurse practitioner; see dictated note in file.

X-RAY
Left 4th finger.

FINDINGS
Some soft tissue swelling is present at the PIP joint. There is minimal irregularity along the dorsolateral margin of the base of the 4th middle phalanx. This could represent a small, nondisplaced, avulsion fracture, but no definite fracture line is visible. The finger is otherwise normal.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
NOTE
Patient was seen today by nurse practitioner; see dictated note in file.

X-RAY
Left hand.

FINDINGS
There is a slightly offset oblique fracture through the 5th metacarpal. The fragments are maintained in good alignment. No additional fractures are identified. Hand is, otherwise, normal.

John Blackburn, MD

JB:XX

D: 4/22/20—
T:
Chapter 11
Solutions
Answers to Review Exercises

Exercise 11.1
1. r
2. t
3. m
4. g
5. c
6. v
7. h
8. q
9. p
10. k
11. i
12. f
13. d
14. u
15. w
16. b
17. e
18. a
19. j
20. s
21. o
22. l
23. n

Exercise 11.2
1. k
2. j
3. p
4. e
5. l
6. o
7. m
8. c
9. b
10. d
11. n
12. g
13. i
14. f
15. a
16. h

Exercise 11.3
1. electroencephalogram
2. tympanic membrane
3. cerebrospinal fluid
4. pupils equal, round, reactive to light and accommodation
5. deep tendon reflexes
6. extraocular movement or motion

Exercise 11.4
1. intraoperatively
2. faxe
3. instillation
4. nuchal
5. cord
6. cuddled
7. interpersonal
8. phase
9. reflection
10. nuchal
11. installation
12. intramuscular
13. refraction
14. paraplegia
15. Cord
16. knuckles
17. coddle
18. peritonsillar
PROCEDURE NOTE

Julia Liberstrom         April 24, 20--

INDICATIONS
This 71-year-old lady is having pain in both thumbs and at the site of a ganglion cyst near her right wrist. She has been taking ibuprofen 600 mg b.i.d., but has had some nosebleeds and GI upset. There is a tender ganglion cyst along the tendon in the right wrist. There is some pain with extension of the thumbs bilaterally. The most tender and troublesome area appears to be along the ganglion cyst.

PROCEDURE
The right wrist area was prepped with alcohol and Betadine. Anesthesia was 1% lidocaine. No significant amount of fluid could be withdrawn. It was injected with a combination of 1% lidocaine and Aristospan. Patient tolerated the procedure well.

IMPRESSION
Tendinitis and ganglion, right wrist; overuse left wrist and thumb.

PLAN
Ibuprofen 200-600 mg t.i.d. with food for analgesia. Return p.r.n.

Lynn Solinski, MD
LS:XX
D: 4/24/20—
T:
CHART NOTE

Andrew Brewster

April 24, 20--

SUBJECTIVE
Patient complains of daily headaches located behind the right eye for 5 days. He does have some nausea and vomiting with the headaches. Also he complains of flashing lights in the eye, which last for a few minutes, and then he gets the headache. The headaches are not associated with any particular time of day or activity. Andrew is, otherwise, in good health. He has taken anti-inflammatory medication without improvement. Cafergot has been prescribed in the past. Mother had CVA at age 55.

OBJECTIVE
EARS: TMs are clear.
EYES: PERRLA. EOMs are intact. Funduscopic exam reveals normal disks and venous pulsations.
MOUTH AND THROAT: Clear.
FACE: Sinus percussion reveals no tenderness.
NECK: Supple without tenderness or adenopathy. No nuchal rigidity.
NEUROLOGIC: Cranial nerves 2-12 are intact. DTRs are normal. Muscle strength and coordination are normal.

ASSESSMENT
Vascular headache, cluster, or migraine variant.

PLAN
Midrin capsules two q.4 h. p.r.n. at first sign of headache. Trial of amitriptyline 10 mg at h.s. Patient may be a candidate for Imitrex. Recheck p.r.n. or immediately if symptoms worsen.

Lynn Solinski, MD

LS:XX

D: 4/24/20—
T:
Dear Dr. Saakara

RE: Marsha Dahlheimer

Thank you for agreeing to see Marsha Dahlheimer for neurological consultation. She is a 79-year-old, right-handed, retired clerk who is chiefly concerned about a fall she took 1 week ago when she had an episode of right leg numbness. She did not lose consciousness. Normally she walks a lot. She denies any syncope, limb numbness or paralysis, sphincter disturbances, headaches, or memory problems.

PAST MEDICAL HISTORY: Positive for an episode of unconsciousness a year ago while she was on the telephone. Marsha is hypertensive. She underwent cataract surgery with intraocular lens implant 3 weeks ago. For many years she has had a tremor involving her upper limbs, head, and voice. The tremor is not constant, and she is able to dress and feed herself without complication. She recently was started on an aspirin a day.

Family history: Remarkable for a brother with Parkinson and a sister with macular degeneration.

EXAMINATION:
GENERAL: Blood pressure is 140/65. Pulse 92 and regular. The sensorium is clear. In particular there are no language, memory, or apraxia problems.
HEENT: The right periorbital and forehead regions are still affected by the subcutaneous hemorrhage. The extraocular movements, pupils, funduscopy, visual fields, jaw opening, and tongue movements are normal. The face is symmetrical and of normal sensation. The head displays a coarse tremor.
NEUROLOGIC: The hand outstretched also shows a similar but somewhat faster tremor distally. The coordination and strength are well preserved; however, the tone seems a little more increased on the right side. The deep tendon reflexes are present and symmetrical in the upper limbs and at the knees, but diminished at the ankles. Toes are downgoing. The sensory
examination reveals a symmetrical, stocking-type decrease in pinprick and temperature
sensation. She is only able to appreciate the vibrating 128-Hz tuning fork for 4 seconds.

The patient has signs of a symmetrical, mild peripheral neuropathy. I am uncertain of the
significance of the asymmetric upper limb tone.

Thank you for assisting in the care of Ms. Dahlheimer. I anticipate hearing from you regarding
your recommendations for this patient.

Sincerely

Lynn Solinski, MD

LS:XX
CHART NOTE

Jared Carlos

SUBJECTIVE
The patient has had epilepsy since age 12. He has been on phenobarbital 90 mg b.i.d. without side effects. He reports no convulsions or new neurological symptoms. Jared continues to work.

OBJECTIVE
The sensorium is clear. The speech is dysarthric. The extraocular movements are full. The pupils and fundi are normal. There is a slight ptosis on the right side. The face is symmetrical. The motor examination is normal, and the sensory examination is nonfocal. The deep tendon reflexes are symmetrical.

ASSESSMENT
Epilepsy with well-controlled seizures.

PLAN
He has not had an EEG in many years. He will check with his neurologist to see about repeating that.

Lynn Solinski, MD

D: 4/24/20—
T:
Dear Dr. Colburn

RE: Donovan Westrum

Donovan is the 71-year-old patient whom I spoke with you about earlier today regarding his complaint of visual loss.

He states he has a shadelike change moving from right to left across his right upper outer visual field. He has had dark black or bluish color with bright red flashes of light, which caused difficulty in seeing in that visual field. Symptoms have been persistent over the last 2 days. He has no history of documented vascular disease. He is on one aspirin a day.

On examination in my office today, his weight is 212. BP 140/60. Pulse 60. I see no evidence for glaucoma, macular degeneration, or detached retina. There does appear to be a right-sided visual field cut. As I lowered my finger in his right visual field, it seems to cut off in the mid- to upper portion laterally on the right. There are no left-sided symptoms and no left-sided deficits. I did not see any abnormalities on funduscopic exam. No other neurologic deficits were noted on exam.

I suspect a focal vascular event on the right due to the partial visual loss on the right side.

As you recommended he was sent for carotid ultrasound and then will be seen by you. He may also need MRI or CT scan.

Thank you for assisting in Mr. Westrum’s care.

Sincerely

Lynn Solinski, MD

LS:XX
By fax
CHART NOTE

Arnold Stronovich

SUBJECTIVE
Arnold has left cheek numbness. He also had left arm numbness lasting about 30 minutes or so that started yesterday, and it has occurred 2 to 3 times today. There is no dizziness, headache, nausea, lightheadedness, problems with balance, or aphasia. There is no history of fall or concussion. The area involved is only the left cheek and left arm. No motor function problems. His hand had temporary paresthesia, but had normal strength. He is a nonsmoker.

Family history: Significant for massive cerebral hemorrhage in his father resulting in death; mother had multiple sclerosis.

OBJECTIVE
BP 128/70. Temperature 99.
HEENT: Tympanic membranes are normal. Conjunctivae are normal; full EOMs. The area involved is only the left cheek. There is no discoloration or numbness of cheek presently. Facial expressions are normal. Pharynx appears normal.
NECK: Carotid bruits are bilaterally negative. Cervical nodes are negative.
LUNGS: Clear to auscultation and percussion.
HEART: Normal S1 and S2.
ABDOMEN: Negative.
EXTREMITIES: Extremities are warm; no clubbing or cyanosis; good peripheral pulses. There is no particular numbness of the extremities.
NEUROLOGIC: Grossly intact. Reflexes are 1+ and symmetric. Romberg is normal. Gait is normal; no ataxia.

ASSESSMENT
Questionable transient ischemic attack.

PLAN
One adult aspirin per day stat and daily. He is advised to have a complete physical examination with screening labs within the next week. Patient was told to go to emergency if any recurrence of symptoms.

Lynn Solinski, MD

LS:XX

D: 4/24/20—
T:
Chapter 11, Item 7

HISTORY AND PHYSICAL REPORT

Lia Jen Chambers

April 24, 20--

HISTORY OF PRESENT ILLNESS
Lia presents today with the following complaints: cough productive of yellowish-green sputum, fever, sinus congestion, bilateral ear pain, swollen node in her neck, dizziness, and vertigo.

PAST MEDICAL HISTORY
Usual childhood diseases with many ear infections. Patient has never had a tympanogram. She states that she does not notice much hearing difficulty. One episode of herpes zoster without complications. Sciatica treated with physical therapy several years ago.

EXAMINATION
Temperature 99.2.
ENT: TMs are scarred. Maxillary sinus regions are tender bilaterally. Throat is clear.
NECK: Reveals a 1-cm tender anterior cervical node on the right.
LUNG: Reveal basilar rales that partially clear with deep breathing.
HEART: Tones are normal.
ABDOMEN: Negative.
NEUROLOGICAL EXAMINATION: Awake, alert, and oriented. Good strength in all groups. Sensation is intact to light touch. Deep tendon reflexes are 1+ and equal bilaterally. Cranial nerves 2-12 are intact. Cerebellar testing including finger-to-nose is within normal limits. She has horizontal gaze nystagmus bilaterally with no vertical nystagmus. Vertigo seems to be worse with sitting or moving of her head.

LABORATORY
White count is 7,600. Chest x-ray shows bilateral breast implants but is negative for infiltrate or congestive failure. Sinus films show mucosal thickening on the right, but are otherwise negative.

ASSESSMENT
1. Upper respiratory infection with sinusitis, pharyngitis, and bronchitis in a smoker.
2. Acute labyrinthitis.

TREATMENT
Patient was given Valium 2.5 mg IV with marked improvement in her vertigo. She was prescribed Biaxin 500 mg b.i.d. for 10 days; Antivert 25 mg t.i.d. p.r.n. for dizziness; and Tylenol p.r.n. for discomfort. She is to get plenty of rest, push fluids, and avoid salty products. Lia is to return in 72 hours if symptoms persist.

Lynn Solinski, MD

LS:XX

D: 4/24/20—
T:
CHART NOTE

Richard Lighttree          April 24, 20--

SUBJECTIVE
This patient was working on his car, pounding underneath it when something fell into his left eye.

OBJECTIVE
There is a punctate, metallic foreign body superficially embedded in the left cornea at 3 o'clock position. Remainder of eye exam is unremarkable. We were unable to check visual acuity because of eye irritation.

ASSESSMENT
Corneal foreign body.

PLAN
Pontocaine anesthesia and then a #25-gauge needle was used to remove the foreign body, Sulfacetamide eye drops administered and eye patch placed. Eye precautions given. Follow up in 24 hours if not completely cleared.

Lynn Solinski, MD

LS:XX

D: 4/24/20—
T:
CHART NOTE

Heather Sherman        April 24, 20--

SUBJECTIVE
Heather has had 1 week of rhinorrhea and mattering of the lower lateral aspect of the left eye. She does not wear contacts. There is no photophobia. Heather states that her vision is less clear on the left side.

OBJECTIVE
Without glasses her vision is 20/80 in both eyes. PERRLA. Extraocular muscles are intact. Conjunctivae and sclerae are clear. Fundus is normal on left. There is no foreign body in the conjunctival sac. I can't see the lacrimal gland very well, but there is no mass by palpation. There is no discrete stye along the lower lid margin and no sign of blepharitis. TMs and pharynx are clear.

ASSESSMENT
Probable early conjunctivitis in the setting of a viral upper respiratory infection. Symptoms may be less because she has been using Visine.

PLAN
Gantrisin drops 2 to eye q.i.d. Patient to return if not improved.

Lynn Solinski, MD
LS:XX
D: 4/24/20--
T:
Chapter 11, Item 10

CHART NOTE

Tamara Neubauer        April 24, 20--

SUBJECTIVE
The patient presents with right eyelid which is red and swollen. About a week ago she
complained that the corner of her right eye was irritated. No other symptoms. This morning she
noticed that the right upper eyelid was swollen and irritated. No discharge has been noted. No
symptoms in her other eye. No earache, sore throat, fever, or congestion.

OBJECTIVE
EYES: Conjunctival injection in right eye with some periorbital edema and some edema of the
conjunctiva. No discharge.

ASSESSMENT
Stye in the right upper eyelid, laterally.

PLAN
Sodium Sulamyd drops to right eye for 10 days. Warm packs alternating with cool packs for
relief of edema. Return p.r.n.

Lynn Solinski, MD
LS:XX
D: 4/24/20—
T:  
CHART NOTE

Timothy Blesi

SUBJECTIVE
This 40-year-old male was hit in the right eye by a miniblind causing a cut in the white part of his eye. He has had mild pain but no visual problems, no photophobia, and no blurred vision.

OBJECTIVE
There appears to be a laceration/abrasion of the right sclera with surrounding subconjunctival hematoma. PERRLA. There does not appear to be any involvement of the cornea. Fluorescein stain shows some mild uptake over the injury site.

ASSESSMENT
Scleral abrasion, right eye.

PLAN
Garamycin ophthalmic solution, 1 to 2 drops to right eye every 4 hours for a few days. Recheck if problem continues or symptoms worsen.

Lynn Solinski, MD

LS:XX

D: 4/24/20--
T:
Chapter 12
Solutions
SUBJECTIVE
Patient is a 77-year-old anxious-appearing man who complains of changes in his eating habits. He states that he sometimes has difficulty swallowing, like it “just does not go down right.” He also has noted dark stools which are occasionally black, but without apparent blood. He has not noted any rectal bleeding. There has been no nausea, emesis, belching, or cramping. No constipation or diarrhea. Patient is a diabetic on insulin.

OBJECTIVE
BP 164/86. Pulse 88. The patient is in no acute distress, but appears worried. There is no lymphadenopathy. Abdomen is soft and nontender without guarding or rigidity. Liver, kidneys, and spleen are not palpable. There are no masses or organomegaly. Stool is guaiac positive.

ASSESSMENT
1. Gastrointestinal bleeding.
2. Dysphagia, etiology unknown.

PLAN
Schedule patient for H&P with Dr. Kim.

John Blackburn, MD
JB:XX
D: 4/27/20—
T:
Case 1, Item 2

HISTORY AND PHYSICAL EXAMINATION

Rolland Severson               April 28, 20--

CHIEF COMPLAINT
Patient is admitted for complete workup for dysphagia and GI bleeding.

HISTORY OF PRESENT ILLNESS
Patient is an anxious-appearing elderly white male in no acute distress. For the past 5 to 7 days, he has noted increasing difficulty with eating including anorexia and dysphagia. There has been no nausea or emesis, no belching, no cramping, no diarrhea or constipation. He has noticed occasional black stool, but no bright red blood per rectum.

PAST MEDICAL HISTORY
1. Diabetes since age 24, presently on Humulin 10 units q.a.m.
2. Pneumonia, age 43.
3. Hypercholesterolemia.
4. Diabetic retinopathy and neuropathy.
5. Thrombophlebitis, right leg following a surgery.
6. Chronic joint pain.
7. Angina with exertion.

PAST SURGICAL HISTORY
1. Open reduction with internal fixation of right ankle due to a work injury.
2. Herniorrhaphy.
3. Cholecystectomy.
4. Laminectomy, L4-5.
5. Arthroscopy, right knee.

MEDICATIONS
1. Humulin 10 units q.a.m.
3. Naprosyn 25 mg t.i.d.
4. Aspirin gr 2.5 daily.
5. Metamucil one tablespoon in 8 ounces of water daily.

ALLERGIES
No known drug allergies.

Social history: Patient is a retired construction foreman. He lives with his wife. He is capable of maintaining their home. He has smoked cigarettes in the past, but does not currently smoke. He will have an occasional alcoholic beverage. He drinks 1 to 2 cups of caffeinated beverage per day.

Family history: Father had diabetes with poor control and multiple complications including dialysis for nephropathy, amputation of right leg due to vascular insufficiency, and
paresthesias. Mother had macular degeneration, osteoporosis, and anxiety attacks. Patient had 4 siblings, 2 now deceased. One sister had degenerative joint disease and has had hip replacement; 1 sister had metastatic breast cancer treated with radiation and chemotherapy.

REVIEW OF SYSTEMS
HEENT: Negative.
RESPIRATORY: No chest pain, but some dyspnea on exertion.
CARDIOVASCULAR: No history of tachycardia, palpitations, or angina other than occasional chest tightness with exertion.
GASTROINTESTINAL: No hematochezia. Some anorexia for the past 5 to 7 days with dyspepsia/dysphagia and black stools. No diarrhea. Takes Metamucil for regularity. No rectal complaints. Nocturia x2.
NEUROMUSCULAR: Chronic joint pain and stiffness.

PHYSICAL EXAMINATION
HEENT: Normocephalic. Some diabetic retinopathy is visualized.
LUNGS: Clear to auscultation and percussion.
HEART: Cardiac exam reveals a regular rate and rhythm with normal S1 and S2. There is a grade 1/6 systolic murmur at the apex.
ABDOMEN: Soft and nontender without masses or hepatosplenomegaly.
RECTAL: No masses. Stool on gloved finger is guaiac positive. Prostate is 3+ enlarged and boggy.
EXTREMITIES: There is 2+ pedal edema bilaterally; no cyanosis. Peripheral pulses are palpable. Calves are negative.
NEUROLOGICAL: Intact.

LABORATORY DATA
Hemoglobin today is 10.0; WBC 9,800.

PLAN
1. Admit to hospital for complete workup.
2. Routine labs, chemistry profile, basic metabolic panel, ECG, and chest x-ray.
3. Referral to Lia Luez, MD, in gastroenterology for possible GI and barium x-rays, endoscopy, and CT of abdomen.

Lee W. Kim, MD

LWK:XX

D: 4/28/20—
T:
May 5, 20--

Merlin Williams, MD
300 Central Avenue
Lakewood, CO 80134

Dear Dr. Williams

RE: Rolland Severson

Your patient, Mr. Severson, is being returned to your care. He came to our clinic with complaints of dyspepsia, dysphagia, and black stools. He was admitted to the hospital for a GI workup and seen by Lia Luez, MD, of the gastroenterology department. There was no active bleeding site found in any of the testing that was performed. The bleeding was most likely due to his excessive use of nonsteroidal anti-inflammatories. His poor eating habits exacerbated the problem.

Following surgery he has done well. On exam today his vital signs are stable. Lungs show diminished breath sounds bilaterally, and he has been encouraged in deep breathing to fully expand his lungs. A chest x-ray revealed no evidence of pneumothorax or pulmonary disease. There is no change in his cardiovascular status. His discharge hemoglobin was 10.6.

It has been suggested to Mr. Severson that he make a follow-up appointment with your office to recheck his hemoglobin in 1 week. We would like it to get to at least 12. He has been told to avoid the excessive use of nonsteroidals for his chronic pain and to check with you regarding his options for pain relief.

Thank you for referring this interesting gentleman. I anticipate that he will do well in the immediate future.

Sincerely

Lee W. Kim, MD

LWK:XX
CHART NOTE

Naomi Geiger

CHIEF COMPLAINT
Chest tightness.

SUBJECTIVE
Patient complains of chest tightness or pressure for the past 1 to 2 days. She has no increased sweatiness, pain radiation, or dizziness. She has had these episodes in the past, but has refused workup.

OBJECTIVE

LABORATORY
ECG shows normal sinus rhythm. There is a 1-mm ST depression in leads II, III, and AVF.

ASSESSMENT
Unstable angina.

PLAN
Patient scheduled with Internist Lynn Solinski for complete physical prior to hospitalization.

Debra Litman, MD

DL:XX

D: 4/29/20—
T:
Case 2, Item 2

HISTORY AND PHYSICAL EXAMINATION

Naomi Geiger          April 30, 20--

CHIEF COMPLAINT
Chest pain.

HISTORY OF PRESENT ILLNESS
This 88-year-old female with history of hypertension has been complaining of chest pain or pressure for the past 1 to 2 days. There is no history of diaphoresis, palpitations, tachycardia, or pain that radiates to the left arm. She does have chest pain and dyspnea on exertion with walking a flight of stairs. The pressure feeling goes away with rest; she will occasionally take a nitroglycerin tablet sublingually.

PAST MEDICAL HISTORY
The patient’s cardiac risk factors are high including obesity, hypertension, hyperlipidemia, and a family history for coronary disease. She also suffers from seborrheic dermatitis.

SURGICAL HISTORY
Appendectomy, cholecystectomy, hysterectomy, and bilateral salpingo-oophorectomy for severe endometriosis, and cataract removal with lens implant in left eye.

MEDICATIONS
1. Enalapril (Vasotec) 10 mg b.i.d.
2. Procardia 20 mg t.i.d.
4. Lipitor 10 mg daily.
5. Aspirin 1 tablet daily.
6. Calcium carbonate 400 mg b.i.d.
7. Daily vitamin.

ALLERGIES
Environmental allergies; no known drug allergies.

Family history: One brother with asthma and emphysema died from lung cancer at age 61; 1 sister had a CABG due to coronary occlusion and stenosis in at least three arteries; father died at age 84 from cerebrovascular accident; mother died at age 67 from pulmonary embolus following a hip fracture.

Social history: The patient is a retired banker. She is a nonsmoker and does not drink alcohol. She limits her coffee intake to 1 cup of decaf per day.

REVIEW OF SYSTEMS
SKIN: Negative.
HEENT: Negative.

(continued)
RESPIRATORY: No fevers, cough, sputum, or wheezing. She has occasional nocturnal dyspnea, some orthopnea, and recent dyspnea with exertion.
CARDIOVASCULAR: Occasional chest pressure in the past. Positive history for ankle and leg edema.
GASTROINTESTINAL: No weight change, change in bowel habits, or hematochezia.
ENDOCRINOLOGICAL: No polydipsia, polyphagia, or polyuria.
URINARY: Patient denies dysuria, nocturia, urgency, or incontinence.
GYNECOLOGICAL: Four normal deliveries.
NEUROLOGICAL: No history of head injury. No headache, syncope, vertigo, or paralysis.

PHYSICAL EXAM
GENERAL: BP 186/100. Pulse 96. Respirations 30. Afebrile. This is a well-developed, well-nourished, obese white female who seems to be in some discomfort due to chest “pressure.” Patient is alert and oriented x3.
SKIN: There are multiple nevi scattered over back and shoulder regions.
NECK: Supple without thyromegaly. Jugular venous distention is noted.
CHEST: Pendulous breasts without masses. Normal breath sounds without rales or wheezes.
HEART: Regular rate and rhythm. Heart tones are normal.
ABDOMEN: Abdomen is soft and nontender; no hepatosplenomegaly or masses were palpated. No CVA tenderness. Surgical scars are noted.
GENITALIA: Normally atrophic female external genitalia.
EXTREMITIES: Strength, tone, and bulk were normal throughout. No joint deformity noted; no scoliosis noted. Two plus ankle edema. No calf tenderness. Femoral pulses 2+ bilaterally.
NEUROLOGICAL: Intact sensation. Deep tendon reflexes are symmetric and equal. Normal gait.

ASSESSMENT
Myocardial infarction.

PLAN
1. Blood work to include stat cardiac enzymes. Fasting labs: in a.m., do routine blood studies and chemistries.
2. Repeat ECG in a.m.
3. Myocardial infarction protocol per hospital routine.
4. Patient to be seen and treated by a cardiothoracic surgeon, Lorraine Clifford, MD.

Lynn Solinski, MD
LS:XX
D: 4/30/20—
CHART NOTE

Naomi Geiger                  May 13, 20--

CHIEF COMPLAINT
Left leg swelling and pain.

SUBJECTIVE
Patient was discharged from hospital 1 week ago following cardiac workup with angiogram. She has not been compliant with her cardiac rehab exercises and tends to sit most of the day with her legs in the dependent position. She has not been wearing TEDs.

OBJECTIVE
Alert and in no acute distress. Skin is warm and dry. BP 186/98. Temperature 99.8°. Lungs are clear to auscultation and percussion. Surgical sites are clean without sign of infection. The left lower extremity is reddened, warm, swollen, and tender to palpation. The right extremity is negative.

LABORATORY
Prothrombin time stat.

ASSESSMENT
Deep venous thrombosis.

PLAN
Patient is readmitted to hospital for initiation of IV anticoagulants and adjustment of Coumadin.

Debra Litman, MD

DL:XX

D: 5/13/20—
T:
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