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Woodhull General Surgery

SOAP NOTE # A

Course of illness:

The patient is a 55 y/o female with a PMHx for HLD, IDA, morbid obesity, and prior partial gastrectomy (10/13/2023). She has had multiple prior visits with bariatric surgery for evaluation of persistent GERD symptoms. Despite 6 months of treatment with pantoprazole and Gas-X, she reports no improvement and even worsening reflux symptoms. An upper GI series and KUB later showed a moderate-sized hiatal hernia (4-5cm) with associated esophageal reflux. After consultation with bariatric surgery, she was deemed an appropriate candidate for conversion to gastric bypass with hiatal hernia repair. The patient agreed to proceed with surgical intervention.

Subjective:

March 4th, 2026

Patient is a 55-year-old female POD #1 s/p laparoscopic hiatal hernia repair with gastropexy. Seen at bedside this morning. Incisional pain is well controlled with medication. Reports bilateral supraclavicular pain rated 9/10 radiating to the neck and lower jaw; worsens with neck flexion and when drinking water. States that chewing ice chips is better tolerated than consuming liquids since they melt and goes down slowly. Per patient, consumed 4-oz of water since the surgery. Denies N/V, SOB, fever, chills. No BM yet since the procedure but did void x2 overnight. Patient able to ambulate to out of bed to toilet independently. Denies symptoms of GERD. Per nursing staff, no acute events overnight.

Objective:

<u>Vital signs:</u>

Temp: 97.7 F

BP: 108/58

HR: 60

RR: 12

O2 sat: 100% RA

<u>Physical exam:</u>

General: Patient is alert and oriented x3 (time/person/place). She appears uncomfortable due to pain while in fowler's position on bed. Well-kept in hospital gown and appears her stated age.

Neck: tenderness to palpation and crepitus noted bilaterally. No signs of tracheal deviation noted. Range of motion limited due to pain. No scars, masses noted.

Chest: tenderness to palpation and crepitus noted at supraclavicular region bilaterally. No apparent chest lesion, masses, trauma, deformities noted.

Cardiovascular: regular rate and rhythm

Lungs: Respiration WNL, unlabored respiration, lung sounds clear to auscultation bilaterally, no accessory muscle use noted

Abdomen: soft, non-distended, negative rebound tenderness and guarding. Surgical incision sites are dry and intact. Incision sites are well-approximated with sutures, dry, no signs of infection, no drainage, erythema resolving and healing. No signs of wound dehiscence.

Post-op labs

	3/4/26	**3/3/26**
WBC	7.2	11.26
HGB	9.3	10.6
HCT	29.0	32.5
Platelets	174	158

	3/4/26	**3/3/26**
Na+	136	139
K+	4.2	4.1
Cl-	102	98
CO2	25	27
BUN	12	20
Creatinine	0.65	0.57
Ca+2	8.2	9.8

Intake/output (3/3-3/4)

Intake: 1,717.5 ml

- IV lactated ringers infusion – 1,547.5 ml
- IV piggyback clindamycin (600mg in NaCl solution) – 50 ml
- PO water – 120 ml

Output: Patient voided x 2 in toilet overnight, unable to quantify amount.

Post-op imaging

CXR (3/3/26)

Findings: There are small bilateral pneumothoraces. The cardio mediastinal silhouette is exaggerated by technique. Bony structures are stable. There is air overlying the soft tissues.

Impression: small bilateral pneumothoraxes

Assessment

55 y/o female POD 1 s/p laparoscopic hiatal hernia repair with gastropexy, presenting with subcutaneous crepitus and tenderness at the supraclavicular region that radiates to the neck and lower jaw bilaterally. Pain is worse on exertion and when drinking fluids. Post-op CXR shows bilateral subcutaneous emphysema and pneumothoraces. Crepitus most likely due to CO2 insufflation during laparoscopy. Besides this, patient is recovering well from general anesthesia, surgical sites are clean and healing. Will continue to monitor.

Plan:

- Continue DVT prophylaxis, Heparin. Have patient ambulate out of bed to chair, and if tolerable, walk around the ICU unit with assistance

- Continue incentive spirometry use every 1-2 hours

- Order repeat CXR, re-access pneumothoraces

- Pain control as needed, Toradol or Tylenol

- Continue bariatric diet stage 1. Drink 1 once or small sips of liquid every 15 minutes as tolerable.

- Continue monitoring vitals