

MEDICAL REVIEW AND SUMMARY CONCERNING xxxxxx xxxxx

CONFIDENTIAL ATTORNEY WORK PRODUCT

01/27/02

**BASIC LIFE SUPPORT
FIELD REPORT**

(p. 2)

Chief compliant. Chest pain. Abrasion to bridge of nose, right and left hand. Chest pain.

2229 hours. Pulse 72. Respirations 22. Blood pressure 160/?.

01/27/02

AMBULANCE RECORD

(p. 1)

Driver of vehicle in traffic collision. Breathing, circulation, and temperature, color with in normal limits. Glasgow coma score of 15.

2229 hours. Pulse 72. Respirations 22. Blood pressure 160/palpable.

2241 hours. Pulse 76. Respirations 20. Blood pressure 152/86. Primary and secondary spine precautions.

Chief compliant. Neck and chest pain. Distal peripheral motor sensory intact before and after application. Mild trauma. Restrained driver of the vehicle with front-end damage. No interior damage to vehicle.

01/27/02

**BASIC LIFE SUPPORT FIELD
REPORT**

(p. 2)

2241 hours. Pulse 76. Respirations 20. Blood pressure 152/? Follows commands. Abrasion on nose. Complaining of chest pain. Lungs clear bilaterally, equal rise and fall. Abdomen soft. Spine, complaints of pain. Abrasion bilateral hands. Patient found in car. Paramedics on scene. Cervical collar on. Air bag deployment. Patient complaining of chest pain with respirations in seatbelt area. Left-sided chest only. Will

contact. No oxygen. Minor abrasion for head and hands.

01/27/02 **EMERGENCY ROOM**
XXXXXXXX HOSPITAL

01/27/02 **TRAUMA ROOM**
ADMITTING ORDERS
LISA XXXXXX, M.D.
(p. 15-16)

Oxygen nasal cannula. Continuous EKG. Blood pressure and oximetry monitoring. Large-bore I.V. cannulas for fluid resuscitation. Obtain temperature. Use warm blanket. CBC without differential and repeat hemoglobin and hematocrit every 30 minutes until stable. Amylase, alcohol level. Hepatitis C, type modified crossmatch. Lateral cervical spine, chest x-ray, 12-lead EKG. Morphine 2 mg every 15 to 30 minutes as needed. X-rays, thoracic spine, lumbar spine, brain, abdomen, neck, chest, and lateral chest x-ray. Urinalysis with drug screen.

2240 hours. Mode of transportation ground. Traffic collision. Hit median divider head-on. Positive seat belt. No air bag. Mechanism of injury is blunt chest.

Trauma surgeon Dr. Xxxxxxx notified at 2310 hours. Arrived at 2320 hours.

Trauma nurse xxx notified at 2310 hours. Arrived 2311 hours.

Other Dr. xxxxxxxxx notified 2310 hours. Arrived 2310 hours.

Respiratory therapist T. xxxxxx notified 2310 hours. Arrived 2310 hours.

Neurosurgeon Dr. xxxxx notified at 2350 hours, spoke with Dr. Xxxxxx.

Cardiology Lousara xxxx notified 2352 hours, spoke with Dr. Xxxxxx.

Past medical history is positive for C5 fracture, no surgery. Patient 5 feet 8. Stated weight 100 kg.

Family notified, here in emergency room, admitted to ICU room 8.

Time Summary Emergency Department 2240 hours.

Trauma 2310 hours.

CT 2330 hours.

Radiology 0010 hours.

ICU 0035 hours.

01/27/02

EMERGENCY FLOW SHEET

(p. 17-19)

Oxygen saturation 99% to 100% throughout. Glasgow coma score 15 throughout. Champion trauma score of 16 throughout.

Upper and lower extremities within normal limits. Speech clear. Eyes conjugate. Head and neck with cervical collar, precautions. Belt abrasion equal. Rise and fall of chest. Complaining of shortness of breath and pain on breathing. Monitor shows strong sinus rhythm without ectopy (abnormal beats). Skin warm and dry to touch. Abdomen large, round with hypoactive bowel sounds. Normal male genitalia. Unable to assess urine. No skeletal or extremity deformities noted. Laceration bridge of nose.

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**EMERGENCY DEPARTMENT
NURSING FLOW SHEET**

(p. 22-24)

Initial vital signs: Temperature 98 degrees. Pulse 80. Respirations are 2? Blood pressure 148/96. Awake, alert, and oriented x 4. A traffic collision driver. Chest pain with palpation. Left elbow surgery and neck fracture.

Past medical history positive for encephalitis, meningitis. Pain 5/10.

(p. 26)

2310 hours. Patient was upgraded from emergency room. Dr. xxxxxxxx at bedside. Ordered chest x-ray. I.V. started. Labs drawn. Seat belt abrasion noted. Complaining of difficulty breathing. See assessment.

2320 hours. Dr. Xxxxxx took over case. Dr. xxxxxxxx gave report. Reassess patient.

01/27/02 **LABS**
(p. 264)

2325 hours: Ethanol less than 10, reference range less than 10.

01/27/02 **EMERGENCY DEPARTMENT**
NURSING FLOW SHEET
(p. 22-24)

2330 hours. Trauma nurse and tech transported patient to CT scan with monitor without incident for head CT, neck, and chest.

01/27/02 **PHYSICIAN'S ORDERS**
LISA XXXXXX, M.D.
(p. 43-45)

2335 hours. Sternal fracture. Rule out cardiac contusion, pulmonary contusion, closed head injury, neck strain. Patient on adxxxxxxx stable. Intake and output hourly. Vital signs every hour for 24 hours and then every two hours and as needed. Neuro assessment hourly and as needed. Change Protonix 40 mg I.V. every 24 hours. Morphine 2 to 4 mg I.V. every two hours as needed for pain. Tylenol every four hours as needed for pain.

CBC, hemoglobin, and hematocrit every day x 2. Electrolytes every day x 3. BUN, creatinine, glucose, every day x 3. EKG daily for two days. Cardiac enzymes every eight hours x 3. Type and hold of four units

packed cells for 72 hours. Test film daily. While in bed until cleared by Dr. Xxxxx. Bed rest, may turn. Cardiac monitor. Eggcrate mattress. Vascular assessment every eight hours and as needed. Antihemolytic precautions: nose, pneumatic device.

Assessment and plan with in 48 hours. Oxygen at two liters nasal cannula. Oximetry.

01/27/02 **EMERGENCY DEPARTMENT**
NURSING FLOW SHEET
(p. 22-24)

2345 hours. Labs redrawn. Dr. Xxxxxx told about abdominal distension and increased size. CT of abdomen ordered.

01/27/02 **EMERGENCY DEPARTMENT**
NURSING FLOW SHEET
(p. 22-24)

2350 hours. Call Dr. Xxxxx for neurosurgery. Dr. xxxxxxxxx of cardiology and spoke with Dr. Xxxxxx.

01/28/02 **CT OF ABDOMEN AND PELVIS**
MICHAEL XXXXXX, M.D.
(p. 247)

No evidence of visceral injury in the abdomen or pelvis. Tiny cyst is present in the upper pole of the left kidney.

01/28/02 **CHEST X-RAY**
MICHAEL XXXXXX, M.D.
(p. 252)

Mild congestive heart failure.

<u>01/28/02</u>	<u>CT OF THE LUNGS</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 245)	Sternal fracture. No evidence of mediastinal hematoma or pneumothorax. The study was performed and interpreted after hours.
<u>01/28/02</u>	<u>CT MAXILLOFACIAL BONES</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 246)	No evidence of fracture.
<u>01/28/02</u>	<u>X-RAYS STERNUM</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 248)	Fracture of upper sternum.
<u>01/28/02</u>	<u>CT OF THE SPINE</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 249)	No evidence of fracture or subluxation of the cervical spine.
<u>01/28/02</u>	<u>LATERAL CERVICAL SPINE</u> <u>FILM</u> (p. 250)	Degenerative changes. No evidence of fracture.
<u>01/28/02</u>	<u>CT OF THE BRAIN</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 242)	Normal noncontrast CT of the brain. Bilateral maxillary sinus disease.

<u>01/28/02</u>	<u>EMERGENCY DEPARTMENT NURSING FLOW SHEET</u> (p. 22-24)	0010 hours. Trauma nurse and tech transported patient to radiology for thoracic and lumbar spine without incident.
<u>01/28/02</u>	<u>THORACIC AND LUMBAR SPINE FILMS</u> <u>MICHAEL XXXXXX, M.D.</u> (p. 251)	No evidence of the thoracic spine degenerative changes. No evidence of fracture of the lumbar spine.
<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>JEFFREY XXXXX, M.D.</u> (p. 46)	0030 hours. Place patient in Aspen collar.
<u>01/28/02</u>	<u>EMERGENCY DEPARTMENT NURSING FLOW SHEET</u> (p. 22-24)	0035 hours: Trauma nurse and tech transported patient to ICU without incident. Report given to xxxx, R.N. Met with Dr. XXXXXX and ordered to keep cervical collar on until neurosurgeon clearance. Back board off. Log rolled only. Pending radiology report.
<u>01/28/02</u>	<u>NURSING ADXXXXXXXXX ASSESSMENT</u> (p. 82-87)	Patient wear glasses, hearing aids at home. Sternal pain. Intensity 2-8/9. Medications are Advil or aspirin, Maalox occasionally about once a week. Smokes 2½ packs per day for 50 years. Quit 04/01/01. Never uses alcohol. Quit 20 years ago. Patient with left-sided abrasion.
<u>01/28/02</u>	<u>INTENSIVE CARE FLOW SHEET</u> (p. 94)	Glasgow coma score within normal limits. Cranial nerves within normal.

01/28/02

PHYSICIAN'S ORDERS
LISA XXXXXX, M.D.

(p. 46)

0050 hours. Okay for morphine PCA 1 mg every 15 minutes 30 mg with four-hour limit. No basal rate. Okay, off backboard. Flat logroll only.

01/28/02

PHYSICIAN'S ORDERS
ARTHUR XXXXXXXXXXXX, M.D.

(p. 46)

0110 hours. Echo Doppler in the morning. Rule out contusion.

01/28/02

CARDIOLOGY CONSULTATION
ARTHUR XXXXXXXXXXXX, M.D.

(p. 37-39)

Reason for consultation: Status post chest trauma. Rule out cardiac contusion.

63-year-old white male, previously healthy, without any prior cardiac history, was in a motor vehicle accident earlier this morning. He was driving his car on the 405 going about 55 to 65 miles per hour. A taxicab swerved out of control and hit the car. The patient then lost control of his car and ran into the median divider sustaining blunt trauma of the chest from the steering wheel. He did not have airbags. He was wearing a seat belt, as were all the passengers in the car. He did not lose consciousness. He was brought into the Xxxxxxx Hospital Regional Medical Center Trauma Service under cervical spine precautions.

His chief complaint was chest pain.

CT scan of the chest did not reveal any pericardial effusion or any obvious injury to the aorta.

He is now in the intensive care unit still under cervical spine precautions. He does have some chest pain currently.

Patient quit smoking in April 2001 and prior he smoked 50 years, times one to four packs per day.

History of ethanol in the past, none currently.

Medications at home, none.

Past surgical history is positive for hemorrhoidectomy. No surgery. Fracture, repair of the left elbow.

On examination, reveals he is in no apparent distress. In C-spine precautions. Heent pupils equal, round, and reactive to light. Extraocular movements intact. Oopharynx clear. Neck unable to examine because no obvious ecchymosis on the chest. Heart regular rate and rhythm. No murmurs, gallops, or rubs. Lungs clear. Oblique bruise over the right abdomen secondary to seat belt trauma. Extremities with no edema.

Chest x-ray reveals borderline cardiomegaly, possible mild congestive heart failure pattern. EKG reveals normal sinus rhythm with RSR prime pattern in leads V1. Normal PR interval normal. Normal QRS interval. No ST or T wave changes.

Laboratories within normal limits with the exception of glucose 229. CPK 200 with MB of 8. Troponin less than 0.5. Ethanal less than 10.

Impression:

1. Status post motor vehicle accident with blunt trauma to the chest.

The chest CT does not reveal any obvious fluid in the pericardium. An echocardiogram is pending this morning. With regards to other evidence for cardiac contusion, the patient does not have any significant atrial or ventricular ectopy. His PR and QRS intervals are normal and thus there is no objective evidence thus far for cardiac contusion.

2. Possible pulmonary contusion. The patient x-ray has some suggestion of mild congestive heart failure pattern. This may be secondary to pulmonary contusion and should be followed.

Plan:

1. Await echocardiogram
2. Serial chest x-rays.
3. Observe with cardiac monitor x 24 hours to detect any ectomy or bundle-branch block, which may suggest cardiac contusion.

01/28/02

ECHOCARDIOGRAM
(p. 232-234)

Unremarkable Doppler study. Moderate concentric left ventricular hypertrophy (enlargement). Normal valve structures. Normal left ventricular size and function. Normal pericardium.

01/28/02

PHYSICIAN'S PROGRESS NOTES
ARTHUR XXXXXXXXXXXXX, M.D.
(p. 63)

0115 hours. Patient status post motor vehicle accident blunt trauma to the chest. Now in ICU, fully responsive in normal sinus rhythm without ectopy. Chest CT preliminary, no pericardial effusion. Monitor chest. Normal sinus rhythm. No ST or T changes. Chest x-ray with questionable mild congestive heart failure pattern. No evidence thus far of cardiac contusion. No evidence for tamponade or pericardial effusion. Question mild pulmonary contusion. Recheck echo in the morning. Serial EKGs.

Cardiac markers for 24 hours.

01/28/02 **NURSE'S NOTES**
J. XXXXXX, R.N.
(p. 173)

0500 hours. Morphine PCA. Relaxation techniques. Patient states morphine working well to almost complete relief of pain in times.

01/28/02 **NURSE'S NOTES**
(p. 173)

0815 hours. Patient states good/adequate sternal pain relief. Pain increases with deep breaths. Complaining of mild superficial discomfort superior and lateral to left eye. CT preliminary results "sinus fracture." Only pain is as above. Dr. Xxxxxx given preliminary CT and x-ray results over the phone. No new others. Patient to maintain flat pending examination by Dr. Xxxxx. Neuro: With Aspen collar remaining in place. Numbness or tingling or pain.

01/28/02 **PHYSICIAN'S ORDERS**
JEFFREY XXXXX, M.D.
(p. 47)

0900 hours. Aspen collar to remain in place. May increase head at bed to less than 30 degrees, bedside with assistance to void.

01/28/02 **CHEST X-RAY**
MICHAEL XXXXXX, M.D.
(p. 241)

1004 hours. No acute disease in the chest.

01/28/02 **PHYSICIAN'S ORDERS**
ARTHUR XXXXXXXXXXXX, M.D.
(p. 47)

0935 hours. Chest x-ray. EKG in the morning. Needs cardiac monitor for 24 hours.

01/28/02

HISTORY AND PHYSICAL

LISA XXXXXX, M.D.

(p. 34-35)

Reason for admission:

1. Chest contusion.
2. Sternal fracture.
3. Rule out cardiac contusion.
4. Pulmonary contusion.
5. Pulmonary effusion.
6. Nasal laceration.

63-year-old restrained driver in a motor vehicle accident. Apparently, the patient was driving in the rain and had some problems with his frontal defoggers and then subsequently hit another vehicle head-on at a slight angle; the car then spun out and proceeded to hit the median at a relatively high speed, somewhere around 60 to 70 miles/per hour. He denies any loss of consciousness at the scene and primarily complained of chest pain over the sternal area and difficult with respirations. He was brought to the emergency room as a regular basic life support patient and subsequently upgraded as a trauma patient because of symptomatology and mechanism.

An EMS system was rung at 2208 hours. He arrived at the scene at 2220 hours. Initial vital signs were pulses 72, respirations 22, and blood pressure 160/palpable with sinus rhythm. Patient was alert and oriented. No I.V. was started. Glasgow coma score was 15. It was loaded up at 2238 hours when they arrived at XXXXXX Hospital Regional Trauma Center at 2250 hours.

Physical examination: In general, primary survey was notable for a well-developed male in a moderate amount of distress secondary to pain. Pupils were equal and reactive to light bilaterally. Tympanic membranes were clear. There is a small laceration over his nares over the bridge. There was no associated soft tissue swelling. There was no other evidence

of facial trauma. He was tender over the C4-C5 in the cervical spine area.

(p. 36)

Chest x-ray is unremarkable. Sternal fracture in mid aspect. Thoracic and lumbar spine fractures. Moderate degenerative joint disease. Head shows no acute process, sinus disease only.

Maxillofacial CT, no acute fracture seen.

CT of the neck, no acute fracture seen.

CT of the chest, sternal fracture. No evidence of cardiac contusion. No evidence of pericardial fluid. Mild pulmonary contusion over the left with a small pleural effusion.

CT of the abdomen shows no major organ injury.

Total critical care time 2310 hours to 0010 hours.

01/28/02

PHYSICIAN'S PROGRESS NOTES

LISA XXXXXX, M.D.

(p. 65)

Feels well except for chest pain anteriorly. Alert and oriented. Pupils equal and reactive to light. Moves all extremities spontaneously to commands. Decreased breath sounds at the bases. Abdomen round, soft, nontender. Positive bowel sounds. Chest x-ray large heart, blunting angles bilaterally. Extremities without deformity.

Assessment: Closed head injury, sternal fracture, rule out cardiac contusion, pulmonary contusion. Telemetries for 24 hours. Serial enzymes.

Neurosurgery to clear cervical spine. Advance diet, speech, cognitive evaluation.

01/28/02 **NEUROSURGERY**
JEFFREY XXXXX, M.D.
(p. 64)

Patient seen and examined. Films reviewed. Status post motor vehicle accident with neck trauma. Now better. Neuro intact. Awake, alert, and oriented x 3. Range of motion, but no _____. Moves all extremities. Neck nontender now. CT shows spondylosis predominantly C5-C6. No fracture.

Impression: Cervical spondylosis.

Plan is for physical therapy. Discontinue collar. I will follow.

01/28/02 **NEUROSURGICAL TRAUMA**
JEFFREY XXXXX, M.D.
(p. 20-21)

I was asked to see Mr. Xxxxx by Dr. Lisa Xxxxxx for traumatic injury sustained. This is a 63-year-old man who is in a motor vehicle accident. He hit the median divider and he was the driver of his car. He did a head-on collision. He is wearing a seat belt. The air bag did not deploy. He had blunt chest injury and is being treated for cardiac contusion. He complained of cervical tenderness.

According to the emergency medical services, pre-hospital care report, Mr. Xxxxx was found to be awake and alert and fully oriented. He was given a Glasgow coma score of 15. His head was found to be atraumatic (without trauma). His neck was found to be within normal limits. He was immobilized because of his mechanism only. Mr. Xxxxx was taken to Xxxxxxx Hospital Regional Medical Center Trauma Department. He underwent primary and secondary survey by Dr. Xxxxxx. Images were obtained and I was consulted.

Past medical history is positive for elbow surgery and previous neck fracture.

Medications are none.

Patient is awake, alert, and fully oriented. He is pleasant. He has no complaints of neck tenderness at this time. Pupils are equal, round, and reactive to light and accommodation. The extraocular muscles are intact. His head is atraumatic and normocephalic. There is no Battle's or raccoon sign. Tongue and face are symmetric. There is no pronator drift. The upper and lower extremities are strong and symmetric and move well. There is no obvious loss of pinprick or touch throughout the upper and lower extremities. Deep tendon reflexes are symmetric and slightly brisk at the knees. He has wrinkling of his neck and beard. I cannot find any previous incisions.

Diagnostic imaging: CT of the head shows no bleed or midline shift. Ventricles and cisterns are of normal size and appearance and symmetric. CT scan of the cervical spine shows no fracture or subluxation. There is significant spondylosis of the C5-C6 with bone spur formation and degenerative changes.

Impression. Cervical spondylosis and degenerative changes with whiplash symptoms resolving. Closed head injury with mild concussion.

Recommendations. Continue observation and treatment for cardiac contusion and pulmonary contusion. Speech and cognitive evaluation and physical therapy for the cervical spine. Occupational therapy consult also. I will follow with you.

<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>JEFFREY XXXXX, M.D.</u> (p. 47)	1115 hours. Clear liquid diet. Advance diet as tolerated. Speech and cognitive evaluation, may transfer to floor on telemetry, okay with Dr. XXXXX.
<u>01/28/02</u>	<u>NURSE'S NOTES</u> (p. 173)	1200 hours. Patient took 120 cc liquid with nausea but no vomiting. Medicated for same.
<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 48)	Foley intake and output. Zofran 4 mg every six hours as needed for nausea or vomiting. I.V. push.
<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>JEFFREY XXXXX, M.D.</u> (p. 48)	1330 hours. Discontinue collar. Physical therapy for cervical range of motion. Occupational therapy consult. Evaluate and treat. 1330 hours. Okay to transfer out of ICU from neuro standpoint.
<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 48)	1345 hours. May not transfer due to pulmonary.
<u>01/28/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 49)	1800 hours. In and out catheterization every six hours as needed for not voiding.

01/28/02 **NURSE'S NOTES**
(p. 173) **1800 hours.** Patient stable. Awake and oriented. No change. Taking orals well. Steady on feet to void. Unable to void. In and out catheterization with clear yellow urine.

01/28/02 **NURSE'S NOTES**
(p. 174) **2000 hours.** Patient complaining of pain 3/4 to mid-chest, sternal pain. Visible facial grimace and splinting. Sleep in between awake periods. Good relief. Allowed to stand at side of bed to void. Tolerated okay. Unsteady.

01/29/02 **NURSE'S NOTES**
(p. 174) **0100 hours.** Patient began to desaturate. Nasal cannula 2 liters applied. Physician called. Wheezes heard all lung fields. New onset. Patient with history of 50 years of smoking. Head at bed elevated. Proventil treatment started. Back to sleep with improved saturation at 97%.

01/29/02 **PHYSICIAN'S ORDERS**
xxxxx, M.D.
(p. 49) **0115 hours.** Proventil 0.5 med nebulizer treatment now and every six hours.
0200 hours. Foley catheter in if in and out cath again. Maalox 30 mg every six hours as needed.

01/29/02 **CHEST X-RAY**
Sxxxxxx xxxx, M.D.
(p. 253) Xxxxxly stable since 01/28/02 at 0350 hours with no acute infiltrate.

<u>01/29/02</u>	<u>NURSE'S NOTES</u> (p. 174)	0400 hours. Patient wheezing with any exertion. Change nasal cannula to humidified cool mist mask. Patient appears more comfortable. Saturating 99%.
<u>01/29/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>T. xxxxxx, M.D.</u> (p. 52)	Hemoglobin A1c now. Add respiratory treatment Atrovent. Change breathing treatments to every four hours. May transfer to floor if okay with cardiology. Sputum culture and sensitivity.
<u>01/29/02</u>	<u>LABS</u> (p. 278)	0512 hours. Hemoglobin A1c 6.6, reference range 4 to 6.
<u>01/29/02</u>	<u>NURSE'S NOTES</u> (p. 174)	0540 hours. Chest x-ray requested earlier. Appears whiter, fluffy, patient remains with wheezes. Saturating 99%. Physician called Lasix orders to keep open I.V. Arterial blood gases. Photophone x-ray.
<u>01/29/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>Mxxxx, M.D.</u> (p. 49)	0540 hours. Incentive spirometry every hour while awake. Arterial blood gases now. Decrease I.V. fluids to keep open rate. Lasix 20 mg I.V. now.
<u>01/29/02</u>	<u>NURSE'S NOTES</u> (p. 174)	0700 hours. Lasix result, 350 cc urine out. Lungs continue with wheeze. Questionable rub. Incentive spirometry started earlier to 1000 cc.

<p><u>01/29/02</u> <u>NURSE'S NOTES</u> (p. 175)</p>	<p>Patient's lungs clear, but wheezes with extensive "fluffy" compared to 01/28 a.m. chest x-ray. Took meals and liquids well. Out of bed in chair for 2½ hours.</p> <p>Patient was up in chair for an hour and a half. Upon returning to bed, he stated he had wheezes, which became mostly clear after he settled down in bed and received breathing treatment.</p>
<p><u>01/29/02</u> <u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 50)</p>	<p>0830 hours. Patient must remain in ICU.</p> <p>Advance diet as tolerated. Low sodium and low cholesterol.</p>
<p><u>01/29/02</u> <u>PHYSICIAN'S PROGRESS NOTES</u> <u>ARTHUR XXXXXXXXXXXXX, M.D.</u> (p. 66)</p>	<p>1015 hours. Mild shortness of breath. Positive chest pain at impact sight. Saturating 99%. Expiratory mild wheezing. EKG normal. Chest x-ray, no evidence of cardiac contusion, likely pulmonary contusion. Agree with diuresis.</p>
<p><u>01/29/02</u> <u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 50)</p>	<p>1020 hours. Lasix 20 mg I.V., potassium 20 mg orally twice a day for 24 hours. Chem 7 in the morning.</p>
<p><u>01/29/02</u> <u>PHYSICIAN'S PROGRESS NOTES</u> <u>JEFFREY XXXXX, M.D.</u> (p. 67)</p>	<p>Awake and alert. No complaints of neck pain. Neck nontender. Moves all extremities well and symmetrically. Stable cervical spine, clear.</p>

01/29/02

PHYSICIAN'S PROGRESS NOTES

LISA XXXXXX, M.D.

(p. 68)

Patient without complaints. Still has marked pain with respirations. Chest x-ray shows decreased lung volumes bilaterally. Increased intravascular markings. Question mild congestive heart failure. EKG within normal sinus rhythm. Lungs with inspiratory wheezes. Abdomen round, firm, nontender.

Assessment: Sternal fracture, closed head injury, rule out cardiac contusion, blossoming pulmonary contusion.

Continue ICU for pulmonary status. Pulmonary toilet. Out of bed to chair.

01/29/02

COGNITIVE EVALUATION

(p. 86-87)

Patient oriented to name, age, birthday, address, phone number, and place, year, month, day, date and purpose. Patient independent with following commands. Answering questions, conversation, simple and complex. Patient's reading comprehension functional at sentence and paragraph level. Vocalization, automatic production of verbal modes of expression. Answers simple question. Uses meaningful conversation. Each mechanism functional, cognition functional, immediate memory, short-term memory, long-term memory learning, thought organization, reasoning, problem solving, and mental control all functional. Patient admitted. Glasgow coma score of 15. Positive seat belt. No air bag. Post-head injury/concussion. Initiated cognitive evaluation. Cognitive skills within functional limits. Discharged home. Follow up.

01/29/02

PHYSICAL ASSESSMENT

(p. 90)

Bed mobility, minimal assistance. Supine to sit, minimal to moderate assistance. Transfers, contact guard assistance. Balance, good+. Mobility assistance, contact guard assistance, for 3 feet with front-wheeled walker for weightbearing. Motor: Range of motion within functional limits knee

and below. Left hip flexion 4+, remaining within functional limits. Right hip strength 4, remaining within functional limits. Neck, trunk, ankle, elbow, shoulders, wrist, hands, toes within functional limits.

01/30/02 **PHYSICIAN'S PROGRESS NOTES**
ARTHUR XXXXXXXXXXXXX, M.D.
(p. 70)

0530 hours. Doing okay. Mild shortness of breath. Saturating 97% on 40% face mask. Looks well. Lungs with expiratory wheezes. Rhythm normal sinus without ectopy.

Impression: Pulmonary contusion.

Okay to go to floor. Will follow peripherally. Gentle diuresis.

01/30/02 **PHYSICIAN'S PROGRESS NOTES**
JEFFREY XXXXX, M.D.
(p. 70)

Awake and alert. Complaining of stiff neck. No changes noted. Neck nontender. Doing well. Walking well. Hard to breathe, stable. Agree with physical therapy.

01/30/02 **PHYSICIAN'S ORDERS**
LISA XXXXXX, M.D.
(p. 52)

0930 hours. Lasix 40 mg orally twice a day. Potassium 20 mg orally daily for 24 hours. May go to floor.

01/30/02 **PHYSICIAN'S ORDERS**
ARTHUR XXXXXXXXXXXXX, M.D.
(p. 51)

1000 hours. Okay to transfer without telemetry.

01/30/02

PHYSICIAN'S ORDERS

LISA XXXXXX, M.D.

(p. 53)

Transfer to surgical floor. Regular diet. Low sodium. Low cholesterol.

Diagnosis: Status post motor vehicle accident. Sternum fracture. Pulmonary contusion. Physical therapy evaluate and treat. Regular _____ TEDS. Vital signs every four hours. Intake and output every shift. I.V. to keep open. D5 Lactated ringer's. Morphine PCA 1 mg every 15 minutes. Protonix 40 mg. Tylenol every four hours as needed. Maalox every six hours as needed. Maalox every six hours as needed. Zofran 4 mg every six hours as needed. Aggressive pulmonary toilet. Oxygen for nasal cannula. On cool aerosol. Keep saturation greater than 95%. Continue pulse oximeter. Every four-hour med nebulizers with Proventil and albuterol. CPT bilaterally as tolerated every four hours. Incentive spirometry every hour while awake. Foley to gravity. Out of bed to commode with assistance. Chest x-ray, CBC, Chem-7 in the morning.

01/30/02

CHEST X-RAY

Exxxxxx xxxxxx, M.D.

(p. 254)

Increasing fluid accumulation in left hemithorax.

01/30/02

PHYSICIAN'S PROGRESS NOTES

LISA XXXXXX, M.D.

(p. 69)

Temperature maximum 100.4. Productive cough with green-yellow sputum. Chest x-ray looks wet. Bilateral pleural effusions left greater than right. Complaining of persistent sternal pain. Saturating 96% to 98% on 40% face mask. Lungs decreased at the bases bilaterally.

Assessment:

1. Closed head injury.
2. Sternal fracture.
3. Pulmonary contusion.

Transfer to floor if okay with cardiology. Aggressive pulmonary toilet. Physical and occupation therapy consult.

01/30/02 **PHYSICIAN'S PROGRESS NOTES**
JEFFREY XXXXX, M.D.
(p. 70)

Awake and alert. Complaining of stiff neck. No changes noted. Neck nontender. Doing well. Walking well. Hard to breathe, stable. Agree with physical therapy.

01/30/02 **PHYSICAL THERAPY**
(p. 176)

Out of bed with minimal assistance. Continues with front-wheeled walker for 100 feet with contact guard assistance. Transfers to wheelchair with minimal assistance. Probable transfer to the floor this afternoon.

01/30/02 **NURSE'S NOTES**
(p. 176)

1400 hours. Ambulated well with physical therapy. Chair for an hour and a half. Sputum culture and sensitivity. Gram stain sent. Good appetite. Morphine PCA in use, as per report given.

01/30/02 **SPEECH THERAPY**
KIM xxxxxx
(p. 177)

1525 hours. Reviewed chart. Discussed with patient. Completed cognitive evaluation. Cognitive skills within functional limits provided education regarding possible deficits and possibility of outpatient speech therapy. Provided brain injury cover letter with contact phone numbers. Discharge from follow-up.

01/30/02 **NURSE'S NOTES**
M. xxxxxx, R.N.
(p. 177)

1600 hours. Received patient from ICU with oxygen 2.5 liters per nasal cannula and oxygen saturation 98%. Alert and oriented. Vital signs stable. Afebrile. Auscultated expiratory wheezes in all lobes. Patient with no complaints of pain at this time.

<u>01/30/02</u>	<u>NURSE'S NOTES</u> <u>S. xxxxxxxx, R.N.</u> (p. 177)	2007 hours. Patient complaining of pain only on inspiration. Splinting with pillow. Breath sounds with expiratory faint wheezes bilaterally.
<u>01/31/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>JEFFREY XXXXX, M.D.</u> (p. 71)	Awake and alert. Neck stiffness at baseline. Neuro without change. Stable. Complaining of breathing problems secondary to contusion. Call for additional needs or concerns.
<u>02/01/02</u>	<u>PHYSICIAN'S ORDERS</u> (p. 54)	Occupational and physical therapy.
<u>01/31/02</u>	<u>PHYSICAL THERAPY</u> (p. 177)	1055 hours. Active range of motion exercises, standing balance, strengthening exercises. Supine to dangle with moderate assistance. Sit to stand with minimal assistance. March in place for 3 minutes with front-wheeled walker contact guard assistance. To chair with minimal assistance.
<u>01/31/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>LISA XXXXXX, M.D.</u> (p. 54)	1840 hours. Discontinue Foley catheter. Patient may shower. Physical and occupational therapy to ambulate. Wean oxygen off if tolerated. Discharge planning.

<u>01/31/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>LISA XXXXXX, M.D.</u> (p. 71)	1900 hours. Patient without complaints. Lungs with decreased breath sounds left greater than right. Discontinue Foley catheter. Up out of bed. Physical and occupational therapy. Patient may shower.
<u>01/31/02</u>	<u>NURSE'S NOTES</u> (p. 178)	1900 hours. Patient on continuous pulse oximetry with saturations between 96 to 100% on 1.5 liters of oxygen by nasal cannula. Respiratory treatment per respiratory therapy as ordered. CPT done (chest physiotherapy) done today. Cardiorespiratory therapy, patient tolerated okay. Incentive spirometry at bedside. Patient encouraged to use incentive spirometry. Wheezes throughout lung fields. Clears with treatment. Patient encouraged to deep breath and cough. Patient using pillow to splint when coughing. Oxygen saturation 96 to 100%.
<u>01/31/02</u>	<u>NURSE'S NOTES</u> <u>S. xxxxxxxx, R.N.</u> (p. 178)	2000 hours to 02/01/02 0700 hours. Awake, alert, and oriented x 3. Denies complaints of pain. Breath sounds with expiratory wheezes all fields and diminished in the bases. Productive cough for thick tan. Using PCA for positive pain control. Will continue to monitor.
<u>02/01/02</u>	<u>CHEST X-RAY</u> <u>Exxxxxx xxxxxx, M.D.</u> (p. 255)	Increasing consolidation and effusion at the left base compared to the previous study.
<u>02/01/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>JEFFREY XXXXX, M.D.</u> (p. 72)	Awake and oriented. Complaining of shortness of breath. Neck better. Still decreased range of motion. No arm or hand symptoms. Stable. Neck at <u>baseline</u> . Recommend continuing treatment for pulmonary contusion. Will follow as needed.

02/01/02

OCCUPATIONAL THERAPY

LORI xxxx

(p. 88)

Patient married. Independent with activities of daily living. Ambulates without device. Works driving trucks delivery, engines-head lift. Upper extremities active. Range of motion within functional limits. Strength shoulders 3+/5 bilaterally. Elbows to fingers 4/5 bilaterally. Patient sensation not tested. Patient denies deficits. Upper extremity coordination xxxxx is fair. Fine is good. No edema. Tone within functional limits. Grip 4/5 bilaterally. Pain in chest with upper extremity movement for feeding, hygiene, grooming, upper extremity dressing. Lower extremity dressing “out of bed.”

Patient independent with feeding, hygiene and grooming with chair at sink. Upper extremity dressing minimal assistance secondary to I.V. Lower extremity dressing, toileting is standby assistance. Bathing is minimal assistance. Home making is maximum assistance. Endurance for activities of daily living fair. Easily short of breath and desaturates. Oxygen at 2 liters by nasal cannula. Patient complaining of chest pain and bilateral trunk flexion. Oriented x 4. Level of alertness good. Following directions good. Patient hard of hearing. Attention span fair+. Memory fair+. Problem solving fair+. Cooperative, spatial relations within functional limits for activities of daily living.

02/02/02

PHYSICIAN'S ORDERS

(p. 54)

Reports of test in file. Echocardiogram this morning. Call for results. Discontinue oximeter.

02/01/02

DISCHARGE PLANNING

(p. 179)

1200 hours. Met with patient discussed potential follow up with patient when physical and occupational therapy evaluation. Room air oxygen saturation. Patient can arrange for transportation. Daughter lives with patient.

<u>02/01/02</u>	<u>NURSE'S NOTES</u> (p. 179)	1200 hours. Try to wean oxygen off. Saturation dropped to 91% on room air. 97% on 2 liters. Patient continues getting respiratory treatment. Wheezing and rhonchi present in all lung fields. Activity intolerance. Patient helped up to chair. A little weak on his feet. His endurance low. It does not feel patient is safe for shower due to this and due to oxygen saturation drops down when patient off oxygen.
<u>02/01/02</u>	<u>OCCUPATIONAL THERAPY</u> <u>LAURIE xxxxxx</u> (p. 179)	1300 hours. Patient easily short of breath or desaturates. Requires oxygen 2 liters/minute by nasal cannula. Left up in chair at bedside.
<u>02/01/02</u>	<u>PHYSICAL THERAPY</u> (p. 179)	1600 hours. Patient transfers out of bed with standby assistance. Gait training for 300 feet with front-wheeled walker. Oxygen of 4 liters.
<u>02/01/02</u>	<u>NURSE'S NOTES</u> <u>A. xxxx, R.N.</u> (p. 180)	2000 hours. Instructed to use PCA to control pain adequately. Patient using PCA appropriately. Reports pain levels 3-5/10.
<u>02/02/02</u>	<u>NURSE'S NOTES</u> <u>A. xxxx, R.N.</u> (p. 181)	0000 hours. Wheezes throughout lung fields. Encouraged to cough and deep breathe and use incentive spirometry. Oxygen saturation 95% on 3 liters by nasal cannula.
<u>02/02/02</u>	<u>NURSE'S NOTES</u> (p. 180)	0000 hours. Wheezes throughout lung fields. Respiratory therapy every four hours. Aggressive pulmonary toilet. Encouraged to cough and deep

breathe. Saturating 94 to 96% on 3 liters of oxygen. Wheezing unchanged.

0900 hours. Respiratory therapy treatment as ordered. Encouraged use of incentive spirometry. Productive cough with expiratory wheezes. Up in chair today. Tolerated activity. No shortness of breath at rest. Oxygen 2 to 3 liters in use. Afebrile. Assess pain level, position of comfort. Encourage activity. PCA in use. States feeling better today. Able to sit in chair. Will switch to oral pain medications today.

02/02/02 **PHYSICIAN'S PROGRESS NOTES**
(p. 73)

Prior dyspnea. IPPB protocol.

02/02/02 **ECHOCARDIOGRAM**
(p. 236-237)

Technically difficult echocardiogram. Accurate M-mode measurements could not be obtained. Normal left ventricular size and systolic function. Valvular structures appear normal.

02/02/02 **CHEST X-RAY**
ANTHONY xxxxxxxx, M.D.
(p. 256)

Stable appearance to the chest showing a small left pleural effusion. No pneumothorax.

02/02/02 **PHYSICAL THERAPY**
(p. 180)

1146 hours. Supine to sit with contact guard to minimal assistance. Sit to stand with contact guard assistance. Gait for about 300 feet x 1 with front-wheeled walked contact guard assistance. Portable oxygen at 2 liters. Stand to sit with standby assistance. Sit to supine with minimal assistance for bilateral lower extremities. Bed mobility with minimal assistance. Minimal assistance with scooting to head at bed. Patient with increased

fatigue from shower this morning, but was good effort. Patient complaining of sore chest.

<u>02/02/02</u>	<u>OCCUPATIONAL THERAPY</u> <u>K. xxxx, O.T.</u> (p. 180)	1500 hours. Issued Reacher and socks for lower body dressing, toileting. Minimal assistance with lower body dressing. Standby assistance with toileting. Independent with pericare. Care safety.
<u>02/02/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>Dx xxxxxx, M.D.</u> (p. 55)	1700 hours. Discontinue I.V. and PCA. Vicodin one to two orally as needed for pain.
<u>02/03/02</u>	<u>PHYSICIAN'S ORDERS</u> (p. 55)	Discharge planning for the morning. Diet as tolerated.
<u>02/03/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> (p. 73)	Afebrile. Vital signs stable. Chest clear. Tender sternum. Abdomen benign.
<u>02/03/02</u>	<u>PHYSICAL THERAPY</u> (p. 181)	1040 hours. Out of bed with standby assistance. Gait for 500 feet x 1 with front-wheeled walker and contact guard to bedside chair with standby assistance.
<u>02/03/02</u>	<u>NURSE'S NOTES</u> (p. 181)	1600 hours. Assess patient's pain scale from 1 to 10. Medicate as needed. Assess lung sounds. Oxygen saturation. Respiratory therapy during IPPB. Head at bed elevated 30 degrees. Monitored cough. Encouraged incentive spirometry. Patient complaining of discomfort in

lungs and chest. Refuses any pain medications. Respiratory rate 20 to 28. Lungs diminished in bases and wheezes noted on left side. Oxygen saturates 94% on 2 liters. Patient gets short of breath on exertion. Patient with productive cough with yellow thick green secretions. Chest x-ray showed left pleural effusion with increased consolidation on left base. Patient with large amounts of secretions. Patient resting comfortably with no distress noted.

02/04/02

CHEST X-RAY

Exxxxxx xxxxxx, M.D.

(p. 257)

Bilateral pleural effusions and infiltrates left greater than right.

02/04/02

PHYSICIAN'S PROGRESS NOTES

LISA XXXXXX, M.D.

(p. 74)

Doing well. Still has episodes of shortness of breath. Was refusing nebulizers with increased symptoms. Lungs with few rhonchi, left greater than right.

Assesment: Sternal fracture and pulmonary contusion. Increased activity. Discharge planning.

02/04/02

**MULTIDISCIPLINARY
INITIAL ASSESSMENT**

C. xxxxxx, R.N.

(p. 89)

Patient alert and oriented. Patient lives at home with spouse. Patient has a front-wheeled walker at home. Oxygen at 4 liters with 95% saturation. May need oxygen for home use.

02/04/02

PHYSICAL THERAPY

E. xxxx

(p. 182)

1000 hours. Patient transfers in and out of bed with standby assistance. Gait training of 270 feet with front-wheeled walker. Oxygen of 4 liters. Patient slightly short of breath with ambulation. Oxygen saturation before

ambulation 91%, after ambulation 95% with 4 liters of oxygen.

02/04/02

NURSE'S NOTES

S. xxxx, R.N.

(p. 182)

1245 hours. Head at bed elevated. Patient on 2 liters nasal cannula. Oxygen saturations monitored. Assessed rate of respirations lung sounds for distress. Patient short of breath and unable to speak a complete sentence clearly because respirations so labored. Respiratory therapy notified. Respiratory therapy stated patient denied treatment this morning. I explained to the patient the necessity of treatment and patient complied. Treatment given. Patient under less stress breathing. Oxygen saturation 94%. Patient continues with shortness of breath. Respirations 20 to 24. Patient with complaints of pain on anteroposterior pain and chest "stabbing pain." Vicodin given with relief. Oxygen saturation 95%. Encouraged respiratory treatment. Encouraged patient out of bed. Dr. Xxxxxx aware of patient's pains and shortness of breath.

02/04/02

OCCUPATIONAL THERAPY

(p. 183)

1500 hours. Patient seen for lower body dressing. Standby assistance to edge of bed. Standby assistance to verbal cues for lower body dressing. Patient doing better today. Decreased shortness of breath with activities of daily living. Still on 3 liters/minute oxygen.

02/04/02

PHYSICAL THERAPY

E. xxxx

(p. 183)

1500 hours. Patient transfers in and out of bed independently. Gait training of 400 feet with front-wheeled walker, oxygen at 4 liters with standby assistance. 100 feet with walker with standby assistance. Gait tolerated well. Gait is steady without walker.

<u>02/04/02</u>	<u>CHEST X-RAY</u> <u>ROBERT xxxxxxx, M.D.</u> (p. 258)	1750 hours. Small left-sided pneumothorax
<u>02/05/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>LISA xxxxxxx, M.D.</u> (p. 55)	Discharge planning. Lasix 10 mg I.V. or orally now. Chest x-ray stat. Okay for I.V. to remain out.
<u>02/05/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> (p. 183)	0145 hours. Medicated with Vicodin two tablets for chest pain complaints. Positive relief. Patient sleeping at long intervals. Vital signs stable. IPPB every four hours by respiratory therapy with oxygen inhalation. Continue with pulse oximetry. Cough and deep breathing exercises. Oxygen saturation ranging 95 to 97%. Lung sounds improving with treatment.
<u>02/05/02</u>	<u>CHEST X-RAY</u> <u>Exxxxxxx xxxxxxx, M.D.</u> (p. 260)	Bibasilar consolidation and effusions left greater than right.
<u>02/05/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>KEN xxxxxxx, M.D.</u> (p. 74)	0900 hours. Patient seems short of breath. Vital signs stable. Chest x-ray yesterday, question pneumothorax. Check arterial blood gases. Follow up chest x-ray and pulmonary evaluation.
<u>02/05/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>INTERVENTIONAL RADIOLOGY</u> (p. 76)	Bilateral chest ultrasound. No significant drainable fluid on either side.

<p><u>02/05/02</u> <u>PHYSICIAN'S ORDERS</u> <u>xxxxxxx, M.D.</u> (p. 56)</p>	<p>0900 hours. Arterial blood gasses. Portable chest x-ray. High resolution CT of the chest. No contrast.</p>
<p><u>02/05/02</u> <u>LUNG SCAN</u> <u>ROBERT xxxxxx, M.D.</u> (p. 259)</p>	<p>Bilateral pleural effusions. Bibasilar atelectasis. Fractured sternum. No evidence of pneumothorax. Study reviewed with Dr. Ken Xxxxxxx.</p>
<p><u>02/05/02</u> <u>PHYSICAL THERAPY</u> <u>E. LANG</u> (p. 183)</p>	<p>0915 hours. Patient transfers independently. Gait training 300 feet with oxygen of 4 liters and standby assistance. Gait is steady. Complains of shortness of breath with ambulation. Patient's oxygen saturation before ambulation is 95% with oxygen, after ambulation is 91%.</p>
<p><u>02/05/02</u> <u>PHYSICIAN'S ORDERS</u> <u>xxxxxxx, M.D.</u> (p. 56)</p>	<p>0943 hours. Chest x-ray can be done in department with the chest x-ray.</p>
<p><u>02/05/02</u> <u>NURSE'S NOTES</u> <u>M. xxxxx, R.N.</u> (p. 184)</p>	<p>1000 hours. Respiratory therapy, given treatment this morning. Lungs clear after treatment. Slight expiratory wheezes to left lobes. Continue with pulse oximetry. Dr. xxxxxx in to see patient today. Arterial blood gasses to be done also today. Encouraged patient to deep breathe, use incentive spirometry, and ambulate. Patient on 2 liters oxygen nasal cannula. Saturating 98%. Patient up and ambulating in the hallways with oxygen. Increased shortness of breath with activities.</p>

02/05/02

PULMONARY CONSULTATION

GEORGE xxxxxxxx, M.D.

(p. 40-42)

Impression:

1. Blunt chest trauma.
2. Sternal fracture.
3. Pleurisy.
4. Left pleural effusion.
5. Tobacco abuse.
6. Reactive airway disease with significant restrictive dysfunction related to above.

Recommendations:

1. V/Q scan.
2. Venous Doppler.
3. Thoracentesis.
4. Subcutaneous low molecular weight heparin.
5. Add Mucomyst to current respiratory therapy.

63-year-old male involved in a motor vehicle accident on 01/28/2002. He sustained a sternal fracture and had blunt chest trauma. He is felt to have pulmonary contusion. He was admitted to the hospital via trauma protocol. The cervical spine was cleared. Neurosurgical consultation was obtained for blunt head trauma. Glasgow coma score, however, was 15 in the field. He did not lose consciousness at all throughout these episodes. He was in the ICU and subsequently transferred to floor.

Yesterday, he developed a bout of pleuritic chest pain in the left scapula with some vague pain noted in the left anterolateral chest. Initially, he has anterior medial chest pain reproduced by external chest wall pressure. There is no orthopnea (positional shortness of breath), paroxysmal nocturnal dyspnea or pedal edema. He episodically will feel dyspneic (breathless). He feels as if there is mucous stuck in the middle of his windpipe and is unable to clear. He occasionally coughs producing a

yellowish mucous. His wife was at the bedside during this interview. He has no fever, chills, or sweats. The case was discussed with Dr. xxxxxxx.

Patient's medication is none. Here in the hospital is receiving Vicodin (narcotic), Protonix (for gastroesophageal reflux precautions), on oxygen, and receiving inhaled therapy for IPPB.

Past surgical history is remarkable for hemorrhoidectomy. Fracture repair of the left elbow. Remote history of spinal meningitis in childhood.

He is married. Drank "heavily in the past," but none currently. He smoked well over 50 pack years, quit in April 2002.

On review of systems, he denies chronic headaches, blurred vision, or ringing in the ears. There is no fever, chills, or sweats. No nausea, vomiting, diarrhea, or melena (blood in the stool). No urgency, frequency, or urinary hesitancy. No major arthritic complaints as mentioned. Left arm fracture. No difficulty walking. No depression, anxiety, or excessive stress. No hormone or thyroid therapy. No excessive coldness to the skin.

Examination: Saturation is currently 96% (normal). However, throughout the conversation, he intermittently desaturated while talking and felt somewhat dyspneic. He has occasional use of accessory muscles with respirations, increased anterior posterior diameter. Mild prolongation of the expiratory phase. Diminished breath sounds 1/4th of the way up on the left with dullness to percussion and decreased diaphragmatic excursion, left greater than right. There is some anterior chest wall tenderness in the region of the manubrium sterni. There is no lateral chest wall tenderness. Heart regular rate and rhythm. No murmur or gallop. Abdomen soft and nontender. Extremities without cyanosis, clubbing, or edema. No xxxxx motor or sensory focality.

Respiratory cultures are relatively unremarkable consistent with normal flora.

Chest x-ray shows borderline cardiomegaly with mild flattening of the diaphragms. Haziness at the left base.

CT scan confirms the presence of bilateral effusion, left greater than right.

Echocardiogram shows a difficult study but ejection fraction is approximately 72%. No focality is noted. Intrinsic left ventricular hypertrophy is seen.

CAT scan of the brain is relatively unremarkable. Cervical spine was cleared. He had a mild degree of sinusitis on CAT scan.

Summary: Patient presents with dyspnea and ineffective cough.

02/05/02

PHYSICIAN'S PROGRESS NOTES
GEORGE xxxxxxxxxxx M.D.
(p. 75)

Labs just drawn with sternal fracture (left pleural effusion). Plan is for ventilation perfusion scan. Venous Doppler.

02/05/02

PHYSICIAN'S ORDERS
(p. 57)

Stat V/Q scan. Continue with Doppler lower extremities. _____ left chest. Pleural fluids for culture and sensitivity. Cell count with differential. LDH protein cytology. Lovenox 60 mg subcutaneous every 12 hours. Respiratory treatment. Xopenex and Atrovent every four hours by hand held nebulizer. Add Mucomyst 1 cc 10% every treatment.

<u>02/05/02</u>	<u>NURSE'S NOTES</u> (p. 184)	<p>1430 hours. Patient went down for a V/Q scan. Complaining of left chest also wheeled down for ultrasound, Doppler study of lower extremities.</p> <p>Stat labs done as soon as ordered. Simpli-Red. Dr. xxxxxxxx made aware. Okay Dr. xxxxxxxxxxxxs order for Lovenox. Lovenox 50 mg.</p>
<u>02/05/02</u>	<u>BILATERAL VENOUS ULTRASOUND</u> <u>ROBERT xxxxxxx, M.D.</u> (p. 261)	<p style="text-align: center;"><u>LOWER EXTREMITIES</u></p> <p>Normal study.</p>
<u>02/05/02</u>	<u>VENTILATION PERFUSION SCAN</u> <u>ROBERT xxxxxxx, M.D.</u> (p. 262)	<p>Low probability for pulmonary embolism.</p>
<u>02/05/02</u>	<u>SPIROMETRY</u> <u>M. xxxxxxxx, M.D.</u> (p. 238)	<p>Mild obstructive defect, response to bronchodilators is significant. There is moderate reduction of the vital capacity.</p>
<u>02/05/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>xxxxxxxx M.D.</u> (p. 58)	<p>Benadryl 25 mg orally every six hours as needed for itching.</p>
<u>02/06/02</u>	<u>PHYSICIAN'S ORDERS</u> (p. 58)	<p>Advair 500/50 one twice a day. Add Mucomyst 1 cc 10% to each treatment.</p>

<u>02/06/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> <u>GEORGE xxxxxxxxxxx, M.D.</u> (p. 77)	Severe dyspnea-orthopnea. Pneumonia, pleurisy, and hypoxia.
<u>02/06/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> (p. 78)	Better, tolerating diet. Still some shortness of breath.
<u>02/06/02</u>	<u>NURSE'S NOTES</u> <u>C. xxxxx</u> (p. 187)	0700 hours. Medicated with pain medications. States good relief. Breath sounds with wheezes in upper anterior chest. Crackles audible throughout all lobes. Respiratory treatment. Dr. xxxxxxxxxxx in to see and write new orders, continue pulse oxymetry 93 to 95%.
<u>02/06/02</u>	<u>PHYSICAL THERAPY</u> <u>E. xxxxx</u> (p. 184)	Patient transfers independently Gait training of 600 feet without assistive device. Slightly short of breath with ambulation.
<u>02/06/02</u>	<u>DISCHARGE PLANNING</u> (p. 186)	1130 hours. Met with patient to discuss need for home oxygen. Discussed option of oxygen from xxxxxx I considering cost. Patient is aware of above and will follow up if discharge is imminent and need for oxygen established.
<u>02/07/02</u>	<u>NURSE'S NOTES</u> <u>xxxxxxxx</u> (p. 187)	0730 hours. Vicodin orally for sternal pain. Effective for relief, sleeping. IPPB treatment. Saturating 98%. Lung sounding better today.

<u>02/07/02</u>	<u>PHYSICIAN'S ORDERS</u> (p. 58)	CBC, Chem. 7 today. Discharge planning. Social service consult.
<u>02/07/02</u>	<u>PHYSICIAN'S ORDERS</u> <u>Dxxxxxxxx, M.D.</u> (p. 59)	1145 hours. Mineral oil 30 cc orally now. Oxygen saturation room air study per respiratory therapy. Call lab result with any abnormalities.
<u>02/07/02</u>	<u>PHYSICAL THERAPY</u> <u>E. xxxx</u> (p. 187)	1320 hours. Gait training of 300 feet with oxygen 4 liters with standby assistance.
<u>02/07/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> (p. 78)	Afebrile. Vital signs stable. Ambulates with assistance. Chest clear. Discharge planning.
<u>02/07/02</u>	<u>PHYSICAL THERAPY</u> <u>E. xxxx</u> (p. 187)	Patient up and ambulating independently. Will discharge patient from physical therapy to ambulate with nursing.
<u>02/07/02</u>	<u>PHYSICIAN'S PROGRESS NOTES</u> (p. 79)	Still with sternal pain. Assessment: Sternal fracture, laryngitis. Wean oxygen. Albuterol as needed.

02/07/02

NURSE'S NOTES

S. xxxx. R.N.

(p. 187)

1610 hours. Assess patient's pain on scale from 1 to 10. Medication as needed. Patient with complaints of pain as a 6/10. Vicodin given x 2. Patient with complaints of apin in chest area/sternum. Positive relief from medications.

1615 hours. Dr. xx xxxxxx ordered oxygen saturation study with respiratory therapy. Patient 2 liters of oxygen as needed. Lung sounds diminished in the bases. Denies respiratory distress, but become short of breath on exertion.

02/07/02

PHYSICIAN'S ORDERS

(p. 59)

Decrease albuterol, multidose inhaler, two puffs every four hours as needed for shortness of breath. Have respiratory _____. Arterial blood gasses in the morning.

02/07/02

NURSE'S NOTES

S. xxxx. R.N.

(p. 187)

1615 hours. Respiratory treatment given to patient, oximeter on. Patient taught how to use inhalers per respiratory therapy. Will continue to monitor.

02/07/02

xxxxxx I HOME MEDICAL

(p. 320)

1615 hours. Respiratory rate at 18. Respiratory treatment given to patient. Oximeter on. Patient taught how to do inhalers.

02/08/02

NURSE'S NOTES

(p. 188)

0400 hours. Medicated for complaints of pain especially with movement, on inhalers with respirations even and unlabored.

02/08/02

xxxxxx I HOME MEDICAL

(p. 320)

0400 hours. Medication given for complaints of pain especially with movement. On inhalers with respirations even and unlabored. Continue

to monitor.

02/08/02 **PHYSICIAN'S PROGRESS NOTES**
Dx xxxxxx, M.D.
(p. 59)

0800 hours. Ambulating desaturation study per respiratory therapy on room air.

02/08/02 **NURSE'S NOTES**
xxxxx. R.T.
(p. 188)

0900 hours. Room air arterial blood gas done. See chart for result. PaO2 53. Saturation 88%. Patient at rest. Patient qualifies for home oxygen use to be setup up at later time. Patient placed on 2 liters/minute nasal cannula. Add nebulizer, given. Patient awake, oriented, cooperative.

02/08/02 **PHYSICIAN'S PROGRESS NOTES**
(p. 80)

Resting comfortably.

Assessment: Sternal fracture. Advair as needed without albuterol. Home oxygen.

02/08/02 **PHYSICIAN'S ORDERS**
(p. 60)

1145 hours. Home with discharge instructions and prescriptions. Prescriptions on chart per Dr. XXXXXXXXX to discharge planning. Dr. XXXXXXXXX to give home oxygen orders.

02/08/02 **SOCIAL SERVICES**
(p. 188)

1430 hours. Spoke with patient and family about cost of prescriptions, family _____ to help with part of cost of prescriptions. Provided helping hands H voucher for 100 dollars. Patient to discharge home with family.

02/08/02

DISCHARGE SUMMARY

LISA XXXXXX, M.D.

(p. 30-31)

Admission diagnoses:

1. Closed head injury, status post motor vehicle accident.
2. Sternal fracture.
3. Pulmonary contusion.

The patient was admitted to the ICU and underwent serial enzymes EKG and echocardiogram. Neurosurgery and cardiology consultations were obtained. Cardiology felt there was no evidence of cardiac contusion. There was marked pulmonary contusion based on chest x-ray. They diuresed him on hospital day #1. His diet was advanced and speech cognitive evaluation was obtained on hospital day #1. The cervical spine was cleared by neurosurgery on hospital day #1 also.

Physical and occupational therapy were instituted. He had poor pulmonary toilet and remained in ICU to encourage pulmonary toilet. The hospital day #3, his lungs sounds were diminished at the base but he was doing better in his strides per pulmonary toilet and then he was transferred to the floor with aggressive pulmonary toilet and physical and occupational therapy involvement. Hospital day #3, he had a temperature maximum 99.7. His Foley was discontinued and his activity level was increased. He was started on IPPB (breathing treatment). The hospital day #5. Once again his activity was increased.

On hospital day #7, discharge planning was begun. Repeat chest x-ray on hospital day #8 showed question of the pneumothorax. This was repeated and did not pan out to show any kind of pneumothorax. He did have an episode of shortness of breath, and a V/Q scan was obtained which was negative. Bilateral venous Dopplers were negative. The ultrasound of the chest was performed and there was no drainable fluid collection. The patient began to markedly improve after this episode. Pulmonary toilet was the biggest liability. Patient subsequently discharged to home 11 days

after admission to the hospital.

Discharge medications: Darvocet-N 100 (for pain). He was discharged on oxygen two liters by nasal cannula. Advair, bronchodilator, steroid, albuterol (respiratory medications). He will follow up with me in the office in one week's time. He will follow with Dr. XXXXXXXXX in the ensuing week also.

02/08/02 **XXXXXXXX HOSPITAL**
XXXXXX I
(p. 321)

I am taking the portable from our closet. They will call when they arrive home so that concentrator can be delivered. They understand the COD of 197 dollars and 12 dollar refill fee.

02/08/02 **XXXXXX I DELIVERY TICKET**
(p. 324)

Oxygen concentrator with humidifier portable "E" system 197 dollars COD.

02/11/02 **CHEST ULTRASOUND**
CRAIG XXXXXX, M.D.
(p. 263)

No evidence of significant pleural fluid on either side.

02/18/02 **XXXXXXXXXXXX VALLEY SURGICAL**
GROUP
(p. 333)

Patient history: 63-year-old married male. Reason for visit is car accident. He has allergies but they do not know to what. Medication albuterol as needed. Propoxy acetam every four hours. Advair Diskus two a day. Patient does not smoke.

02/18/02 **LISA XXXXXX, M.D.**
(p. 334)

Discharged 02/08/02. Short of breath with talking as well with activity. Still has chest wall tenderness centrally, left and right. Positive chills.

Bending over, picking hurts. Eating okay. Lost 8 pounds since the accident. Breath sounds distant but clear breath sounds bilaterally. Heart regular, rhythm. Abdomen soft, nontender.

Assessment: Consistent, pulmonary contusion, sternal fracture.

Will see pulmonary physician closer to home.

03/26/02

UNIVERSITY OF xxxxxx
(p. 347)

Reason for visit: Blunt chest trauma. Status post motor vehicle collision two months ago without closed head injury. Sternal fracture. Now feels well, but complaining of “stuttering” voice since accident. No shortness of breath. No chest pain. Chest x-ray shows resolving pleural effusion. No pneumothorax. No surgical issues. Needs medicine follow-up. Needs neurology consult.

03/27/02

UNIVERSITY OF xxxxxx
(p. 351)

A 63-year-old here requests pulmonary referral. Hospitalized for motor vehicle accident at xxxxxxx. Referred here to see Pulmonary. Patient with tobacco history. Reports shortness of breath and needs oxygen. When talks, also complaining of stuttering. Motor vehicle accident on 01/27/02, hospitalized at Xxxxxxx. Seat-belted driver on freeway, hit median. Stuttering when talks. Patient states it began after motor vehicle accident.

Patient talking, Oxygen saturation 98% to 99%. Ambulating while in clinic. Saturating 95% to 96%. Patient with no past medical history. Status post motor vehicle accident on 01/27/02 with resultant lung and chest injury secondary to seatbelt with difficulty breathing since accident. Short of breath only with talking. Denies dyspnea on exertion (breathlessness on exertion). No paroxysmal nocturnal dyspnea. No

orthopnea (positional shortness of breath). No chest pain with exertion. Positive cough with clear sputum. No hemoptysis (bloody sputum). Smokes one to three packs per day for 50 years, quit one year ago. Currently on albuterol, Advair, Darvocet. No alcohol. Generally short of breath with talking. Pulse oximetry 99% on room air at rest, not talking, and talking, 95% with exertion.

Assessment:

1. Short of breath of questionable etiology. Referred to pulmonary. Discontinue oxygen.
2. Stuttering. Referred to neurology.

03/27/02 **UNIVERSITY OF xxxxxx**
REFERRAL
TO
NEUROLOGY
(p. 353)

Diagnosis: Stuttering.

A 63-year-old male status post motor vehicle accident. Complaining of stuttering since the accident. Pulse oximetry 99% on room air. Unclear if head trauma per patient. Chest x-ray, CT, ultrasound, ventilation-perfusion scan within normal limits. Question etiology.

03/27/02 **UNIVERSITY OF xxxxxx**
REFERRAL
(p. 355)

Patient with no past medical history. Status post motor vehicle accident. Complaining of shortness of breath and stuttering with talking since motor vehicle accident. Has been on oxygen since motor vehicle accident with saturation 95% to 99% on room air with walking and talking. Positive tobacco two to three packs per day for 50 years. Chest CT, ventilation-perfusion scan, ultrasound, chest x-ray within normal limits. Quit smoking one year ago. Requesting etiology is shortness of breath.

<u>03/27/02</u>	<u>PRESCRIPTION</u> (p. 434)	Ibuprofen 600 mg 90 tablets one orally three times per day as needed.
<u>03/28/02</u>	<u>CHEST X-RAY</u> (p. 425)	Pleural calcification on diaphragmatic pleural surface, left lung, which may be related to previous asbestos exposure. Correlate clinically, no evidence of acute cardiopulmonary disease appreciated.
<u>04/02/02</u>	<u>xxxxxxx I PICK UP</u> (p. 326)	Oxygen supplies picked up.
<u>04/08/02</u>	<u>PULMONARY FUNCTION TEST</u> (p. 403)	Mild restriction.
<u>04/22/02</u>	<u>UNIVERSITY OF xxxxxx REFERRAL</u> (p. 360)	Did not keep up appointment.
<u>05/08/02</u>	<u>UNIVERSITY OF xxxxxx REFERRAL</u> (p. 362)	<p>Patient is status post chest wall trauma with motor vehicle accident in January 2002. Long history of tobacco use until just one year ago. Complaining of shortness of breath and “stutter.” Spirometry consistent with obstruction. Expiratory wheezing audible without auscultation even.</p> <p>Impression: Acute bronchitis/bronchospasm, COPD, stutter consistent with anxiety due to accident. Pulmonary function test with lung volumes primary _____ regarding anxiety. Prednisone 60 mg daily on sliding</p>

course, antibiotics, and Serevent. Follow up in three to four weeks.

63-year-old with no past medical history. Status post motor vehicle accident in January 2002 with shortness of breath with sitting and talking since. Patient is on oxygen since motor vehicle accident but saturating 95% to 99% on room air. Motor vehicle accident with fracture of sternum and bruise to heart and lung. Positive shortness of breath mainly with exertion and talking. Resolves with rest. No shortness of breath with walking. Positive stuttering since accident. Positive wheezing since accident, is rare. Positive chest pain with rest, sharp for minutes. Works as a truck driver, carpenter, meat cutter.

Lungs clear to auscultations bilaterally. Patient's past medical history is significant for tobacco use, motor vehicle accident, and history of asbestos exposure. Positive tobacco history, probably secondary to COPD. Hold pulmonary function test with bronchodilator. Start Serevent, course of steroids, and course of antibiotics. Positive tobacco two to three packs per day for 50 years. No alcohol now, heavy in the past. No intravenous drug use. Chest x-ray shows pleural calcification, left lung.

05/10/02 **UNIVERSITY OF xxxxxx**
(p. 363)

Status post motor vehicle accident. Complaining worsening hearing loss of left ear since motor vehicle accident.

05/10/02 **UNIVERSITY OF xxxxxx**
(p. 364)

COPD since motor vehicle accident. Patient seen by pulmonary thought secondary to COPD. Prescriptions of Levaquin and steroid taper. Complaining of hearing on the left. Walked just 40 minutes. Patient with a history of COPD and shortness of breath since motor vehicle accident in January 2002. Stuttering, here for follow-up. Complaining of decreased hearing in the left ear and tinnitus since motor vehicle accident.

Postconcussion head syndrome. Complaining of head trauma as per patient, shortness of breath unchanged since last visit. Shortness of breath likely COPD, question bronchitis, stuttering, hearing loss. Chest pain similar to gastroesophageal reflux disease. Zantac prescribed. Continue prednisone taper, Levaquin, albuterol multidose inhaler, Combivent, and Advair.

05/20/02 **AUDIOLOGY**
(p. 365)

Motor vehicle accident on 01/28/02. New decreased hearing, left ear greater than right ear. Occasional tinnitus five minutes to three hours in left, dizzy when lies down. No otitis media. Right ear pressure. Moderate to profound sensorineural hearing loss, both ears, right greater than left. Referred to Dr. Nadiswaran.

05/30/02 **UNIVERSITY OF xxxxxx**
(p. 367-368)

Here for eye examination. Patient wants a new prescription. Foreign body removal, right eye two years ago.

Past medical history: Healthy. History of shortness of breath. Visual acuity with correction on the right 20/25. Patient's albuterol, Advair, Darvocet, ibuprofen.

Assessment: Myopic astigmatism.

06/12/02 **UNIVERSITY OF xxxxxx**
(p. 369)

Medications: Ibuprofen 600 mg, inhalant Advair, Zantac? Patient with COPD, clear one year ago. Status post motor vehicle accident. Here for follow-up. Still complaining of shortness of breath with inhalers. See ENT for hearing loss.

Examination reveals lungs with no wheeze. Tympanic membranes

normal.

Impression:

1. COPD.
2. Hearing loss.

Continue medications. Pulmonary function tests, labs, ENT, hearing aids. Increasing shortness of breath since motor vehicle accident 01/02. Here for follow-up. Continues to complain of stuttering, improved over the last one and a half to two months and hearing loss progressive worse since January accident.

Assessment: Shortness of breath. Hold pulmonary function test. Referred to pulmonary clinic. Hearing loss referred back to audiology for hearing. Stuttering, neuro. Check PSA, lipids, CBC, and chem panel.

06/19/02

UNIVERSITY OF xxxxxxx
(p. 371)

Question shortness of breath with chronic bronchitis/bronchospasm. Obtain echo. Patient with no past medical history other than motor vehicle accident. Presents with shortness of breath with even walking. Patient with home oxygen since motor vehicle accident but with saturations to 95% and 99% on room air.

06/19/02

PULMONARY FUNCTION TEST
(p. 407-409)

Findings are consistent with COPD. A bronchitic type with bronchodilator response. Arterial blood gas normal. No prior study for comparison.

06/19/02

UNIVERSITY OF xxxxxx
(p. 371)

Currently short of breath at baseline, occurs with walking and talking. No significant change in shortness of breath. Occasionally 1.5/10 pain in left chest occurs at night, cough rare, rare sputum gray. Patient off oral prednisone. Patient is using Combivent, Advair.

Past medical history is significant for motor vehicle accident, which results in shortness of breath. Pulmonary function test with moderate obstruction with positive reversibility, DLCO pending. Unclear etiology. Echo immediately post motor vehicle accident, normal. Will check echo. Consider exercise test, but patient with few signs and symptoms consistent with congestive heart failure/cardiac disease.

06/28/02

UNIVERSITY OF xxxxxx
(p. 373)

Patient on ibuprofen and Zantac 150 mg twice a day, Advair. Question loss of consciousness post motor vehicle accident, patient started stuttering 02/06. Motor vehicle accident was 01/27. Stuttering has improved since the accident. Positive history of stuttering in childhood. Tobacco for 15 years, quit on 04/01/01, two to two and a half packs per day, quit alcohol 15 years ago, two six packs per day. Sister has multiple sclerosis. Awake, alert, and oriented. Can spell world backward. Good serial 3s, 3/3 naming, 2/3 recall at 30 minutes. Repetition intact. Neuro exam essentially normal.

Differential diagnosis: Axonal injury versus stress and anxiety. Would get OCMH phone number if feels need to see psychiatrist for anxiety. Discharged from neurology clinic.

(p. 374)

Difficult to read. Poor copy. Status post motor vehicle accident with loss of consciousness at outside hospital, admitted for one week. CT of head,

negative. Patient began having difficulty with stuttering about one week later. Also complaining very brief vertigo during when he lies down, not associated with movement. Also complaining of shortness of breath since motor vehicle accident, hearing loss.

Past medical history is otherwise unremarkable. History of stuttering in remote past.

Social history is significant for wife with aneurismal rupture recently.

On examination, patient is stuttering 16 F words in one minute. Good naming repetitions, slight difficulty with three-step commands. Patient reemergence of stuttering after motor vehicle accident, more likely related to anxiety and stress than to any organic brain disease. No further neurological evaluation indicated, discharged from neurology. Follow up as needed.

07/03/02

ECHOCARDIOGRAM

(p. 413)

Normal mitral valve. Trace mitral regurgitation. Normal aortic route. Left atrium appears normal in size. Normal tricuspid valve. Trace tricuspid regurgitation. Pulmonary artery pressure is 33 mmHg. Aortic valve appears normal. Normal aortic valve flow and systole and diastole. Normal right ventricle size, thickness and function and two-dimensional study. No evidence of pericardial effusion. Normal left ventricle size and function.

08/16/02

UNIVERSITY OF xxxxxx

(p. 376)

Patient with COPD, status post motor vehicle accident. Since that time has had increased dyspnea on exertion and stuttering of speech.

Assessment: Underlying COPD with compounded with bronchospasm.

Probable allergic rhinitis. Increased shortness of breath since motor vehicle accident. Here for follow-up. Shortness of breath unchanged. Little relief with Advair, Combivent. Positive nasal congestion, cough, dyspnea on exertion, shortness of breath with talking.

Examination reveals 1 to 2+ right turbinate swelling. Positive oropharyngeal cobblestoning. Lungs with positive crackles.

Assessment:

1. Shortness of breath, normal echo. Results of pulmonary function test pending. Continue Advair, Combivent, Flonase twice a day.
2. Stuttering. No neurological or neuro clinic. Referred to psyche.

Increased blood sugar. Repeat fasting blood sugar.

08/21/02 **UNIVERSITY OF xxxxxx**
REFERRAL
(p. 378)

To pulmonary for shortness of breath. Exercise testing. Patient is a smoker with shortness of breath, out of proportion to lung and heart disease. Patient litigation for motor vehicle accident in January 2002. Evaluate for cause of shortness of breath.

08/21/02 **UNIVERSITY OF xxxxxx**
REFERRAL
(p. 379)

Patient on Advair, Combivent, ranitidine, Flonase. Patient complaining only of history of motor vehicle accident, seen in clinic treated with Serevent. No short of breath, so can walk for miles but more short of breath than usual, also with talking. Chest pain with movement 1/10. Not exertional. _____. No left arm pain. Occasional cough with blood or black flecks. Involved in litigation secondary to motor vehicle accident. Positive tobacco 60 years one pack per day. Oxygen saturation 99% on room air. Presently, shortness of breath out of proportion to given

pulmonary function test. Echocardiogram, question deconditioning. Exercise test, pulmonary. Continue Advair and Combivent.

08/29/02 **UNIVERSITY OF xxxxxx**
(p. 381)

Initially has random blood sugar of 180 and repeat fasting 100. No polydipsia (increased thirst). No polyuria (increased urination). Eats candy regularly, likes milky way. Ophthalmology, diabetes mellitus, eye evaluation. No concentrated sweets. Patient with COPD asked to return to clinic regarding fasting blood sugar 156. Asymptomatic. Positive fatigue. Positive family history. Regular diet and exercise.

Assessment: Diabetes mellitus, referred to Diabetes Mellitus Education Clinic.

09/25/02 **UNIVERSITY OF xxxxxx**
(p. 382)

Here for disability forms to be filled out. He claims severe COPD is his disability. Not oxygen dependent. Not steroid dependent per patient. Previous trauma from motor vehicle accident in past. Pulmonary function, PAM. Patient reports that any limited walking produces significant dyspnea. Has some difficult situation. Patient has no objective disability on pulmonary exam or pulse oximetry. Referred to pulmonary service if disability not proven to medical service. Here for disability forms. No new complaints today. Complaining of severe shortness of breath, labored breathing. Lungs clear to auscultation. No disability. Referred to outside physician.

09/30/02 **OPHTHALMOLOGY**
EXAMINATION
(p. 383)

Medications: Ibuprofen, Advair, Zestril (blood pressure medications, pain medications).

12/17/02

UNIVERSITY OF xxxxxx
(p. 386)

Patient complaining of shortness of breath with and without activity. Seen and examined. Motor vehicle accident in January 2002. No significant head trauma, but had chest contusion. Thereafter developed persistent shortness of breath. Worse when he gets upset or angry or with bending over. Also developed stuttering. Has had pulmonary function test, obstructive and restrictive changes, Advair and Combivent. He is taking but states not helpful. Past history of working with a specialist.

Respiratory rate 24, sitting with open mouth. Positive accessory muscle use. Bilateral expiratory wheeze. Lungs with dry crackles. Persistent shortness of breath. Rule out interstitial lung disease. High resolution CT scan. May need trial of prednisone. After follow-up today no new complaints. Shortness of breath persists with rest, mild and increases with exertion, but no exercise limitation secondary to shortness of breath. Question anxiety component. Chest pain non-cardiac.

12/17/02

UNIVERSITY OF xxxxxx
(p. 384)

Patient with persistent shortness of breath and wheezing of unclear etiology, post motor vehicle accident. Relevant history of COPD. High resolution chest CT.

03/31/03

UNIVERSITY OF xxxxxx
(p. 387)

Did not keep up appointment.