INPATIENT CASE STUDY #1

DISCHARGE SUMMARY

Date of Admission: January 04

Date of Discharge: January 14

DISCHARGE DIAGNOSIS:

1. Colon cancer involving the hepatic flexure
2. Post hemorrhagic anemia secondary to above
3. Gastric erosions

PROCEDURES PERFORMED:

1. Right Hemicolectomy
2. Colonoscopy with brush biopsy of large intestine
3. Upper GI Endoscopy with biopsy

HISTORY OF PRESENT ILLNESS: See H&P for full details

HOSPITAL COURSE: Upper GI endoscopy was performed which showed erosions which did not appear to be the source of the patient's acute anemia. Colonoscopy performed which documented a colon cancer at the hepatic flexure. The patient underwent a hemicolecotomy. The patient received two units of packed cells because admission hemoglobin was 7.1 and hematocrit was 21.2. After transfusion, the hemoglobin was 9.7 and the hematocrit was 30.7. H&H at discharge were 9.9 and 29.5. These are to be followed as an outpatient in two weeks. Electrolytes were unremarkable. Laboratory data was within normal limits including EKG, chest x-ray, lytes, BUN, creatinine, serum calcium level and urinalysis.

DISCHARGE MEDICATIONS:

1. Ferrous sulfate 324 mg b.i.d.
2. No aspirin products
3. Tylenol two tabs q4h for back pain

DISPOSITION:

Outpatient follow up scheduled; repeat CBC in two weeks.

ADDENDUM:

Path report returned showing infiltrating, differentiated, mucin secreting adenocarcinoma of the right colon. Tumor had penetrated into but not through the muscularis propria, proximal and distal resection margins were free of tumor. LS spine x-rays showed subluxation at L4-5 presumably related to arthropathy. Chest x-ray showed left lower lobe pneumonia resolved on follow-up x-ray.
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HISTORY AND PHYSICAL

CHIEF COMPLAINT: Gastrointestinal bleeding.

HISTORY OF PRESENT ILLNESS: Seventy five year female with history of bowel resection and hysterectomy many years ago. She presents to the office because of progressively worsening fatigue, pale complexion, and dyspnea on exertion with palpitations upon going up a flight of stairs. On further questioning she complains of heartburn, relieved by Maalox. She takes Bufferin for low back discomfort. She also notes approximately a ten pound weight loss in the last three months. She denies changes in bowel habits, melena or blood per rectum. The only current medication she is on is aspirin on a PRN basis for her low back discomfort. She has not seen a physician for many years except for a respiratory tract infection-like illness when she saw me for the first time three weeks ago.

SOCIAL HISTORY: Non-smoker, negative ETOH abuse

FAMILY HISTORY: Significant for her brother dying of a heart attack. Her father died at the time of gallbladder surgery because of complications. Her mother died of congestive heart failure.

REVIEW OF SYSTEMS: See above

PHYSICAL EXAMINATION:

GENERAL: The patient's blood pressure is 130/70, heart rate is 84 per minute, respiratory rate is 20, she is afebrile; elderly white female with a pale complexion appearing in acute distress with a pain rating of 6.

HEAD: Sclerae are white, conjunctivae are quite pale, pupils equal, round reactive to light.

NECK: Without jugular venous distention or carotid bruits, no thyromegaly.

LUNGS: Clear

HEART: Regular rate and rhythm without murmur.

ABDOMEN: Soft, nontender without masses or organomegaly.

BREASTS: Without discrete masses or nipple discharge

PELVIC: Unremarkable. Pap smear and examination were deferred.

RECTAL: Examination reveals tight anal sphincter tone with positive guaiac stool.

EXTREMITIES: The lower extremities are without edema or tenderness. She has positive distal pulses, no cyanosis

DATA BASE: Outpatient hemoglobin, repeated is at 7.4 with hematocrit of 24.5, MCV 57, platelet count 339,000. Her cardiogram revealed normal sinus rhythm with minimal nonspecific ST wave findings; otherwise normal. Further data base is pending.

ASSESSMENT:
1. Anemia secondary to gastrointestinal blood loss, the source of which is unclear at this point.
2. The patient is relatively stable clinically for her severe anemia. However, she would need to be monitored closely during transfusion.
3. Work up will include an upper endoscopy. If this is unrevealing, it will be followed by a lower colonoscopy or a barium enema procedure.
4. A mammogram will be performed during the patient's hospitalization as well as lumbosacral spine films.
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GASTROENTEROLOGY CONSULTATION REPORT

CHIEF COMPLAINT: Fatigue

PRESENT ILLNESS: This 75 year old female presented because of progressive fatigue. She also noted shortness of breath and some palpitations. She has not noticed any definite stool changes.

In the early 2009 she had a hysterectomy for what she described as partially solid and partially soft tumor. She was not told the specifics about the pathology. However, she was told her “bowels would not cause her any more problems because they have straightened it out.” She took this to mean there had been some indication of associated bowel resection but has no proof of such.

PHYSICAL EXAMINATION:

She is elderly but very pleasant and alert female and is overweight. Vital signs are presently satisfactory.

HEENT: Unrevealing.
Neck: no bruits, jugular venous distention or adenopathy.
Chest is clear.
Heart: regular rhythm, no murmur.
Abdomen: overweight with a BMI of 32; nontender, no masses
Breasts: not re-examined.
Pelvic: not redone by me.
Rectal: examination was not repeated.
Extremities: no edema, no deformity. Femoral, popliteal pulses are excellent.

HOSPITAL COURSE: The patient was found be to anemic and has been transfused. Colonoscopy was carried out and a large polypoid lesion was noted at the hepatic flexure. Biopsies were done. Complete colonoscopy was completed to the cecum.

IMPRESSION:

1. Right colon lesion-probable carcinoma
2. Anemia secondary to #1.

RECOMMENDATIONS:

1. Right colectomy.
2. With her bowel presently clean from today's earlier colonoscopy, I feel that in the morning it would be reasonable to vigorously pursue proceeding with the colectomy for the following day
3. Bowel preparing and antibiotics would be ordered in the morning if the schedule can be arranged.
4. I have discussed the details of the surgery and have explained the potential complications.

Thank you for asking me to see this patient.
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PROCEDURE REPORT

DATE: January 8

PROCEDURE: Esophagogastroduodenoscopy

INDICATIONS: Iron deficiency anemia and probable GI blood loss.

PREOPERATIVE MEDICATION: Valium 6mg IV, Demerol 20 mg, Pontocaine throat gargle.

PROCEDURE: With the patient in the left lateral position an Olympus XQ panendoscope was passed into the esophagus. The esophageal mucosa appeared normal. There was no inflammatory change or ulceration. The EG junction found at the 38 cm level. The stomach entered. The gastric mucosa in the fundus reviewed with retroflexion maneuver and found to be normal. There was one very small erosion on the curve of the antrum. This does not appear to have been a bleeding site. The pylorus was symmetrical. The duodenum was entered; duodenal cap, second and third portions were examined and found normal. This area was reviewed several times and no abnormalities were seen.

The endoscope was then slowly withdrawn. The patient tolerated the procedure well.

DIAGNOSTIC IMPRESSION:

1. Small gastric erosion but not site of recent bleeding.
2. Recommend colonoscopy.
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PROCEDURE REPORT

DATE: January 9

PROCEDURE: Colonoscopy and Biopsy

INDICATIONS: The patient has severe iron deficiency anemia. Hem occult positive stools were found.

PREOPERATIVE MEDICATIONS: Valium 5 mg and Demerol 15 mg IV

INTRAOPERATIVE MEDICATION: Glucagon 0.5 mg IV

PROCEDURE: With the patient in the left lateral position, an Olympus CF colonoscope was introduced into the rectum. The rectal mucosa appeared normal. There was no evidence of inflammation. The scope then advanced to the sigmoid. There was considerable spasm and irritability of the sigmoid.

The patient rolled into supine position. The scope advanced to the descending and transverse colon. In the area of the hepatic flexure there is a large polypoid mass which is firm and has superficial ulceration. It measures approximately 4-5 cm, although the exact size is difficult to tell because it fills the lumen of the colon. This is just around the ascending part of the hepatic flexure. The scope then advanced into the ascending colon and into the cecum. There was no further evidence of lesions.

The scope was gradually withdrawn. Because of its size, I did not think the lesion could be removed endoscopically. Biopsies were taken, the scope was then withdrawn and the patient tolerated the procedure well.

DIAGNOSTIC IMPRESSION:

1. Polypoid mass at the hepatic flexure which is probable CA
2. Anemia and occult bleeding secondary to #1
3. Recommend a surgical referral

PATHOLOGY REPORT

DATE OF PROCEDURE: January 9

DATE OF REPORT: January 10

SPECIMEN: Biopsy/ hepatic mass, hepatic flexure colon

CLINICAL DIAGNOSIS: Anemia, Hepatic flexure mass, Suspect CA

PATHOLOGICAL DIAGNOSIS: Highly atypical glandular clusters, suspicious for adenocarcinoma.
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OPERATIVE REPORT

DATE: January 11

PREOPERATIVE DIAGNOSIS: Right colon mass, probable carcinoma

POSTOPERATIVE DIAGNOSIS: Right colon mass, probable carcinoma

OPERATION: Right colectomy

FINDINGS: 4-5 cm mass in the right colon just inferior to the hepatic flexure, no metastases. The remainder of the exploration is unrevealing.

PROCEDURE: With the patient in the supine position and under satisfactory general anesthesia, the abdomen was prepped and draped in the usual fashion. The abdomen was entered through a midline incision. Exploration was carried out. The right colon was mobilized by incising lateral peritoneal attachments and rotating the colon medially. The right half of the gastric colonic omentum percussibly clamped, divided and tied. The distal ileum was immobilized. Just to the right of the mid colonic artery, the mesentery was incised toward the base and then toward the distal ileum. Blood supply to the right colon distal ileum clamped, divided and tied thus completing division. At approximately 5 cm proximal to the ileocecal valve, the mid transverse colon was cleared and held together with clamps. Small incisions were the made in each. A GIA staple inserted and fired along the antimesenteric border. Anastomosis was completed via transverse application of TAs, specimen was excised. The anchoring sutures proximally and distally were placed and the mesenteric defect was closed, anastomosis was widely patent. Irrigation was carried out. Peritoneum was closed with running Vicryl, fascia with running Vicryl, skin with clips. Sterile dressings applied. Blood loss minimal.

All counts were correct.