ED Evaluation Note-SHY:

University of Pittsburgh Medical Center

Patient: [ ] MRN: [ ] FIN: [ ]
Age: 70 years Sex: Male DOB: [ ]
Associated Diagnoses: None
Author: [ ]

Visit Information

Findings
CHIEF COMPLAINT: Bright red blood per rectum

HISTORY OF PRESENT ILLNESS: 70-year-old male who presents with bright red blood per rectum. 3 days of blood in his stool. Denies melena. No abdominal pain, and no vomiting. Never had this before. Denies chest pain, shortness of breath, dizziness.

REVIEW OF SYSTEMS: All systems listed below were reviewed and are negative unless otherwise noted in the report.
[General]
[EYES]
[ENT]
[Cardiac]
[Respiratory]
[Gastrointestinal]
[Genitourinary]
[Musculoskeletal]
[Dermatologic]
[Neurological]

PAST MEDICAL HISTORY: Includes CAD with stents, diabetes, CHF, BPH

MEDICATIONS: Nursing notes reviewed and agree. Includes Plavix and aspirin

ALLERGIES: Nursing notes reviewed and agree.

SOCIAL HISTORY: English-speaking
PHYSICAL EXAM: Vital Signs: Nursing notes reviewed and agree.
PATENT STATUS: Alert and comfortable
EYES: Pupils equal, EOMI, no injection, icterus or discharge.
NECK: Supple. No swelling or tenderness.
LUNGS: Respirations unlabored with good air entry bilaterally. Breath sounds clear.
HEART: Regular rate and rhythm. No murmur or gallop.
ABDOMEN: Non-distended, non-tender and soft. No organomegaly or masses.
SKIN: Warm and dry.
MUSCULOSKELETAL: No limitation of motion, swelling or tenderness.
Rectal: Gross blood on exam, and hemeoccult positive

DIAGNOSTIC STUDIES:
EKG: Normal sinus rhythm, no ST changes, normal intervals  CBC, chem 10, troponin, type and screen  Hemoglobin is 7.7, lower than usual  Hyperglycemic  Troponin not elevated

HOSPITAL COURSE:
70-year-old male who complains of bright red blood per rectum for 3 days.
Anemic, but not lower than 7. Will need admission for likely lower GI bleed.
Hemodynamically stable. Does take aspirin and Plavix, no Coumadin. Need serial H&H’s, likely GI consult. Does not need emergent GI consult. is patient's PCP. I will admit to internal medicine, service. Admitted in a stable state

Impression and Plan
GI bleed
Anemia
Admission to the hospital

Professional Services
Credentials Title and Author
Credentials: MD.
Title: Attending.

Perform - Completed by ■
Discharge Summary/Day of DC Note:

University of Pittsburgh Medical Center

Patient: □ MRN: □ FIN: □
Age: 70 years Sex: Male DOB: □
Associated Diagnoses: None
Author: □

Discharge Information
Discharge Summary:
Overnight events: Patients H&H came back at 7pm with a Hgb of 6.9. He was consented and given 1 unit of typed&screened PRBC..
Admit Date: 3/2/2017.
Discharge Date: 3/3/2017.
Attending physician: □
Consulting physician: □
Consult Services: GI.
Reason for admission: bloody bowel movements.
Discharge diagnosis: Chronic active hepatitis C (ICD10-CM K73.2, Working, Diagnosis), Diverticular hemorrhage (ICD10-CM K57.31, Working, Diagnosis), GIB (gastrointestinal bleeding) (ICD10-CM K92.2, Working, Diagnosis), History of colon polyps (ICD10-CM Z86.010, Working, Diagnosis).

Demographics
Admitted: 3/02 11:48 Reason: GI BLEED
LOS: 1.2 (Hospital Day: 1) Attending: □ (General Medicine)

PROVIDERS
PCP: □
Attending: □
Referring: □
Consulting: □

Follow-up Appointments
WITHIN 1 MONTH: □
(412) 623-3105
UPP GASTROENTEROLOGY
5200 CENTRE AVENUE, PITTSBURGH, PA, 15232
CALL TO SCHEDULE FOLLOW UP APPOINTMENT TO DISCUSS HEPATITIS C TREATMENT.

WITHIN 1 WEEK: □
(412) 621-6166
PINNACLE INTERNAL MEDICINE ASSOCIATES, LLC
532 S. AIKEN AVENUE
SUITE 201, PITTSBURGH, PA, 15232

Lab Results Not Available at Time of Discharge

Discharge Medications: (As of 03/03/17 15:47)
ASPIRIN (81 MG ORAL TABLET, CHEWABLE) 1 TAB BY MOUTH ONCE A DAY
Hospital Course

This is a pleasant 70 year old gentleman with a past medical history significant for CHF, DMII, CAD s/p stenting 2014 on aspirin & plavix, chronic HCV, multiple colon polyps, and asymptomatic diverticulosis who presents with a 4-day history of bloody bowel movements. He notes that in days prior to those 4 days, he has had stools that have been darker than normal. However, for the 4 days prior to admission, he has been having bright red blood per rectum. He otherwise had no signs or symptoms of hypovolemia or acute anemia. In the ED he had a HR 91 - 76 though somewhat hypertensive BP 160s - 170s/80s. He had not taken his AM HTN meds. Labs notable for Hgb 7.7 down from 13 in January (actually was downtrending to 8.9 1/15 - 1/28), plts 200, BUN 30, Cr 1.2. INR 1.1, PT 13.8. He had a BM in ED with melenic stool and red blood. Admitted to medicine with GI consulted. He had an EGD performed the afternoon of admission that was normal with no source of bleeding localized. He was started on a colon prep for colonoscopy in the AM 3/3. While trending his H&H, he had a drop @7pm 3/2 to 6.9. He was consented and given 1U typed & screened PRBC. In the AM on 3/3, he had a colonoscopy which showed old blood in the entire examined colon with diverticulosis throughout the entire colon as well as one 10 mm polyp in the sigmoid colon removed during exam. No active bleeding was observed during the colonoscopy. The diverticula are the most likely source of the GI bleeding. At the time of discharge, he was stable with no active bleeding per colonoscopy. He was instructed, and understood, that he should return to the ED for any recurrence of GI bleeding for IR angiography/embolization. He demonstrated understanding of instructions to followup with both his PCP and the GI service for continued management of his HCV and diabetes, heart disease. He expressed that he felt comfortable returning to his current living situation at his daughter's house and that she would be able to provide transportation.

Hematochezia: The pt had a 4-day history of BRBPR with various medical history (chronic HCV, liver fibrosis, mild gastropathy, multiple colon polyps, weight loss) concerning for either an upper or lower GI bleed. GI service consulted. Held aspirin, plavix. Started PPI and made NPO prior to EGD, did not start octreotide with no known varices. EGD normal on 3/2, started clears diet and colon prep w/ NPO at midnight for planned colonoscopy. While trending H&H, 3/2 7pm Hgb at 6.9. Consented and transfused 1U typed and screened PRBC. 3am Hgb back up at 7.9. Colonoscopy in the AM 3/3 showed old blood throughout the examined colon with no active bleeding. Diverticulosis found throughout entire
examined colon. One 10mm polyp in the sigmoid colon removed during exam.
- pt instructed to followup with GI service as outpatient in 1 week
- followup results of polyp biopsy
- pt instructed and understood to go to ED for any future GI bleeding for likely IR angiography and embolization

#Chronic HCV : initial concern for cirrhosis leading to EV and hematochezia.
Ruled out EV with normal EGD. Plan to followup on HCV as outpatient
-followup HCV viral loads ordered on day of discharge
-provided prescription to get U/S liver to eval for cirrhosis, portal HTN as outpatient
-followup with GI service as outpatient to evaluate for HepC treatment

# HTN : hypertensive in ED despite BRBPR, anemia - didn't take home HTN meds the morning of admission; slightly dry on exam the day of admission
- continued home lisinopril, lasix
- started light maintenance IV fluids given dryness on exam

#DMII - poorly controlled at home; HgA1C measured at 8.8 during admission
- halved long-acting insulin dose while NPO, otherwise continued home regimen
- continue home regimen at discharge
- followup with PCP for further management of poorly controlled diabetes

#CAD /w stent; CHF
- held home aspirin, clopidogrel during inpt stay given GI bleed; ok to restart at discharge
- continued home atorvastatin, carvedilol, lisinopril, lasix

Results Review
Fishbone Labs (Past 24 hours)

<table>
<thead>
<tr>
<th>AST</th>
<th>ALT</th>
<th>INR</th>
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<tbody>
<tr>
<td>35</td>
<td>24</td>
<td>1.1</td>
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<thead>
<tr>
<th>Ca</th>
<th>Mg</th>
<th>TBili</th>
<th>Phos</th>
<th>AlkP</th>
<th>Anti-Xa</th>
<th>gGTP</th>
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<tr>
<td>8.1</td>
<td>119</td>
<td>0.7</td>
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<td>63</td>
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<tr>
<td>/23.6</td>
<td>4.4</td>
<td>19.9</td>
<td>1.2</td>
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<tr>
<td>03/03 02:50</td>
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</tr>
</tbody>
</table>

Additional Labs (Labs more recent than those in fishbones above plus other selected labs in past 24 hrs - Max 50)

<table>
<thead>
<tr>
<th>Glucose (bedsid)</th>
<th>H</th>
<th>107</th>
<th>3/03 05:31</th>
<th>Glucose (bedsid)</th>
<th>H</th>
<th>116</th>
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<td></td>
<td></td>
<td>17:28</td>
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<tr>
<td>17:28</td>
<td></td>
<td>298</td>
<td></td>
<td>3/03 01:06</td>
<td></td>
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<td>3/02</td>
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<tr>
<td>Glucose (bedsid)</td>
<td>H</td>
<td>107</td>
<td></td>
<td>Glucose (bedsid)</td>
<td>H</td>
<td>272</td>
<td>3/02</td>
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<tr>
<td>3/03 12:06</td>
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<td></td>
<td></td>
<td>16:15</td>
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<tr>
<td>16:15</td>
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<td>279</td>
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<tr>
<td>Glucose (bedsid)</td>
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<td>3/02 21:10</td>
<td>Glucose (bedsid)</td>
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<td>3/03 08:09</td>
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</table>

Microbiology: No microbiology resulted in the past 36 hrs.

Health Status

Allergies
NKA

Problems

Congestive heart failure; COPD (chronic obstructive pulmonary disease); HTN (hypertension); Diabetes mellitus, type II; Benign prostatic hypertrophy; Hepatitis C; CAD (coronary artery disease), native coronary artery; PTCA [Percutaneous Transluminal Coronary Angioplasty]; Insertion of coronary artery stent(s); Myocardial infarction; Percutaneous transluminal coronary angioplasty status; Stented coronary artery

Physical Examination

Day of Discharge Examination Date: 3/3/2017 Exam Date.

Vital Signs (Last 7 in past 36 hours)

<table>
<thead>
<tr>
<th>Vitals</th>
<th>TempC</th>
<th>BP</th>
<th>Pulse</th>
<th>RR</th>
<th>SaO2</th>
<th>FiO2</th>
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<tr>
<td>3/03 12:50</td>
<td>36.2</td>
<td>172/73</td>
<td>78</td>
<td>19</td>
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<td>3/03 12:40</td>
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<td>82</td>
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<td>161/65</td>
<td>91</td>
<td>19</td>
<td>97</td>
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<td>3/03 12:10</td>
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<td>157/95</td>
<td>75</td>
<td>19</td>
<td>97</td>
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<tr>
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<td>36.2</td>
<td>129/65</td>
<td>87</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>3/03 11:55</td>
<td></td>
<td>135/63</td>
<td>79</td>
<td>100</td>
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</tr>
</tbody>
</table>

24 Hr Max Temp: 36.7 at 03/03 06:58  Dosing Wt: 56.2 kg (As of 03:02:17 13:36)
36 Hr Max Temp: 36.7 at 03/03 06:58  BMI: 19.9 (As of 03:02:17 13:36)

Weights (Last 5 in past 7 days)

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Weight(kg)</th>
<th>Dosing Wt = 56.2 kg (As of: 03/02 13:36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/02 13:36</td>
<td>56.2</td>
<td>3/02 09:54 52.0 36.2 56.2 500 125 625 375 0 0</td>
</tr>
</tbody>
</table>

I & O (Summary)

| I&O (03/02) 7a-3p 3p-11p 11p-7a Total (03/03) 7a-3p 3p-11p 11p-7a | Intake: 0 500 125 625 375 0 0 | Output: 0 0 0 0 200 0 0 | Balance: 0 500 125 625 175 0 0 |

General: Alert and oriented, No acute distress.
Eye: Pupils are equal, round and reactive to light, Extraocular movements are intact, Normal conjunctiva, no subconjunctival pallor.
HENT: Slightly dry oral mucosa.
Neck: Supple, Non-tender, No lymphadenopathy.
Respiratory: Lungs are clear to auscultation, Respirations are non-laborated, Breath sounds are equal.
Cardiovascular: Normal rate, Regular rhythm, Normal peripheral perfusion, systolic murmur.
Gastrointestinal: Soft, Non-tender, Non-distended, Normal bowel sounds.
Integumentary: Warm, Intact, No pallor.
Neurologic: Alert, Oriented, Normal sensory, Normal motor function, No focal defects, Cranial Nerves II-XII are grossly intact.
Psychiatric: Cooperative, Appropriate mood & affect.

Discharge Plan
Discharge Summary Plan
Discharge disposition: discharge to home (into the care of family member, self care).
Discharge instructions given: to patient.
Patient/Family Response to Instruction: able to recall/perform demonstration.
Discharge Status: stable.
Dietary Restrictions: diabetic diet.
Prescriptions: continue same medications.
Follow Up Instructions: patient will follow-up with Primary Care Physician, in 1 - 2 weeks.

Professional Services
Credentials and Title of Author
Credentials: MS-4, PhD.
Title: Medical Student.
Supervising MD:  Addendum by  on March 03, 2017 8:09 PM:
Patient seen and evaluated on 3-3-17... discussed in detail with housestaff. All pertinent records reviewed. I have reviewed the documentation to which this note is attached / linked by the blue team and I agree with the content. See my other documentation if needed. Doing well... okay for discharge my standpoint if okay with GI. Follow up as noted.

Perform - Completed by  (on 03/03/2017 12:56)