DATE OF CONSULTATION: June 9, 2023
Mr. Graham is a 67-year-old gentleman with a long history of Crohn's disease. He has had a prior total abdominal colectomy with rectal stump and permanent ileostomy by Dr. Richard Golub many years ago. The patient remotely has also had a rectal procedure by Dr. Nora my associate. He has had several admissions for what sounds like partial bowel obstruction. He presents now with similar complaints of abdominal distention, nausea and vomiting. He has had parastomal hernia repair also in the past by Dr. Goulb and had mesh placed and this mesh just appeared to be apparent on the CT scan. The patient developed nausea and vomiting, was seen in the emergency room and admitted to the hospital and has had nasogastric tube decompression with significant volume outputs. His admission hemoglobin and hematocrit was 18.7 and 57, this morning is 18 and 52. His white count on admission was 13.3, now 13.1. His electrolytes were significantly abnormal. Sodium was 121. His potassium was 52s, creatinine was 2.68. He has had no admissions to the Memorial in the last 6 months to compare with his creatinine was in that interval of time nor a year. The patient had a nasogastric tube placed and as I said had significant output, just looking at the container is quite full this morning and is documented at over 1000mL of output. He does have IV fluids underway and nasogastric tube in place. He is chronically overweight. He says he has chronic dehydration. This may reflect his creatinine? The patient's past history is also significant for.
ALLERGIES: TO PENICILLIN.
MEDICATIONS: He takes
1. Vitamin D2.
2. Ophthalmic drops.
3. Tamsulosin.
4. Simvastatin.
5. Sertraline.
6. Prednisone drops.
7. Zofran.
8. NovoLog.
9. Loratadine.
10. Lisinopril.
11. Levemir.
12. Depo-Testosterone.
13. Carvedilol.
14. Brimonidine ophthalmic solution, aspirin and a biologic under the care of Dr. Lee Mitchel, his gastroenterologist.
PHYSICAL EXAMINATION:
GENERAL: On examination, the patient is resting comfortably in bed with a nasogastric tube in place and a large volume output in the drainage canister.
ABDOMEN: Obese. He addict thick dense scar in the midline without obvious incisional hernias. He has a stoma bag in the right abdomen without obvious parastomal hernia in the supine position. He has no peritoneal signs, rigidity, rebound, or guarding on abdominal examination.
VITAL SIGNS: Show him to be afebrile with a blood pressure 131/81.
EXTREMITIES: Palpably benign.
ASSESSMENT: Crohn's disease, chronic ileostomy with probable recurrent parastomal hernia based on CT appearance, but not by clinical examination. This does not appear to be a point of a bowel obstruction, however. CT findings concerning for bowel obstruction, but he also has known Crohn's, so could this be a Crohn's obstruction.
PLAN: I would recommend the patient continue with nasogastric decompression and fluid resuscitation. He should be seen by Dr. Lee Mitchel, his gastroenterologist to reevaluate him and at some point consider a Gastrografin small bowel follow through. If this is a Crohn's problems and medical therapy is appropriate at this time, we will follow for those and put some referrals. I will be off Saturday and Sunday and my associates will follow him and over the weekend. I do not see any imminent surgery based on his examination today. Again, I do not think the parastomal findings are the point of his obstruction at this time by exam or by CT findings.

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Russell W. Novak, M.D.
D: 06/09/2023 07:57:00
T: 06/09/2023 08:34:14
JobID: 294877090
Confirmation: 16043020

Electronic Signatures:
Novak, Russell (MD) (Signed on 06/09/2023 08:52)
Authored
Interfaces, HL7 (SA) (Entered on 06/09/2023 08:34)
Entered

Last Updated: *06/09/2023 08:52 by Novak, Russell (MD)*

DATE OF SERVICE: June 10,m 2023
Mr. Graham is seen this morning. The patient is afebrile. Vital signs are stable, though he is becoming tachycardic this morning. He complains of continued abdominal discomfort, a bloated feeling is really what he feels like, complains of symptoms that seems consistent with esophagitis and reflux. The patient has an IV rate currently at 75 an hour, though he is a big boy. The patient also states that his ileostomy is putting out and indeed there was gas and fluid inside of it. His NG tube dark fluid, but put out 4500 out of his NG tube just yesterday. Stool volume has not been recorded. Urine output was adequate, though small amount. Laboratory values are still pending at the time of this dictation.
ASSESSMENT AND PLAN: Being worked up for possible small-bowel obstruction versus a Crohn stricture. The problem with this patient at present is he has become massively behind on his IV fluids. Last creatinine was running 2.38. He has had a massive amount of his NG tube. He is a large gentleman, not fat, just large and his IV rate is totally inadequate. We shall give him a fluid bolus at this time. We are going to jump in his rate up to 200 an hour with isotonic saline. I do not plan any further workup. I am definitely not give him Gastrografin study, which he could have even further behind on fluids. We shall recheck labs in the morning. I have requested the nurses to chase down that the labs are actually done that were ordered today.

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John D. Nora, M.D.
D: 06/10/2023 07:53:55
T: 06/10/2023 08:00:08
JobID: 294941757
Confirmation: 16142835

Electronic Signatures:
Nora, John (MD) (Signed on 06/10/2023 16:54)
Authored
Interfaces, HL7 (SA) (Entered on 06/10/2023 08:00)
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Last Updated: *06/10/2023 16:54 by Nora, John (MD)*

DATE OF SERVICE: June 11, 2023
Mr. Graham is seen this morning significantly improved after we have caught up with his hydration. He feels much more alert. Laboratory values are still pending at the time of this dictation, but he has noted a vast improvement. His NG tube output has decreased significantly to where it is now down to 900mL yesterday and it appears much more benign. The patient's ileostomy is continuing to function.
Laboratory values pending, but I believe we are indeed able to proceed with a Gastrografin small bowel follow through today. Major complaint beyond that, however, is that he still has epigastric discomfort, which was quite disconcerting to him. Consider the possibility of upper endoscopy this time.

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John D. Nora, M.D.
D: 06/11/2023 07:59:59
T: 06/11/2023 08:09:32
JobID: 294961888
Confirmation: 16243199

Electronic Signatures:
Nora, John (MD) (Signed on 06/11/2023 14:17)
Authored
Interfaces, HL7 (SA) (Entered on 06/11/2023 08:09)
Entered

Last Updated: *06/11/2023 14:17 by Nora, John (MD)*

DATE OF SERVICE: June 12, 2023
The patient was seen this morning. He was actually sleeping when we saw him, comfortable, says he passed _____ a little bit of stool and gas through a stoma bag. Vital signs have been stable. NG output still significant. A Gastrografin small bowel follow through has been ordered for today. He has been seen by GI, who is following. I agree with Dr. Nora that an upper endoscopy during this hospitalization seems reasonable and appropriate. We will await Gastrografin study and further input from GI.

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Russell W. Novak, M.D.
D: 06/12/2023 08:18:45
T: 06/12/2023 08:25:19
JobID: 294984315
Confirmation: 16344325

Electronic Signatures:
Novak, Russell (MD) (Signed on 06/12/2023 09:23)
Authored
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Last Updated: *06/12/2023 09:23 by Novak, Russell (MD)*

DATE OF SERVICE: June 13, 2023
The patient's small bowel follow through was noted. He asked me about performing a port for him. I did speak to Dr. Marple who says he does do weekly infusions for him and that report was a reasonable idea. I will speak to the patient in the morning to see if he wants a port placed during this admission and then will appropriately schedule pending his input from the patient.

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Russell W. Novak, M.D.
D: 06/13/2023 05:05:52
T: 06/13/2023 05:27:08
JobID: 295118072
Confirmation: 16475952

Electronic Signatures:
Novak, Russell (MD) (Signed on 06/13/2023 19:58)
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Last Updated: *06/13/2023 19:58 by Novak, Russell (MD)*

DATE OF SERVICE: June 14, 2023
Mr. Graham was seen this morning. Small bowel follow through results are noted. He has had a bunch of bowel movements to his ileostomy. The bowel looked nondilated on the scan imaging to me. He is scheduled for a CT today to further evaluate his small bowel. He had requested me to consider placing a port for him. I did speak to Dr. Marple yesterday. He reported that he does almost weekly infusions for the patient for hydration and he thought that placing a port was a reasonable consideration and would be utilized. So, I spoke to the patient today and plan to do that procedure tomorrow, __on___ Thursday, in the operating room. I have discussed the procedure, port placement, risks, benefits, alternatives of therapy and he accepts. Plan for port placed tomorrow.

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Russell W. Novak, M.D.
D: 06/14/2023 07:32:44
T: 06/14/2023 07:41:40
JobID: 295138806
Confirmation: 16541564

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Novak, Russell (MD) (Signed on 06/14/2023 07:56)
Authored

Last Updated: *06/14/2023 07:56 by Novak, Russell (MD)*

DATE OF SERVICE: June 15, 2023
SUBJECTIVE: Mr. Graham is scheduled for port placement today. He understands the procedure, risks, benefits, and alternatives of therapy, port placement later today.

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Russell W. Novak, M.D.
D: 06/15/2023 07:27:06
T: 06/15/2023 08:06:16
JobID: 295216547
Confirmation: 16641226

Electronic Signatures:
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Last Updated: *06/15/2023 08:34 by Novak, Russell (MD)*

DATE OF PROCEDURE: June 15, 2023
PREOPERATIVE DIAGNOSIS: Crohn's and poor venous access for chronic infusions.
POSTOPERATIVE DIAGNOSIS: Crohn's and poor venous access for chronic infusions.
OPERATION PERFORMED: Left subclavian low profile port catheter placement.
SURGEON: Russell W. Novak, MD
ANESTHESIA: General.
ASSISTANT: None.
ESTIMATED BLOOD LOSS: Minimal.
DESCRIPTION OF PROCEDURE: The patient was taken to surgery after informed consent, placed in a supine position following induction of anesthesia. The patient was positioned with a roll in the back, both arms _____ side padded and positioned. Both chest, jaws, neck, shoulders were widely prepped and draped in sterile fashion. Timeout procedure was performed. In deep Trendelenburg, the left subclavian vein was easily cannulated and a guidewire was advanced without resistance. Fluoroscopy showed central location. The patient was taken out of Trendelenburg and soft tissue pocket was created on the chest wall to harbor the port. The introducer was placed over the wire. The wire was removed. The catheter was passed the introducer in standard fashion. Central location position was confirmed by fluoroscopy. Catheter was cut for appropriate length and placed into the port locking cap mechanism in a fashion to prevent kinking, cracking or mushrooming. Venous blood was aspirated, heparin flushed, heparin locked, placed into the pocket, sutured to pectoralis fascia with Prolene sutures times 2. Soft tissue approximated with 3-0 Vicryl and skin with running subcuticular 4-0 Vicryl. Fluoroscopy again showed good positioning. Wound was cleansed and dressed with benzoin and Steri-Strips after Marcaine was installed. The patient was taken to recovery in stable condition for chest x-ray.
CC: ____

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Russell W. Novak, M.D.
D: 06/15/2023 04:37:22
T: 06/15/2023 04:43:06
JobID: 295270297
Confirmation: 16674242

Electronic Signatures:
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Authored
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Entered

Last Updated: *06/16/2023 06:49 by Novak, Russell (MD)*

DATE OF SERVICE: June 16, 2023
Mr. Graham was seen this morning. He was sleeping on rounds. He is comfortable. He said he had minimal to no pain from the port placement. Port site looks clean, dry and intact. Post-placement chest x-ray was benign with no pneumothorax. He is good to go from my standpoint. He seems to be tolerating a diet. __steri's off___ in 1 week. He does not have to have a followup appointment with me as needed. Okay to discharge from my standpoint when medically stable. We will be available as needed.

_____

Russell W. Novak, M.D.
D: 06/16/2023 08:05:19
T: 06/16/2023 08:22:38
JobID: 295293507
Confirmation: 16743519

Electronic Signatures:

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Authored

Last Updated: *06/16/2023 08:32 by Novak, Russell (MD)*