SOAP Note #1 52yo M POD 4 from Hartmann's procedure in Hinchey III and IV diverticulitis

Identifying Data

Full Name: SA
MRN: omitted
Room: 8A-617
Address: omited
Date of Birth: 07/13/1981
Date & Time: 8/31/22
Location : Medicine floor
Religion: unknown
Source of Information: patient
Reliability: reliable
Mode of Transport: ambulance

S: Middle age male evaluated at bed side sitting in chair and found in no acute distress. No acute events overnight. Pain is well controlled on Tylenol 975mg q6. Pt is tolerating clear liquid diet, is not passing flatus or had a bowel movement s/p surgery (POD4). Using incentive spirometer. Denies fever, chills, nausea, vomiting, headaches change in vision, lightheadedness, dizziness, chest pain, SOB, dysuria, or hematuria.

O:

Vitals 8/29/22 2244

BP	131/89 R arm; sitting
Pulse	89BPM
Resp	17; unlabored
Temp	100.2 F; oral
SpO2	98%; on room air

Intake/Output Summary (Last 24 hours) at 8/29/2022 2320
Last data filed at 8/29/2022 2244

	Gross per 24 hour
Intake	2750 ml
Output	3310 ml
Net	**-560 ml**

Medications:

- Acetaminophen 975mg, oral, Q6H
- Albuterol nebulizer solution 2.5mg Q6H
- Gabapentin 200mg, oral, BID
- Heparin Sq injection 5000IU subq, Q8H

- Insulin lispro 6 units subq Q8H
- Lidocaine 5% path transdermal daily
- Omeprazole, 40mg oral, QAM
- Piperacillin-tazobactam 2.275g IV, infusion Q6H SCH
- PRN
    - Dextrose
    - Glucagon
    - Hydromorphone 2-4 mg q4-6hr (PRN pain >7/10)
    - Ondansetron 8mg Q12
    - Simethicone 125mg with meals and QPM
    - Tramadol

Physical exam

General Appearance: Male sitting in bedside chair; Awake, alert, oriented x 3; in no acute distress

Skin: Warm, dry; no suspicious lesions or rashes noted; area around ostomy bag is pink, granular tissue; no erythema, blood or discharge

Heart: Regular rate and rhythm without murmur, gallop or rub.

Lungs: Bilaterally symmetrical chest expansions, All areas are clear to auscultation; no rales, rhonchi or wheezing

Abdomen: Colostomy bag in place; no edema or signs of ischemia; No stool production; mildly distended and tender to touch at the midline; incisional areas in the suprapubic and LLQ are not tender to touch; Tympanic to percussion

Extremities: Warm to touch, pink with no edema noted

Psych: Pt is mildly anxious

Labs:

8.49< 11.1 I 33.0 < 136 8/29/22

WBC trending:

8.07 8/27/22 0513
7.89 8/28/22 0433
8.49 8/29/22 0538

Hgb trending:

11.7 8/27/22 pre-op

9.7 8/28/22
11.1 8/29/22

Results from last 7 days

Lab	Units	08/29/22 0538	08/28/22 0433	08/27/22 0513	08/26/22 2008
SODIUM	mEq/L	138	139	136	138
POTASSIUM	mEq/L	3.7	4.3	4.2	4.2
CHLORIDE	mEq/L	104	106	109*	99
CO2	mmol/L	22.0	24.0	19.0*	21.0*
BUN	mg/dL	11.0	20.0	31.0*	37.0*
CREATININE	mg/dL	1.0	1.1	2.1*	3.3*
CALCIUM	mg/dL	8.0*	8.1*	6.9*	8.9
PHOSPHORUS	mg/dL	2.2*	--	3.4	--
MAGNESIUM	mg/dL	1.6	2.0	1.7	--
ALBUMIN	mg/dL	--	--	--	3.9
TOTALPROTEIN	g/dL	--	--	--	8.6
TOTALBILIRUBIN	mg/dL	--	--	--	0.9
ALKPHOS	U/L	--	--	--	94
ALTSGPT	U/L	--	--	--	7
ASTSGOT	U/L	--	--	--	8

A:

52yo M with pmhx diverticulitis presenting with Hinchey 3 acute diverticulitis, s/p ex. lap end colostomy creation on 8/27/22. Pt was appropriately transferred from SICU to medicine floor awaiting return of bowel function.

- Ambulating regularly with nurses and PT
- No bowel movements or flatus
- Clear liquid diet
- No pain, N/V/D
- No fever

P:

- Continue pain management regimen with Tylenol; hydromorphone and tramadol available per pain scale needs
- Encourage pt to continue get out of bed and walk as tolerated
- Continue clear liquid diet
- Monitor BM production and midline tenderness
- Continue IV Zosyn
- Continue Heparin and incentive spirometer

SOAP NOTE #2: 26yo F on surgery service for fluid collection in pouch of douglas x 3 days

<u>Identifying Data</u>
Full Name: LM

MRN: omitted
Room: 8A-612
Address: omited
Date of Birth: 01/27/1996
Date & Time: 9/6/22
Location : Medicine floor
Religion: unknown
Source of Information: patient
Reliability: reliable
Mode of Transport: ambulance

S: Young female evaluated in room, was getting off bed to vomit. No acute events overnight. Pt reports nausea but decreased pain and no episodes of emesis last night. Pt states her vagina feels dry and itchy. Pt is tolerating, regular diet, passing flatus and has had bowel movements yesterday. She has two soft brown colored stools yesterday 9/6 with no visible blood. Denies fever, chills, nausea, vomiting, headaches change in vision, lightheadedness, dizziness, chest pain, SOB, dysuria, or hematuria.

O:

Vitals 8/29/22 2244

BP	123/74 R arm; laying
Pulse	59 BPM
Resp	17; unlabored
Temp	98.1 F; oral
SpO2	98%; on room air

Medications:
- Acetaminophen 975mg, oral, Q6H
- Heparin Sq injection 5000IU subq, Q8H
- Piperacillin-tazobactam 3.275g IV, infusion Q6 SCH
- Potassium Chloride 40mEq, oral BID
- Vancomycin 1,000mg IV infusion Q12 SCH
- Iohexol (OMNIPAQUE 240) oral constract solution
- PRN
    - Ondansetron 8mg Q12
    - Tramadol

<u>Physical exam</u>
General Appearance: Young female laying in bed;A wake, alert, oriented x 3; agitated

Skin: Warm, dry; no suspicious lesions or rashes noted
Heart: Regular rate and rhythm without murmur, gallop or rub.
Lungs: Bilaterally symmetrical chest expansions, All areas are clear to auscultation; no rales, rhonchi or wheezing
Abdomen: Non-distended; soft; no tenderness, rebound or guarding
Extremities: Warm to touch, pink with no edema noted
Psych: agitated and wants to go home

Labs:
8.80< 11.3 I 33.5 < 514 9/5/22 0749

WBC trending:
8.80 9/5/22 0749
11.44 9/4/22 1101
13.52 9/3/22 0535

Hgb trending:
11.3 9/5/22 0749
11.2 9/4/22 1101
12.3 9/3/22 0535

PLT trending: 514 9/5/22 < 506 9/4/22 < 526. 9/3/22

Results from last 7 days

Lab	Units	09/05/22 0749	09/04/22 0735	09/03/22 1341	09/02/22 0641
SODIUM	mEq/L	136	138	138	136
POTASSIUM	mEq/L	3.1*	3.2*	3.3*	3.2*
CHLORIDE	mEq/L	97*	99	99	98
CO2	mmol/L	25.0	27.0	26.0	24.0
BUN	mg/dL	5.0*	5.0*	5.0*	6.0
CREATININE	mg/dL	0.9	0.8	0.8	0.7
CALCIUM	mg/dL	8.2*	8.4*	8.8	8.2*
MAGNESIUM	mg/dL	--	2.0	1.7	1.7
ALBUMIN	mg/dL	--	--	3.4*	--
TOTALPROTEIN	g/dL	--	--	7.5	--
TOTALBILIRUBIN	mg/dL	--	--	0.2	--
ALKPHOS	U/L	--	--	51	--
ALTSGPT	U/L	--	--	8	--
ASTSGOT	U/L	--	--	16	--

< > = values in this interval not displayed.

Results from last 7 days

Lab	Units	08/31/22 1520
FINAL		No growth at 5 days
PRE		No growth

Imaging:

Radiology

CT Abdomen Pelvis with contrast

Results: CT Abdomen Pelvis with contrast Status: **Final result** **(Exam End: 9/4/2022 11:12)**

Impression

IMPRESSION:

1.There is a 61 mm x 41 mm (transverse) x 51 mm (cephalocaudad) cul-de-sac fluid collection within enhancing rim. It measured 66 mm x 46 mm x 45 mm on the CT scan dated August 31, 2022. There is an unchanged 9 mm in diameter oval fat density within the
collection. There is a new 50 mm x 15 mm fluid density adjacent and immediately to the right of the cul-de-sac fluid collection visible on series 2 image 109. This is probably a new fluid collection. However, it may be fluid within an unopacified bowel
loop.

2.There is a new small right pleural effusion with passive atelectasis of adjacent lung.

3.There are 2 low-attenuation lesions in the right lobe of the liver which are too small to characterize. There is mild intrahepatic biliary ductal dilatation. The patient is status post cholecystectomy. There are surgical clips in the gallbladder bed.

4.A mildly edematous loop of ileum is visible on series 2, image 107 through 110.

A:

26yo F presenting with B/L lower abdominal pain and nausea with old imaging concerning for pelvic collection in pouch of Douglas and now new CT showing another new fluid collection adj to old collection.

- Pain is not in pain at this moment; no fever
- Nausea still present and one emesis episode today

P:

- IR consulted for possible drainage of fluid collections today
- F/U GU workup of calprotectin, PCR, O&P
- Diet: NPO for IR procedure
- Continue antibiotics vancomycin and zosyn
- Hold DVT ppx for IR

SOAP NOTE #2: 42yo s/p total hip repair on L side POD2

Identifying Data
Full Name: LM
MRN: omitted
Room: 8A---
Address: omitted
Date of Birth: 3/1/1980
Date & Time: 9/20/22
Location : Medicine floor
Religion: unknown
Source of Information: patient
Reliability: reliable
Mode of Transport: ambulance

S: 42yo F female evaluated in bed s/p left total hip arthroplasty (LTA) 9/19/22. Pt tolerated surgery however experienced post-op orthostatic hypotension and headache which lead to patient not fully participating in PT. This led to patient staying another night in hospital and delay in discharge. Pt is now weight-bearing as tolerated on LUE. Pain well controlled with medication. Denies fever, chills, nausea, vomiting, headaches change in vision, lightheadedness, dizziness, chest pain, SOB.

O:

Vitals 9/20/22 1705

BP	130/75 R arm; laying
Pulse	73 BPM
Resp	12; unlabored
Temp	97.8 F; oral
SpO2	95%; on room air

BMI: 29.2

Medications:
- Acetaminophen-codeine 300-30mg Q4
- Gabapentin 300mg TID
- Celebrex 200mg BID
- Omeprazole, 40mg oral, QAM
- Sennosides 8.6mg nightly
- Pravastatin 40mg

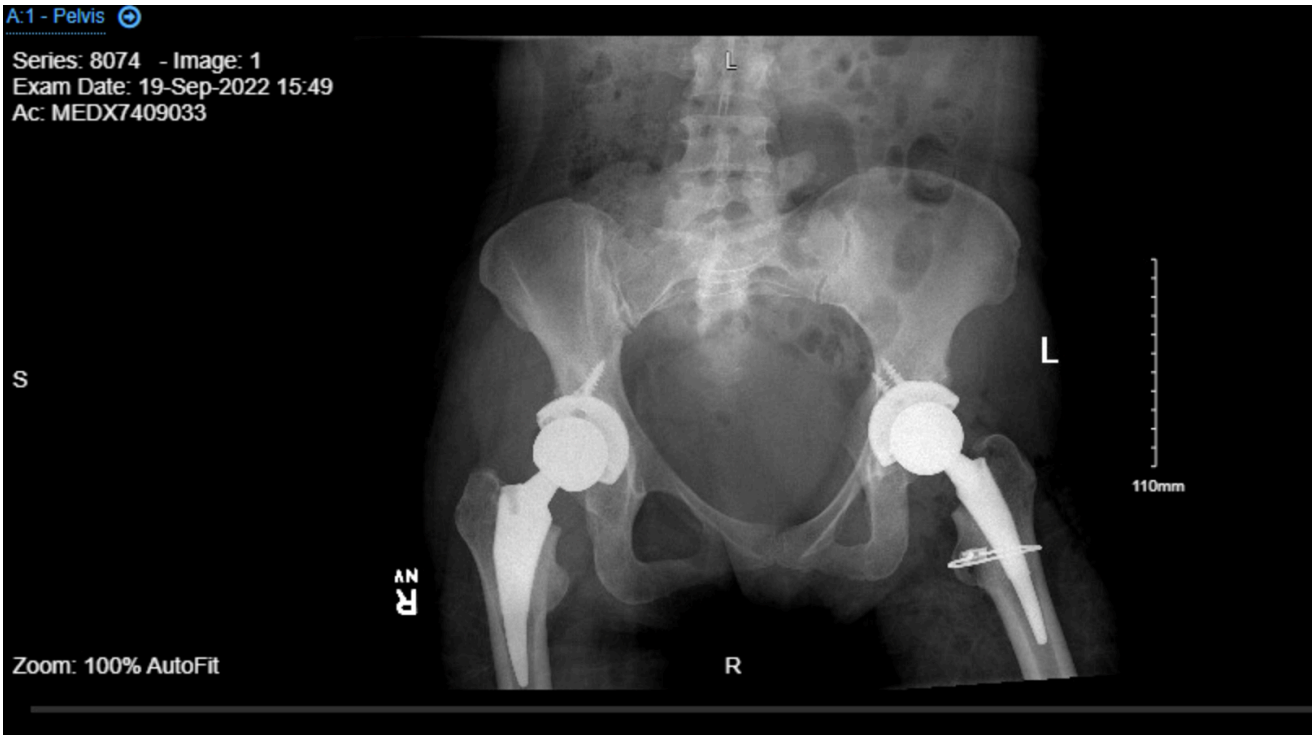
- Ancef 2000mg Q8 in dextrose 50ml
- Aspirin 81mg BID
- PRN
    - Insulin lispro 0-10units before meals and at bedtime (sliding scale)
    - Albuterol nebulizer Q4H
    - Oxycodone 5mg (moderate 4-6 pain scale) Q4 PRN
    - Ondansetron injection 4mg
    - Morphine 4mg IM (for breakthrough pain)
    - Lactulose 10g/15ml TID
    - Ambien 10mg nightly
    - Glucagon 1mg

Physical exam

General Appearance: Middle aged female laying in bed; Awake, alert, oriented x 3;
Skin: Warm, dry; no suspicious lesions or rashes noted
Heart: Regular rate and rhythm without murmur, gallop or rub.
Lungs: Bilaterally symmetrical chest expansions, All areas are clear to auscultation; no rales, rhonchi or wheezing
Abdomen: Non-distended; soft; no tenderness, rebound or guarding
MSK: Left hip dressing intact and dry; thigh is soft and compressible; able to DF/PF ankle and toes; able to do SLR with shit; DP intact;
Extremities: Warm to touch, pink with no edema noted; calves soft with no tenderness; well perfused extremities distally to hip
Psych: lethargic

Imaging: Pelvis x-ray

9/19/22: After surgery for second total hip replacement

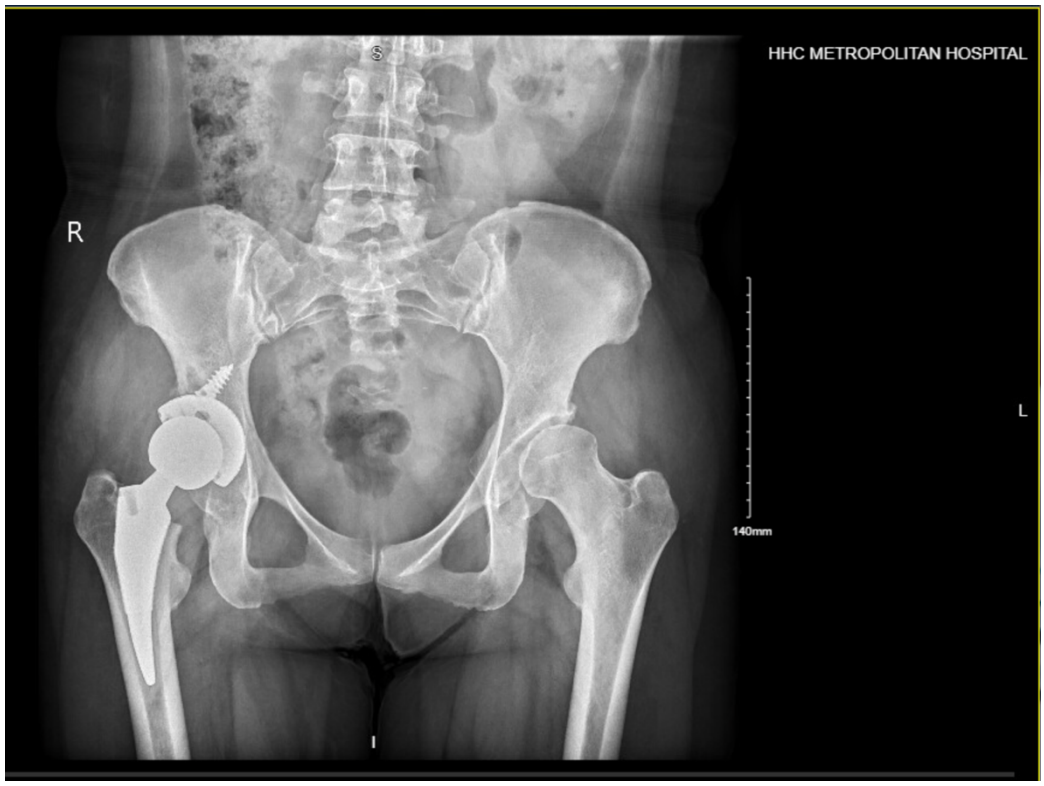


History: 42 years old Female with , post op in PACU.

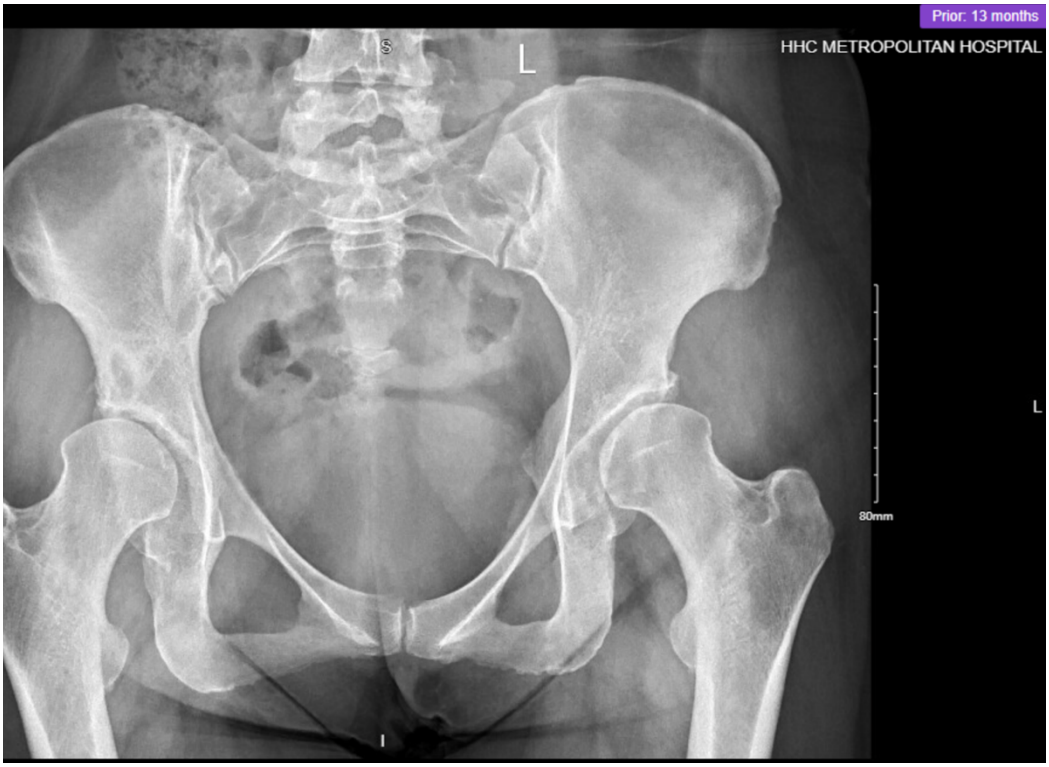
Pelvis and frontal and bilateral 3 views shows patient status post bilateral total hip replacement. No displaced fractures seen. No loosening noted.

IMPRESSION:
IMPRESSION: As above

8/16/22: Pelvis x-ray after first hip replacement



7/20/2021: Pelvis x-ray Before either hip replacement



A:

42yo F with HLD, Vit D deficiency and DDH s/p left total hip arthroplasty (LTA) 9/19/22.

- Pt tolerated surgery well
- Post-op complications of orthostatic hypotension and headache led to not participating in PT
- Not discharged POD1 as planned
- Pain controlled with Mobic QD and Tylenol #3 Q4
- Pt now able WBAT LUE POD2

P:

- Bedside PR evaluation for bed mobility, transfer, strengthening, balance activity, endurance training
- Continue incentive spirometer, pain medication, DVT prophylaxis and bowel regimen
- Precautions: fall, safety, weight-being as tolerated, Forward ROM in LLE
- Discharge planning; pending PT eval