

X1525

Individual Safety Report



OFFICE VIS

\*3133800-9-00-01\*

APR 17 1998

CDU

PATIENT:

DATE:

MARCH 19, 1998

RECEIVED

The patient comes here for follow up. She continues to have low grade fevers around 100. The patient continues to take Tylenol and Naprosyn and states that some times she takes 6-8 tablets of Tylenol a day.

The patient has had a recent MRI of the back and she would like to definite back surgery.

Besides that the patient has not had any more complaints.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temp 99.5 orally, pulse 88, RR 20, BP 142/88, weight 109 lb.

GENERAL: NAD, alert and oriented X3.

HEENT: Unremarkable, no oral thrush. No oral lesions.

NECK: Supple, no JVD, no lymphadenopathy.

LUNGS: Clear to auscultation and percussion.

CARDIAC: Regular rate and rhythm, S1, S2.

ABDOMEN: Bowel sounds present, soft, non tender, no visceromegaly.

EXTREMITIES: No cyanosis, clubbing or edema.

BACK: Marked scoliosis.

LAB DATA:

Shows normal Chem profile, normal iron and iron binding capacity and sed rate of 18 which is normal. White count 7,300, hemoglobin 12.6, Hematocrit 36.9, platelet count of 274,000. Normal differential, normal thyroid function tests. Normal white count, no evidence of anemia, normal platelets. HIV antibody negative. Normal Echocardiogram, 2-D echo and Gallium scan shows marked diffuse activity within the liver which could indicate an inflammatory process such as hepatitis.

IMPRESSION:

1. Fever of unknown origin.
2. Rule out hepatitis.

81525

-2-

MARCH 19, 1998

The patient has persistent low grade fevers and indeed she has documented low grade fevers here in the office. She has a temperature of 99.5 orally here today. The patient has no constitutional symptoms and has not lost any weight. At this point I discussed the results with her and explained that the only thing positive is the positive Galium scan which sometimes can not be very specific. She still wants to pursue the cause of the fever as she still wants to have the back surgery. I recommended the following:

- ✓1. Check hepatitis serology.
- ✓2. Check amylase and lipase.
- ✓3. Check acetaminophen level.
4. Continue to follow her temperature recording but if we don't find any reason for the *low grade fevers* she has had this for years, I don't have any contraindication for her to undergo back surgery.

[REDACTED], M.D.

c.c. Dr. [REDACTED]  
Dr. [REDACTED]

Individual Safety Report  
\*3133800-9-00-02\*

81625

CONSULT



PATIENT:

DATE:

FEBRUARY 26, 1998

REFERRING PHYSICIAN:

Dr.

HISTORY OF PRESENT ILLNESS: The patient is a 32 year old female who comes here for evaluation of fever of unknown origin.

The patient says that in April 1997 she was going to have an epiduroscopy under IV sedation. The patient says that she had local anesthesia with Lidocaine and after this was injected, the patient's temperature seemed to be increased so the patient had a temperature strip placed on her forehead and it read 103.5 and the procedure was cancelled.

Dr. [REDACTED] contacted the Malignant Hyperthermia Hotline. Dr. [REDACTED] of [REDACTED] Hospital was consulted and agreed to cancel the procedure but did not feel a muscle biopsy was indicated because there were no triggering agents used during the episode. The patient states that after this incident in April 1997 she has continued to run low grade temperatures. She takes her temperature every day and it is between 99.4 to 100.1. The patient saw Dr. [REDACTED] on 4/16/97 because of persistent fevers and intermittent chest pressure. The patient had blood cultures done that were negative, mono spot was negative. Full body bone scan was negative for osteomyelitis. The patient had an increased uptake within the region of the right pedicles of the entire thoracic spine. This was probably secondary to prior surgery. The feeling was that the patient had evidence of degenerative joint disease and arthritis.

The patient states that she has continued with low grade fevers and she wanted to have spine surgery. This was scheduled for March 1998 (lumbar decompression) to be done in [REDACTED]. The patient says that she is afraid they will not do the spine surgery because she has persistent fevers. The patient called Dr. [REDACTED] about two weeks ago and told her that there are probably no risks with anesthesia but that he was also doubtful that they would pursue with the spine surgery if she continued to have fevers.

The patient had a trial of Ciprofloxacin in April 1997 and the fevers persisted.

REVIEW OF SYSTEMS: The patient complains of headaches intermittently which are generalized which she attributes to the above pain. The patient has chronic back pain since 1996, also has history of neck pain since 1994. The patient also has some

81525

-2-



intermittent chest pain pressures but she is doing better from that. The patient denies any blurry vision, postnasal drip, photophobia, diplopia, cough, sputum production, shortness of breath, nausea, vomiting, abdominal pain, diarrhea, dysuria, increased urinary frequency or urgency. The patient also denies any weight loss. The patient takes antibiotics before any dental procedures because she was told that she has mitral valve prolapse.

**PAST MEDICAL HISTORY:**

1. Severe scoliosis, diagnosed age 12. She was found to have 68 degree curvature before the operation and she was left with 60 degrees curvature after the operation.
2. History of mitral valve prolapse.

**PAST SURGICAL HISTORY:**

1. 1978 placement of Harrington rods placed for severe scoliosis.
2. 1983 rupture of one of the Harrington rods when she had a swimming accident and the rod had to be removed.
3. 1984 removal of the other rod because she was having significant back pains.

The patient had an accident in which an aluminum object fell over her body and it was thought that the pain could be due to the Harrington rods, so this was removed but the pain persisted.

The patient now is without any Harrington rods at the present time.

**SOCIAL HISTORY:** The patient is single. Denies smoking or alcohol consumption. She works as a graphic designer with computers. She has been working in the same place for two years, denies any environmental problems related with her work place, and denies any foreign travel. She has a dog but the dog is healthy.

**REVIEW OF SYSTEMS:** The patient started with her periods at the age of 13 and her periods are regular.

**PHYSICAL EXAMINATION:**

**VITAL SIGNS:** Temp 99.5. This was repeated on two other occasions in the office and orally was 99.7



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and 99.3. After a while, the patient had a re-check temperature rectally and it was 98.8. Pulse 80, resp 20, weight 107.

GENERAL: NAD. Alert and oriented x3. Thin.

HEENT: PERRLA. EOMI. Sclera anicteric. Oropharynx without lesions.

NECK: Supple. No JVD. No lymphadenopathy.

LUNGS: Clear to percussion and auscultation.

HEART: Regular rate and rhythm. S1, S2. Question murmur. Difficult to detect.

ABDOMEN: Bowel sounds present. Soft, nontender. No visceromegaly.

EXTREMITIES: No clubbing, cyanosis or edema.

NEUROLOGIC: Alert and oriented x3. Grossly nonfocal.

SKIN: Without rashes, synovitis or cellulitis.

IMPRESSION: 1. Fever of unknown origin (low grade fevers).  
 2. History of mitral valve prolapse.  
 3. History of severe scoliosis.

I had a long discussion with Mrs. [redacted] and told her that since she has had fever since April 1997 most likely this is a benign etiology for her fevers. She may have a different thermostat set because I cannot really find much on physical exam to explain her persistent fevers and after a while I re-checked her rectal temperature and she had only 98.8 rectally. In any case, the patient is very anxious about the idea of having the spine surgery cancelled because of the persistent low grade fevers so I agree to do a continuation of fever of unknown origin workup.

PLAN: ✓1. Check CBC with differential, thyroid function tests, sedimentation rate. 2D echocardiogram to rule out vegetation as patient has a question of mitral valve prolapse and has had several dental procedures.  
 ✓2. Check HIV serology as patient is interest as she has had blood transfusions before the availability of HIV testing of blood products.  
 ✓3. Gallium scan.  
 4. RTO in 3 weeks with results of lab tests.

[redacted] M.D.  
 cc: Dr. [redacted]

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AREA/ROUTE/  
ASSOCIATION  
ST



MICROFILM#

NAME	PATIENT ID	ROOM NO.	AGE RG	SEX	PHYSICIAN
ACQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE/TIME 03/19/98 230P	LOG IN DATE 03/20/98	REPORT DATE & TIME 03/23/98 10:44AM

RT STATUS	FINAL	TEST	RESULT		UNITS	REFERENCE RANGE	SITE CODE
			IN RANGE	OUT OF RANGE			
		HEPATITIS B SURFACE ANTIGEN		NONE DETECTED		NONE DETECTED	TP
		HEPATITIS B SURFACE ANTIBODY QL		NON-REACTIVE		NON-REACTIVE	TP
		HEPATITIS B CORE AB TOTAL		NON-REACTIVE		NON-REACTIVE	TP
		HEPATITIS A IGM ANTIBODY		NON-REACTIVE		NON-REACTIVE	TP
		HEPATITIS C ANTIBODY		NON-REACTIVE		NON-REACTIVE	TP

A REPEATEDLY REACTIVE RESULT INDICATES PAST OR PRESENT HEPATITIS C VIRUS (HCV) INFECTION OR POSSIBLY A CARRIER STATE, BUT DOES NOT SUBSTANTIATE INFECTIVITY OR IMMUNITY. HOWEVER, A PATIENT WITH A REPEATEDLY REACTIVE RESULT SHOULD BE CONSIDERED INFECTIOUS.

WITH THE HCV ANTIBODY TEST, FALSE POSITIVE RESULTS CAN OCCUR. THE ABSENCE OF ANTIBODIES TO HEPATITIS C VIRUS DOES NOT RULE OUT INFECTION WITH HCV. THEREFORE, WHEN THE DIAGNOSIS OF NANBH IS STRONGLY SUSPECTED, SEQUENTIAL REPEAT TESTING FOR ANTI-HCV IS RECOMMENDED.

AMYLASE	64	U/L	30-170	TP
LIPASE	16	U/L	7-60	TP
CETAMINOPHEN	<10 L	MG/L	10-20	TP
			POTENTIALLY TOXIC: > 150	

\*\* IF AGE AND/OR SEX ARE NOT GIVEN, REFERENCE INTERVALS SHOWN ARE THE NARROWEST APPLICABLE ADULT MALE AND/OR FEMALE RANGES \*\*

>> END OF REPORT <<

*Disc - [Signature]*

AREA/ROUTE/STATION ASSOCIATION

Individual Safety Report



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MICROFILM

PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
LAB REF. #	COLLECTION DATE & TIME	LOG IN DATE	REPORT DATE	& TIME
	02/26/98 3:00PM	02/27/98	03/02/98	10:19AM

SS#: [REDACTED]

TEST STATUS	TEST	RESULT		UNITS	REFERENCE RANGE	SITE CODE
		IN RANGE	OUT OF RANGE			
	C (INCLUDES DIFF/PLT) WITH SMEAR REVIEW (CONTINUED)					
	ABSOLUTE MONOCYTES	460		CELLS/MCL	200-1100	
	MONOCYTES	6.3		X		
	ABSOLUTE EOSINOPHILS	95		CELLS/MCL	50-550	
	EOSINOPHILS	1.3		X		
	ABSOLUTE BASOPHILS	15		CELLS/MCL	0-200	
	BASOPHILS	0.2		X		
	COMMENT(S)					

MANUAL DIFFERENTIAL PERFORMED

SLIDE EVALUATION CONSISTENT WITH CBC RESULTS.

TID PANEL

T-3 UPTAKE	27	X	22-35
T-4 (THYROXINE) TOTAL	9.2	MCG/DL	4.5-12.5
FREE T4 INDEX (T7)	2.5		1.4-3.8

\*\* IF AGE AND/OR SEX ARE NOT GIVEN, REFERENCE INTERVALS SHOWN ARE THE NARROWEST APPLICABLE ADULT MALE AND/OR FEMALE RANGES \*\*  
 >> REPORT CONTINUED ON NEXT PAGE <<



AREA/ROUTE/... ASSOCIATION

**SB SmithKline Beecham**  
Clinical Laboratories  
MICROFILM#

81525

PATIENT ID	ROOM NO.	ACQ 13	SEC	PH
LAB REF. #	COLLECTED BY	DATE/TIME	LOGGED BY	DATE/TIME

Individual Safety Report



\*3133800-9-00-08\*

TEST	RESULT		UNITS	REFERENCE RANGE	SITE CODE
	IN RANGE	OUT OF RANGE			
EM 23 A					TP
UREA NITROGEN (BUN)	16		MG/DL	7-25	
CREATININE	0.6		MG/DL	0.5-1.4	
BUN/CREATININE RATIO		27 H	(CALC)	6-25	
SODIUM	138		MEQ/L	135-146	
POTASSIUM	4.1		MEQ/L	3.5-5.3	
CHLORIDE	102		MEQ/L	95-108	
MAGNESIUM	1.7		MEQ/L	1.2-2.0	
CALCIUM	8.7		MG/DL	8.5-10.3	
PHOSPHORUS, INORGANIC	3.4		MG/DL	2.5-4.5	
PROTEIN, TOTAL	7.8		G/DL	6.0-8.5	
ALBUMIN	4.4		G/DL	3.2-5.0	
GLOBULIN	3.4		G/DL (CALC)	2.2-4.2	
ALBUMIN/GLOBULIN RATIO	1.3		(CALC)	0.8-2.0	
BILIRUBIN, TOTAL	0.3		MG/DL	0.0-1.3	
ALKALINE PHOSPHATASE	40		U/L	20-125	
LDH, TOTAL	121		U/L	0-250	
GGT	43		U/L	0-45	
AST (SGOT)	17		U/L	0-42	
ALT (SGPT)	9		U/L	0-48	
URIC ACID	2.9		MG/DL	2.5-7.5	
IRON, TOTAL	101		MCG/DL	25-170	
IRON BINDING CAPACITY	406		MCG/DL	200-450	
% SATURATION	25		% (CALC)	12-57	
SED RATE BY MODIFIED WESTERGREN	18		MM/HR	(NR = 20)	TP
WBC (INCLUDES DIFF/PLT) WITH SMEAR REVIEW					TP
WHITE BLOOD CELL COUNT	7.3		THOUS/MCL	3.8-10.8	
RED BLOOD CELL COUNT	3.92		MILL/MCL	3.90-5.20	
HEMOGLOBIN	12.6		G/DL	12.0-15.6	
HEMATOCRIT	36.9		%	35.0-46.0	
MCV	93.9		FL	80.0-100.0	
MCH	32.0		PG	27.0-33.0	
MCHC	34.0		%	32.0-36.0	
RDW	12.4		%	9.0-15.0	
PLATELET COUNT	274		THOUS/MCL	130-400	
ABSOLUTE NEUTROPHILS	4549		CELLS/MCL	1500-7300	
NEUTROPHILS	62.3		%		
ABSOLUTE LYMPHOCYTES	2183		CELLS/MCL	350-4100	
LYMPHOCYTES	29.9		%		

>> REPORT CONTINUED ON NEXT PAGE <<

APR-17-1998 10:01

ASSOC.

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AREA/ROUTE/...

ASSOCIATION

ST

**SB** SmithKline Beecham  
Clinical Laboratories

MICROFILM#

PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
LAB REF. #	COLLECTION DATE & TIME	INDICATE DATE	REPORT DATE	TIME
02/26/98	02/26/98	02/27/98	03/02/98	10:19AM



SSH#:

TEST	RESULT		UNITS	REFERENCE RANGE	SITE CODE
	IN RANGE	OUT OF RANGE			
U-1 AB SCREEN	NON-REACTIVE			NON-REACTIVE	TR

\*\*\*NOTE: A NON-REACTIVE RESULT INDICATES THAT HIV1 (H1LV-III) ANTIBODIES HAVE NOT BEEN FOUND IN THIS PATIENT SPECIMEN. A NON-REACTIVE RESULT, HOWEVER, DOES NOT PRECLUDE PREVIOUS EXPOSURE OR INFECTION WITH HIV1.

>> END OF REPORT <<

*Done - E P*



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[REDACTED]

SEX: [REDACTED] ID. NO. [REDACTED]

COLLECTED: [REDACTED] RECEIVED: [REDACTED] REPORTED: [REDACTED]

SESSION NO. [REDACTED] REQUISITION NO. [REDACTED]

CLIENT NO. [REDACTED] R

Route: [REDACTED]

CLIENT: [REDACTED]

DOCTORS: [REDACTED]

COMMENTS: [REDACTED]

TEST NAME	UNITS	RESULTS	REFERENCE RANGE
0 SCREEN:			
OND TEST		NEGATIVE	NEGATIVE

Individual Safety Report



\*3133800-9-00-10\*

NOTIFIED

~~INTRA~~

4/19/97



ASSOC.

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SEX  ID NO   
 COLLECTED  RECEIVED  REPORTED   
 SESSION NO  REQUISITION NO

CLIENT NO  1 R  
 Route : 40852  
 CLIENT   
 DOCTORS   
 SOURCE   
 Source: BLOOD

MI 1195

TEST NAME	UNITS	RESULTS	REFERENCE RANGE
CULTURE, Blood:			

Preliminary Report  
 PRELIMINARY REPORT: NO GROWTH IN 24 HOURS  
 Blood Culture ID:  
 NO GROWTH IN 7 DAYS.

Individual Safety Report

\*3133800-9-00-11\*

NOTIFIED

~~NOTIFIED~~

4/21/98



# Community Hospital, Inc.

81525

[REDACTED]

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NAME	DATE	UNIT NO.	DOCTOR
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[REDACTED]	3-10-98	[REDACTED]	[REDACTED]
[REDACTED] DOB	[REDACTED]	OUTPATIENT	[REDACTED]
		D6	[REDACTED]

REASON FOR EXAM  
ENDOCARDITIS,



### CONSULTATION REPORT

[REDACTED]

### M-MODE AND TWO-DIMENSIONAL ECHOCARDIOGRAM WITH DOPPLER:

EXAMINATION REVEALS, THERE IS NO SIGNIFICANT PERICARDIAL EFFUSION. LEFT ATRIAL, LEFT VENTRICULAR, RIGHT ATRIAL, RIGHT VENTRICULAR AND AORTIC ROOT DIMENSIONS ARE WITHIN NORMAL LIMITS. THERE IS OVERALL WELL PRESERVED LEFT VENTRICULAR SYSTOLIC FUNCTION. EJECTION FRACTION IN THE 65% RANGE. THERE IS NORMAL AORTIC VALVE SYSTOLIC OPENING. NO SUGGESTION OF SIGNIFICANT AORTIC VALVE STENOSIS. MITRAL AND TRICUSPID VALVES APPEAR MORPHOLOGICALLY NORMAL. PULMONARY VALVE IS NOT WELL VISUALIZED. NO DOPPLER EVIDENCE OF SIGNIFICANT STENOTIC OR REGURGITANT LESIONS. NO OBVIOUS VEGETATION. NO THROMBUS VISUALIZED.

### IMPRESSION:

1. NO SIGNIFICANT PERICARDIAL EFFUSION.
2. NORMAL CHAMBER SIZES.
3. WELL PRESERVED LEFT VENTRICULAR SYSTOLIC FUNCTION. EJECTION FRACTION IN THE 65% RANGE.
4. NORMAL AORTIC VALVE SYSTOLIC OPENING. MITRAL AND TRICUSPID VALVES ARE MORPHOLOGICALLY NORMAL. PULMONARY VALVE NOT WELL VISUALIZED. NO COLOR DOPPLER EVIDENCE OF SIGNIFICANT STENOTIC OR REGURGITANT LESIONS. NO OBVIOUS VEGETATION NOTED.
5. NO THROMBUS VISUALIZED.

[REDACTED] M.D.

[REDACTED]

[REDACTED]

COMMUNITY HOSPITAL  
ORDER ENTRY TRANSCRIPTION RESULTS

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3-02-98

OP

DOB

OUTPATIENT

D6

FEVER

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TOTAL BODY GALLIUM SCINTIGRAPHY:  
THE PATIENT WAS GIVEN 6 MCI OF GALLIUM-67 CITRATE INTRAVENOUSLY AND  
SERIAL IMAGING FOR 72 HOURS WAS PERFORMED.  
THERE IS MARKEDLY PROMINENT ACTIVITY WITHIN THE LIVER. NO OTHER AREAS  
OF ABNORMAL ACTIVITY ARE IDENTIFIED.

IMPRESSION:

THERE IS MARKED DIFFUSE ACTIVITY WITHIN THE LIVER WHICH COULD INDICATE  
INFLAMMATORY PROCESS SUCH AS HEPATITIS. CLINICAL CORRELATION IS  
SUGGESTED. IN ADDITION, FURTHER EVALUATION WITH CT SHOULD BE PERFORMED  
IF CLINICALLY INDICATED.

M.D.

THIS DOCUMENT IS ELECTRONICALLY SIGNED

03/05/98

03/05/98

21:52:05

THURSDAY

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Individual Safety Report



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**Nuclear Imaging**

M.D.

Suite

Phone:

Diplomate of the American Board of Radiology

Individual Safety Report



\*3133800-9-00-15\*

<u>PATIENT</u>	<u>DATE</u>	<u>XRAY</u>	<u>DOCTOR</u>
[REDACTED]	06/26/97	9305	[REDACTED]

WHOLE BODY BONE SCAN

**PROCEDURE:** The patient received an intravenous injection of 25.0mCi TC99M MDP and a whole body bone scan was performed.

**FINDINGS:** Increased uptake is noted in the region of the right pedicles of the entire thoracic spine. Although increased uptake is also noted in the region of the right sternoclavicular joint. Mildly increased uptake is noted within both hips. No other areas of abnormal uptake of radiotracer within bone are noted. Activity is noted within the kidneys and urinary bladder.

IMPRESSION:

SEVERE SCOLIOSIS OF THE SPINE. THERE IS INCREASED UPTAKE WITHIN THE REGION OF THE RIGHT PEDICLES OF THE ENTIRE THORACIC SPINE. THE CLINICAL HISTORY OF PLACEMENT AND REMOVAL OF HARRINGTON RODS IS NOTED. THIS MAY BE SECONDARY TO THE PRIOR SURGERY. CORRELATION WITH RADIOGRAPHS IS RECOMMENDED. THERE IS INCREASED UPTAKE WITHIN THE RIGHT STERNOCLAVICULAR JOINT. THIS MAY BE POST TRAUMATIC IN NATURE. RADIOGRAPHIC CORRELATION IS ALSO RECOMMENDED.

*OOD/Athritis*

M. D.

06/30/97

**NOTIFIED**

*[Handwritten signature]*

*faxed to Dr. [REDACTED]*