Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12979

7 - PROCEDURES

000001

[redacted]

PATIENT: [redacted]
UNIT#:
ACCT#:
TYPE:
LOCATION:
ROOM:

[redacted]

CARDIAC CATHETERIZATION REPORT
Date Of Visit: 06/24/98

cc: [redacted] M.D.
cc: Medical Records

[redacted]

FINAL DIAGNOSES:

1. Arteriosclerotic heart disease:
   A. High grade ostial left main trunk stenosis with the ostium and proximal segment narrowed by 60 percent.
   B. Mild luminal irregularity of the mid segment of the left anterior descending coronary artery with the lumen narrowed by 25 to 30 percent distal to the origin of the first diagonal branch and mid third stenosis of the large diagonal branch with the lumen narrowed by 25 percent.
   C. Essentially normal circumflex coronary artery.
   D. Mild proximal segment stenosis of the main stem right coronary artery with the ostium and proximal segment narrowed by 20 percent.
   E. Normal left ventricular function.

LEFT MAIN TRUNK: With entry of the #6 Fr[redacted]JL-4 diagnostic catheter into the ostium of the left main, there was immediate dampening of intra-coronary pressure and a coronoid type pressure curve was demonstrated. Injection of contrast media into the left main demonstrates significant ostial stenosis at the ostium and proximal segment narrowed by at least 60 percent. The distal portion of the left main widens considerably into at least a 4.0 mm vessel. The left main then bifurcates into the left anterior descending coronary artery and circumflex coronary arteries.

ANTERIOR DESCENDING CORONARY ARTERY: The first portion of the left anterior descending coronary artery is a fairly wide lumened vessel measuring at least 4.0 mm. No luminal narrowings are identified until distal to the origin of the large diagonal branch at which point the left anterior descending coronary artery demonstrates eccentric luminal narrowing, narrowing the lumen by 30 percent.

The large diagonal branch arising from the proximal third segment of the left anterior descending coronary artery demonstrates mild mid third irregularity narrowing the lumen by 25 to 30 percent. This branch is the principal source of blood supply to the high anterolateral wall.

CIRCUMFLEX CORONARY ARTERY: The main stem of the circumflex coronary artery supplies basically three obtuse marginal branches and has fairly limited blood supply to the lateral wall. The main stem of the circumflex coronary artery and its small obtuse marginal branches are smooth walled and normal in appearance.

RIGHT CORONARY ARTERY: "Dominant". The ostium and proximal

000002

[redacted]

segments of the right coronary artery demonstrate mild irregularities with the ostium and proximal segment narrowed by 20 to 25 percent. The right coronary artery is a "dominant" vessel with the large AV branch supplying all of the inferior wall. The distal portions of the main stem right coronary artery and its secondary branches are smooth walled and normal in appearance.

LEFT VENTRICLE: The left ventricular chamber is of normal size and contour. Motion study demonstrates symmetrical contractility of all segments of the left ventricle with an ejection fraction greater than 55 percent. No regional wall motion changes are present. During diastole, the mitral valve opens normally. During systole, there is no mitral regurgitation. There is no obstruction within the left ventricular outflow tract or at the level of the aortic valve. The inter-ventricular septum is intact.

HEMODYNAMIC DATA: Please see data sheet for specific numerical values. The left ventricular end diastolic pressure was normal at rest and no gradient was recorded across the aortic valve.

[redacted]

PATIENT: [redacted]
UNIT#:
ACCT#:
TYPE:
LOCATION:
ROOM:

CARDIAC CATHETERIZATION REPORT
Date Of Visit: 06/24/98

dct 6/28

cc: [redacted] M.D.
cc: Medical Records

[redacted]

FINAL DIAGNOSES:

1. Arteriosclerotic heart disease:
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   B. Mild luminal irregularity of the mid segment of the left anterior descending coronary artery with the lumen narrowed by 25 to 30 percent distal to the origin of the first diagonal branch and mid third stenosis of the large diagonal branch with the lumen narrowed by 25 percent.
   C. Essentially normal circumflex coronary artery.
   D. Mild proximal segment stenosis of the main stem right coronary artery with the ostium and proximal segment narrowed by 20 percent.
   E. Normal left ventricular function.

LEFT MAIN TRUNK: With entry of the #6 French JL-4 diagnostic catheter into the ostium of the left main, there was immediate dampening of intra-coronary pressure and a coronoid type pressure curve was demonstrated. Injection of contrast media into the left main demonstrates significant ostial stenosis at the ostium and proximal segment narrowed by at least 60 percent. The distal portion of the left main widens considerably into at least a 4.0 mm vessel. The left main then bifurcates into the left anterior descending coronary artery and circumflex coronary arteries.

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RIGHT CORONARY ARTERY: "Dominant". The ostium and proximal

000004

segments of the right coronary artery demonstrate mild irregularities with the ostium and proximal segment narrowed by 20 to 25 percent. The right coronary artery is a "dominant" vessel with the large AV branch supplying all of the inferior wall. The distal portions of the main stem right coronary artery and its secondary branches are smooth walled and normal in appearance.

LEFT VENTRICLE: The left ventricular chamber is of normal size and contour. Motion study demonstrates symmetrical contractility of all segments of the left ventricle with an ejection fraction greater than 55 percent. No regional wall motion changes are present. During diastole, the mitral valve opens normally. During systole, there is no mitral regurgitation. There is no obstruction within the left ventricular outflow tract or at the level of the aortic valve. The inter-ventricular septum is intact.

HEMODYNAMIC DATA: Please see data sheet for specific numerical values. The left ventricular end diastolic pressure was normal at rest and no gradient was recorded across the aortic valve.

PROCEDURE: Left heart catheterization, selective coronary arteriography and left ventriculography.

PRE-MEDICATIONS: Versed 1 mg IV.

VASCULAR ACCESS SITE: Under local 2% Xylocaine and 0.5% Sensorcaine anesthesia, a small incision was made in the right inguinal region. The right femoral artery was cannulated with a single wall stick and a #6 French Hemaquet sheath introduced.

ANTI-COAGULATION: The patient entered the Catheterization Laboratory with heparin infusing at 1000 units per hour. The PTT was 95 seconds and, therefore, no supplementary heparin was utilized.

SUCCESSFUL DIAGNOSTIC CATHETERS: A #6 100 cm JL-4 for the left coronary artery. A #6 100 cm NTR for the right coronary artery. A #6 110 cm pigtail for the left ventriculogram.

CORONARY ANGIOGRAPHY: Performed in multiple RAO and LAO projections with cranial and caudal angulation with manual injections of Isovue contrast media.

LEFT VENTRICULOGRAM: Performed in the RAO projection with power injection of 36 cc of Isovue contrast media.

IN ROOM COMPLICATIONS: None.

OUT OF ROOM COMPLICATIONS: None. The patient did experience some mild substernal pressure discomfort following the procedure and as a consequence, IV Tridil was started.

TECHNICAL DIFFICULTIES: None. The patient does develop a very distinct coronoid pressure tracing curve and some pressure dampening with installation of the #6 French diagnostic catheter into the left main trunk.

VASCULAR ACCESS SITE POST PROCEDURE: Upon completion of the procedure, it was determined that the patient was a candidate for fairly urgent coronary artery bypass graft surgery. The Hemaquet sheath was sutured in place with #3-0 silk suture.

PULSES POST PROCEDURE: Dorsalis pedes pulses 2+/4+, right.

PATIENT DISPOSITION: The patient was transferred to the Coronary Care Unit in stable condition with mild chest discomfort (2/10).

TECHNICAL DATA:
Film: Panasonic Video Disc No. [redacted]
Amplifier: 5-7-9 inch Phillips CDI.
Frames Per Second: 15.

CONTRAST MEDIA: Isovue 115 cc.

TOTAL FLUOROSCOPY AND CINEANGIOGRAPHY TIME TIME: 4.1 minutes.

[redacted], M.D.
Job#: [redacted] D: 06/24/98 T: 06/24/98

7/8
[redacted]

000006

ANESTHESIA RECORD

PRE MED [redacted]

DATE 6/24/90 AGE 61 HT 5' 7" WT 75.2 kg

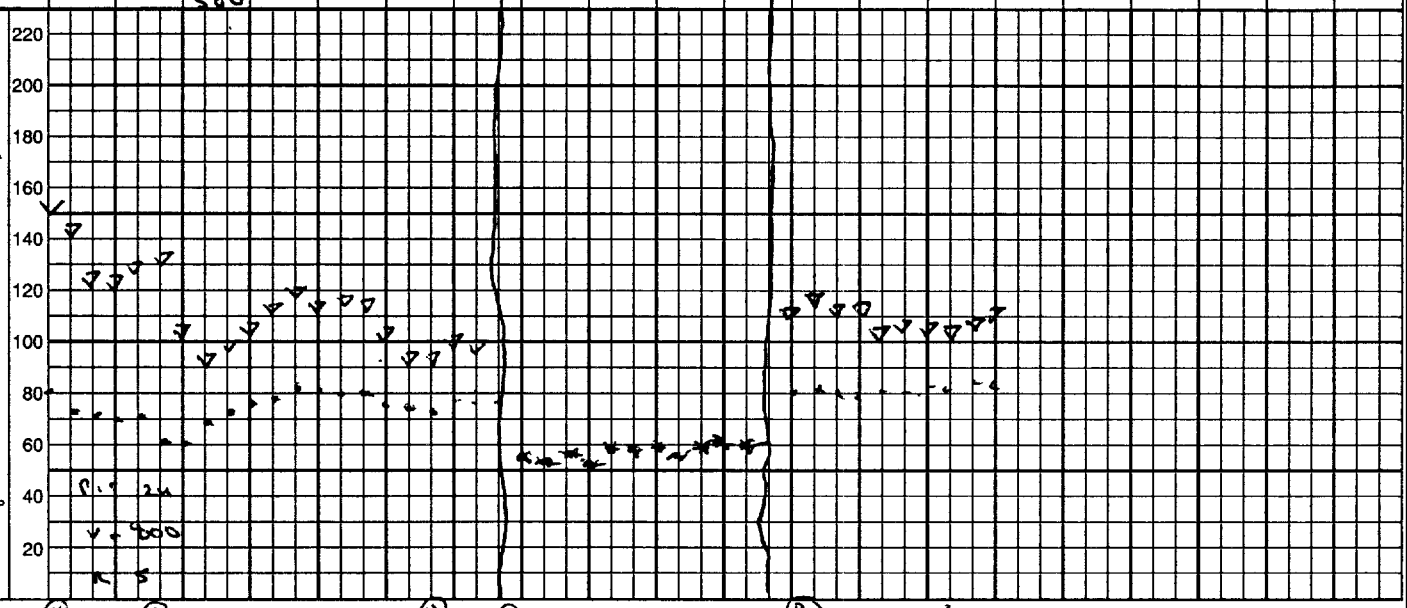
FINAL PRE-ANESTHETIC ASSESSMENT AT: 1325

DRUGS-AGENTS-FLUID-BLOOD

																				TOTALS
N_2O/O_2	2/2											8/								
Enflurane	1%											1%								
Propofol	150																			
Sufenta mg	50	50	50	50	50															
Versed mg	5				5															
Pavulon mg	1/10																			
Dopamine		800mg/500ml																		
Aminos	10mg/kg	400mg/hr																		

TIME: 1330 1400 X 1500 X 1600 X 1700

ECG	NSR	WNL	WNL	WNL								WNL		WNL						
SPO_2 (%)	100	100	100	100								100		100						
$ETCO_2$		35	31	31	31							31								
PAO/LAO			14/66		17/25								19/4.1							
Fluids			500																	



POSTURE (X) (1) (2) (4) (5) (8) (6)

LARYNGOSCOPE	AIRWAY/LMA	ENDOTR TUBE	ANESTH METHODS	EBL
Miller #3	SIZE 4 (ORAL) NASAL	SIZE 7.0 (ORAL) NASAL (CUFF)	SSGA	

IV (SIZE/SITE)

#20 (R) antecubital

SURGEONS [redacted]

ANESTHESIOLOGIST [redacted]

OPERATION

Carc x 2 E lima.

REMARKS

(X) To OR monitors placed; (1) IV NS, 22 IVT; 01 ET, 2% Isoflurane (2) PA + Fem (4) Supraclavicular (5) Interscalene (8) Axillary (6) Off Axillary (7) [illegible] Heavy [illegible] Alt 11%

TIME ANES	START	STOP
	1330	1655
SURG	1420	1600
PAR VS		

ADDRESSOGRAPH

[redacted]

[redacted]

ANESTHESIA RECORD

[redacted]

000007

PRE/POST ANESTHESIA FORM

Pre-Anesthesia Evaluation

Date:_____ Time:_____

1. Historical Information

   a. Significant medical illness:

   Habits:

   CAD: (L) main CAD; ev [illegible] MI; [illegible] angina
   HTN
   overweight

   b. Medications:

   IV [illegible]

   c. Allergies or adverse reactions to medications:

   NKDA

   d. NPO status:

   [illegible]

   e. Previous anesthesia:

   [illegible]

   f. Family History:

2. Significant abnormalities on physical exam:

   c/o cr; angina
   Diaphoretic

3. Significant abnormal laboratory or diagnostic studies:

   [illegible]

4. Assessment & Plan:

   ASA Physical Status 1 2 (3) 4 5 (E)

5. Anesthesia plan, including alternatives, potential risks and complications discussed. All questions answered.

[redacted]

ANESTHESIOLOGIST

POST ANESTHESIA NOTE

No apparent anes complication

Date: 6/25/90 Time: 11:00

[redacted]

ANESTHESIOLOGIST

POST ANESTHESIA DISCHARGE NOTE

☐ To Home

Date:_____ Time:_____

000008

ANESTHESIOLOGIST

[redacted]

☒ Operating Room Supplement Used

[redacted]

OPERATING ROOM FLOW SHEET

DATE: 6-24-98

- TIME OF ARRIVAL 1330 in OR #: [redacted]
- ANESTHESIA TIME 1330 (start) 1645 (transfer)
- INCISION TIME: 1420 (start) 1638 (finish)
- ANESTHESIOLOGIST: [redacted], MD
- SURGEON: [redacted] MD ASSISTANT: [redacted], MD ASSISTANT: [redacted], MD
- PRE OPERATIVE DIAGNOSIS: C.A.D.

- TYPE OF ANESTHESIA:
  - ☒ General: ☒ ET ☐ Mask
  - ☐ Spinal ☐ Concha
  - ☐ Caudel ☐ Thermal Blk.
  - ☐ Epidural ☐ Fluid Warmer
  - ☐ Asc ☒ Pulse
  - ☒ Capnog[redacted]

- OPERATIVE PROCEDURE: CABG x 2; Lima → LAD + Aorta to OM using saphenous vein
- POST OPERATIVE DIAGNOSIS: S/A
- SCRUB NURSE: [redacted] Relief & Times: [redacted]
- CIRCULATING NURSE [redacted] Relief & Times [redacted] OTHER [redacted]

IV THERAPY:	TIME	SOLUTION	CATHETER	WHO STARTED	SITE	IV INTAKE
ARTERIAL	1345	500cc NS c 500U heparin	20G	[redacted]	(L) radial	25
SWAN GANZ	1400	500cc NS c 500U heparin	8F		Rt Vub	25
CVP	1400	1000cc NS c 1000U heparin	16 arrow		Rt Vub	250
KEEP OPEN	1400	500cc .225NS D5 c 500U hep.	8F		side-port swan	100
PERIPHERAL	1340	1000 cc LR	18G		AC (L)	900
						1300
					TOTAL	

MEDICATIONS:	TIME	MEDICATION NAME	DOSE	ROUTE	PREPARED BY	GIVEN BY
RN PREPARED or ADMINISTERED:	1345	Kefzol	2Gms	IV	[redacted]	[redacted]
	1502	Heparin	23,000 U.	Rt atr		
see anesthesia		Amicar 5Gms in 250 NS	see	IV	[redacted]	[redacted]
		Tridil 50 mg in 250 D5	anesthesia	IV		
		Dopamine 800 mg in 500 c D5		IV		

- POSITION: ☒ Supine ☐ Prone ☐ Lithotomy ☐ Jacknife ☐ Other
- POSITION AIDES: [redacted] under head, arms tucked at sides c draw sheet, bumps v. legs, legs frogged
- GROUND PAD SITE: left lateral thigh
- ELECTRO CAUTERY: ☒ Solid State ☐ Bipolar ☐ Sparkgap
- URINARY CATHETERS: ☒ Foley ☐ Other Temp
  Character Cl2 yell Size: 16 Amount gs
  TIME 1350 BY KC
- TOURNIQUET:

Location	Pressure	time up	time down
	0		

- PREP SOLUTION: ☒ Povidone Iodine ☐ Hibiclens ☐ Other
- SPECIMENS: ☐ Culture X Ø ☐ Permanent X ☐ Frozen Section X ☐ Other: Ø
- Xray Taken X Ø
- DRAINS/PACKING: (Location, Size, Type) # 28 F Chest tube x 2 → Ats pleuravac
- IMPLANTS: (Type, size, location, serial #, manufacturer) #

000009

ventricular pacer wires x 2 Rings x 1

- SPONGE COUNT: INITIALS
  1st COUNT: ☒ Correct ☐ Incorrect [redacted] / [redacted]
  2nd COUNT: ☒ Correct ☐ Incorrect [redacted] / [redacted]
  ☐ Correct ☐ Incorrect /
  ☐ Correct ☐ Incorrect /
- NEEDLE COUNT: INITIALS
  1st COUNT: ☒ Correct ☐ Incorrect [redacted]
  2nd COUNT: ☒ Correct ☐ Incorrect [redacted]
  ☐ Correct ☐ Incorrect
  ☐ Correct ☐ Incorrect

TIME	INTERVENTIONS	PATIENT PROGRESS SUMMARY	INITIAL
1512	on CPB.		[redacted]
1605	1 cu-E pump call given.	Off CPB.	

SIGNATURES: [redacted]

WOUND CLASS I

[redacted]

[redacted]al Copy - Patient Chart
Copy - Surgery Record
Copy - Medical Records

Patient:
Unit:
Acct:
Type:
Location:
Room:

REPORT OF PROCEDURE

Date of Procedure:

cc:
cc:
cc:

copy: MD, c/o

SURGEON: MD

ASSISTANT: MD

PREOPERATIVE DIAGNOSIS: Severe ostial left main stenosis with unstable angina, status post recent subendocardial myocardial infarction.

POSTOPERATIVE DIAGNOSIS: Severe ostial left main stenosis with unstable angina, status post recent subendocardial myocardial infarction.

PROCEDURE: Emergent double-coronary artery bypass grafting with (1) left internal mammary artery to left anterior descending and (2) saphenous vein to ramus intermedius.

INTRAOPERATIVE FINDINGS: The internal mammary artery was a small vessel, but had great flow. The saphenous vein was a good conduit. The circumflex system was quite small, but the ramus intermedius was a very large system and the LAD was a good vessel. The patient came off cardiopulmonary bypass without difficulty.

PERFUSION DATA: Flow rate between 4.0 and 5.0 liters per minute. Pump time 52 minutes. Cross-clamp time 38 minutes. Perfusion pressure 90/60 using pulsatile flow with mean of 70. Urine output while on bypass, 275 cc.

METHOD OF MYOCARDIAL PRESERVATION: Cold-potassium blood cardioplegia, 20 meq/l, given down the ascending aorta and also down the vein grafts in approximately 20-minute intervals. Warm-blood cardioplegia given prior to removal of cross-clamp. Oxygenated blood given as the aorta was being fashioned.

DESCRIPTION OF PROCEDURE: With the patient in the supine position under endotracheal general anesthesia, she was prepped and draped in the usual fashion. The right greater saphenous vein was harvested, clipping distal and tying proximal branches and closing the leg with multiple layers of absorbable sutures.

000010

Simultaneously, incision was made from the sternal notch to the xiphoid; sternal saw was used. The left internal mammary was harvested in routine fashion using clips and cautery; it appeared to be a small vessel, but it had excellent flow. The pericardium was incised in longitudinal fashion and sutured to the sternal retractor with a pursestring in the right atrium and right atrial appendage. The patient was systematically heparinized, cannulated and placed on cardiopulmonary bypass. The aorta was cross-clamped and cardioplegia administered. Immediate electromechanical arrest was observed.

The heart was elevated. The obtuse marginal was explored; this was a very small system. The ramus intermedius was a very large system, so the saphenous vein was anastomosed to the ramus intermedius with running 7-0 Prolene. Cardioplegia was administered. The left internal mammary was anastomosed to the proximal LAD with interrupted 7-0 Prolene and the pedicle tacked to the epicardium to avoid torsion. With the head down, the cross-clamp was removed. The heart started beating spontaneously in sinus rhythm. Partial occlusion clamp was placed on the aorta. One 5-mm segment was removed and proximally anastomosed with running 5-0 Prolene suture. Then the partial occlusion clamp was removed. Vein segment was vented with a needle to remove residual air and the distal clip removed, re-establishing flow down the graft. The patient was weaned from cardiopulmonary bypass, decannulated and Protamine administered. Two chest tubes and two temporary pacing wires were placed. The sternum wa[redacted]pproximated with interrupted sternal wires. The linea alba, subcuta[redacted] and subcuticular closed with running absorbables. T[redacted]e counts were reported by the nurse in charge to be co[redacted]pletion of the operation, the patient had excellent h[redacted]-dose Tridil.

[redacted]

[redacted]7P PST T: 06/24/98 11:31p PST

CHARTED:

6/25

[redacted]

000011

[redacted] RESULTS [redacted]

[redacted] ID: [redacted]

ARTERIAL SAMPLE

Number: [redacted]
Date: 06-24-98
Time: 15:27:50
Operator: [redacted]
Patient ID: [redacted]

BLOOD GASES

MEASURED AT 37.0 °C

pH	7.55	
PCO2	30	mm Hg
PO2	323	mm Hg

ELECTROLYTES

Na+	125.7	mmol/L
K+	4.45	mmol/L
iCa++	0.88	mmol/L
Hct	18	%

CALCULATED AT 37.0 °C

HCO3	26.2	mmol/L
TCO2	27.1	mmol/L
BE	3.8	mmol/L
SAT	100	%

ARTERIAL SAMPLE

Number: [redacted]
Date: 06-24-98
Time: 15:53:45
Operator: [redacted]
Patient ID: [redacted]

BLOOD GASES

MEASURED AT 37.0 °C

pH	7.55	
PCO2	26	mm Hg
PO2	282	mm Hg

ELECTROLYTES

Na+	129.1	mmol/L
K+	4.61	mmol/L
iCa++	1.11	mmol/L
Hct	18	%

CALCULATED AT 37.0 °C

HCO3	22.7	mmol/L
TCO2	23.5	mmol/L
BE	0.3	mmol/L
SAT	100	%

iCa	1.0 - 1.2 mmol/L	
HCT	male	42 - 52 %
	female	37 - 47 %

[redacted]

[redacted] ID: [redacted]

ARTERIAL SAMPLE

Number: [redacted]
Date: 06-24-98
Time: 16:37:38
Operator: [redacted]
Patient ID: [redacted]

BLOOD GASES

MEASURED AT 37.0 °C

pH	7.49	
PCO2	33	mm Hg
PO2	72	mm Hg

ELECTROLYTES

Na+	133.2	mmol/L
K+	4.46	mmol/L
iCa++	1.10	mmol/L
Hct	25	%

CALCULATED AT 37.0 °C

HCO3	25.1	mmol/L
TCO2	26.1	mmol/L
BE	2.0	mmol/L
SAT	96	%

Patie[redacted]

Med [redacted]

HAEMONETIC CELL SAVER FLOW SHEET

SURGEON: [redacted] ASST: [redacted]

ANESTHESIOLOGIST: [redacted]

CELL SAVER TECH: [redacted] RELIEF:

PRE-OP DIAGNOSIS: CAD [redacted]

POST-OP DIAGNOSIS:

PROCEDURES: CABGX2 LIMA

EQUIPMENT:

CELL SAVER UNIT: COBE BRAT 2 HAEMONETICS OPEN HEART PACK: X1

RESERVOIR: COBE ANTICOAG. & ASPIRATION ASSEMBLY: X2

BLOOD FILTER: X1 1000 CC NaCl W/30,000 U HEPARIN: X2

PATIENT LAB VALUES:

	Hgb:	Hct:	Temp:	PTT:	P.T.	PLATELET	
PRE-OP:	14.3	42		97	12.4	232,000	
INTRA-OP:							

CELL SAVING PROCESSING DATA:

TIME	HEPARINIZED SALINE	SALINE WASH	WASTE SOLUTION	PACKED CELLS RET.	HCT
1640	300 cc	1000	2000	225 cc	
TOTALS					

COMMENTS:

[redacted]

ADDRESSOGRAPH

[redacted]

6/24/98

[redacted]

PERFUSION RECORD

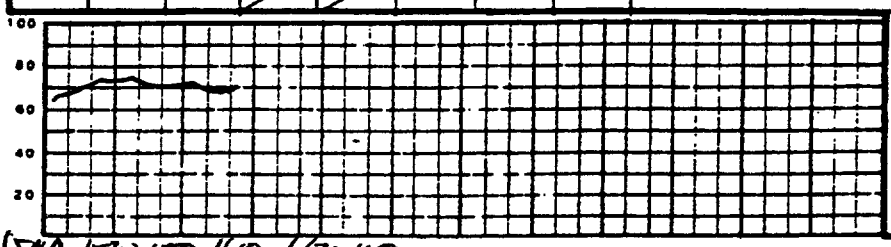
WEIGHT 75 kgm. ALLERGIES NKA

OXYGENATOR [redacted] SER. No. [redacted]

OPERATION CABGX 2 LIMA PULSATIL

PRIME: 1500cc normosol-R, 50 mg of Mattox, 1 gm Ancef, 12000 U Heparin, 1/2 gm Nacylate

TIME	FLOW RATE L/Min.	ART. LINE PRES.	FLOW O_2 / 95-5	TEMP PT / H_2O	AUX BLD. TEMP.	VISIT SENSOR PO_2 (ART.)	ACT	PRE-C.P.B.: ACT 467 K. 3.4 Hct. 42 453
1514	5.0	120	80 / 6	35.4 / 37.8	37.2	68		1/2 gm Nacylate, 50 gm Mannitol
1520	5.0	120	80 / 6	35.6 / 38	37.6	68	472 490	30 gm Mannitol, 1 gm Cacl
1530	4.0	100	85 / 6	36 / 38	38	65 / 127		10 mg LASIX, 10000 U Heparin
1552							573 564	110 mg Lidocaine, 1 gm MGSO4
1600	4.7	120	85 / 5	37.5 / 38	38	65		20 mg KPO4
1604						148		



Blood Cardioplegia: 1500cc

BLOOD SER. No.: 0

TOTAL URINE: 275cc

BLOOD GASES:

TIME	pH	PO_2	PCO_2	B.E.	Hct.	Na	K
		[redacted]		[redacted]			
		See LAB sheet					

BLOOD FLOWS:

L.A.D.: (Papv:) R.C.A. (Papv:)

Circ.: (Papv:) Diag. (Papv:)

PUMP TIMES

ON: 1512 OFF: 1604

A.O. X CLAMP TIMES

ON: 1514 OFF: 1552

TOTALS

X CLAMP: 38 MIN

PUMP: 52 MIN

SURGEONS [redacted] PERFUSIONIST [redacted] OR. No. [redacted]

ANESTHESIOLOGIST [redacted]

000014

PATIENT NAME: [redacted]
UNIT NO:

EXAMS: [redacted] GD CHEST 1V PORT

EXAM: CHEST, PORTABLE, ONE VIEW, 6/25/98 [redacted]

HISTORY: Post-op assessment of heart and lungs.

COMPARISON: 6/23/98.

FINDINGS: New coarse atelectasis has appeared at both lung bases medially. New right subclavian sheath and catheter, with the catheter tip overlying the right atrium and the sheath overlying the superior vena cava. No pneumothorax. Heart size remains normal. New surgical sutures in the sternum and new mediastinal drain. No congestion, pneumothorax, or pleural effusion. There is at least one coronary bypass graft overlying the mediastinum, new.

IMPRESSION:
1. New postsurgical changes following coronary bypass surgery.
2. New bibasilar atelectasis.
3. New right subclavian vascular catheters and mediastinal drain.

DICTATED: 6/25/98, 0840

** REPORT SIGNATURE ON FILE 06/25/98 **
REPORTED AND SIGNED BY: [redacted] M.D.

CC: RADIOLOGIST BILLING COPY; [redacted] MD; [redacted] MD

TECHNOLOGIST: [redacted]
TRANSCRIBED DATE/TIME: 06/25/98 (1524)
TRANSCRIPTIONIST: [redacted]
PRINTED DATE/TIME: 06/26/98 (1002) BATCH NO: [redacted]

[redacted]

NAME: [redacted]
PHYS: [redacted]
DOB: [redacted] AGE: 61 SEX: F
ACCT NO: [redacted] LOC: [redacted]
EXAM DATE: 06/25/98 STATUS: INP
RADIOLOGY NO: ~

[redacted]

ID: [redacted] 23-JUN-98 12:18 [redacted]

25mm/s
10mm/mV
40Hz
Pgm 107A
12SLtm [redacted]

Med:
61yr Ht: Wt:
Sex: F Race:
Loc: [redacted] Room: [redacted]

Vent. rate 56 BPM
PR interval 168 ms
QRS duration 80 ms
QT/QTc 472/448 ms
P-R-T axes 37 32 97

SINUS BRADYCARDIA
NONSPECIFIC T WAVE ABNORMALITY
ABNORMAL ECG

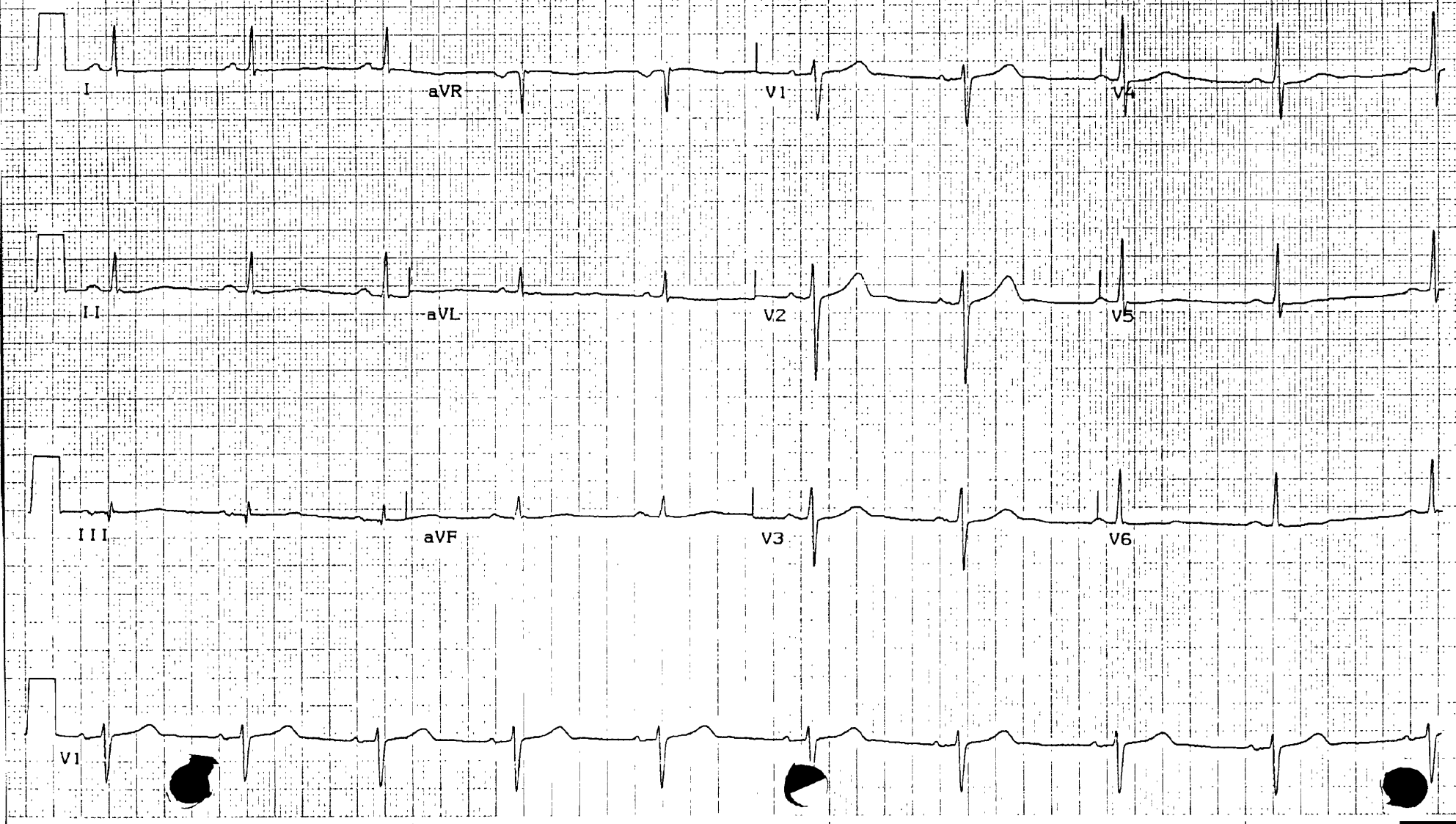
INTERPRETATION UNCONFIRMED

BY ECG PANEL

000016

Referred by: [redacted]

Reviewed by:



[redacted] [redacted]

[redacted]

ID: [redacted]

24-JUN-98 08:46 [redacted]

25mm/s
10mm/mV
40Hz
Pgm 003C
12SL v72

Med:
61yr Ht: Wt:
Sex: F Race:
Loc: Room: [redacted]
Option: BP:
Vent. rate 46 BPM
PR interval 152 ms
QRS duration 84 ms
QT/QTc 484/419 ms
P-R-T axes 23 37 57

MARKED SINUS BRADYCARDIA WITH OCCASIONAL PREMATURE ATRIAL COMPLEXES
ST ABNORMALITY, POSSIBLE DIGITALIS EFFECT
ABNORMAL ECG

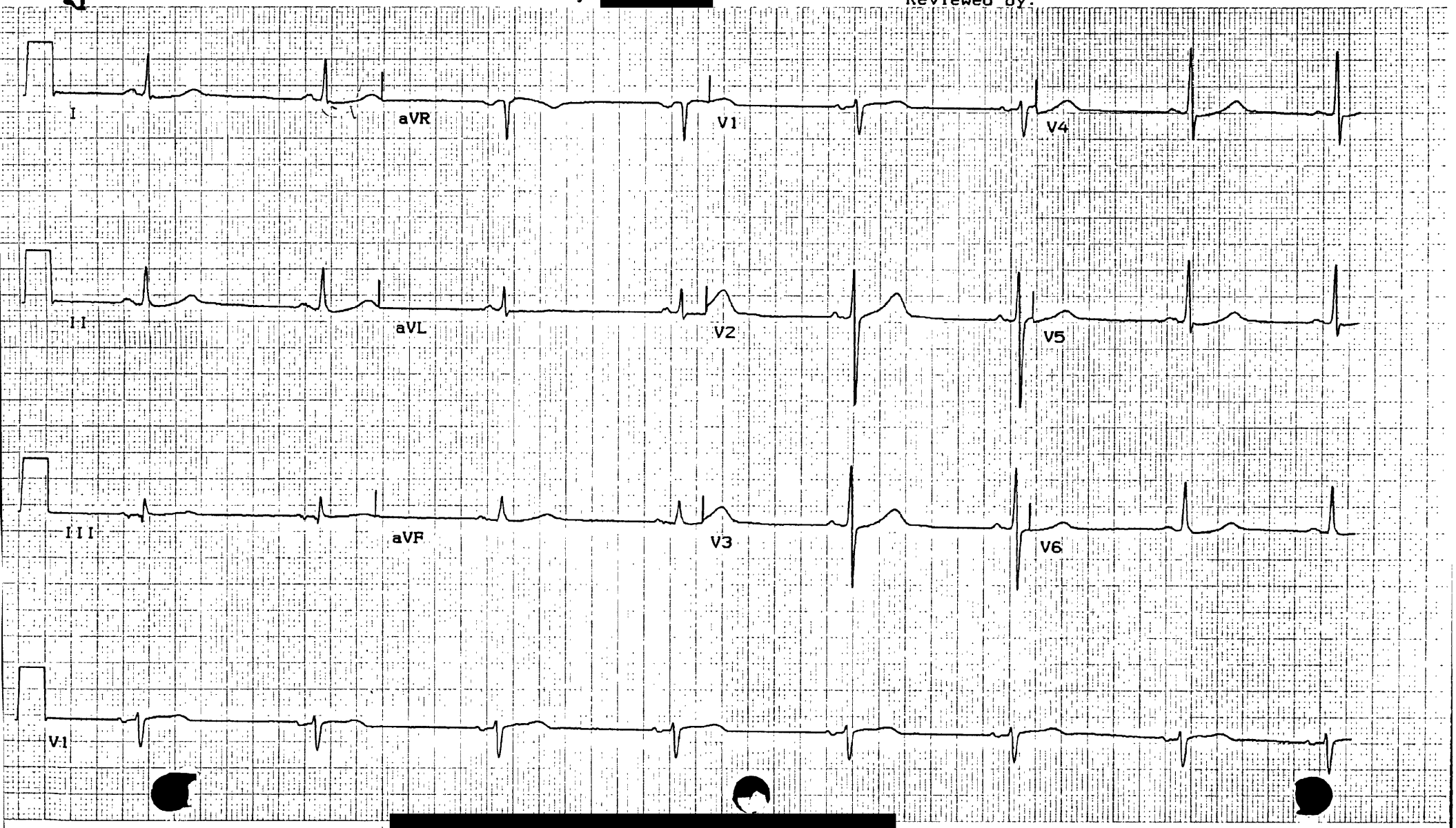
INTERPRETATION
UNCONFIRMED

BY ECG PANEL

000017

Referred by: [redacted]

Reviewed by:



[redacted]

[redacted]

ID: [redacted] 25-JUN-98 05:25 [redacted]

25m[redacted]
10mm/mV
40Hz
Pgm 107A
12SLtm [redacted]

Med:
61yr Ht: Wt:
Sex: F Race: Cauc
Loc: [redacted] Room: [redacted]

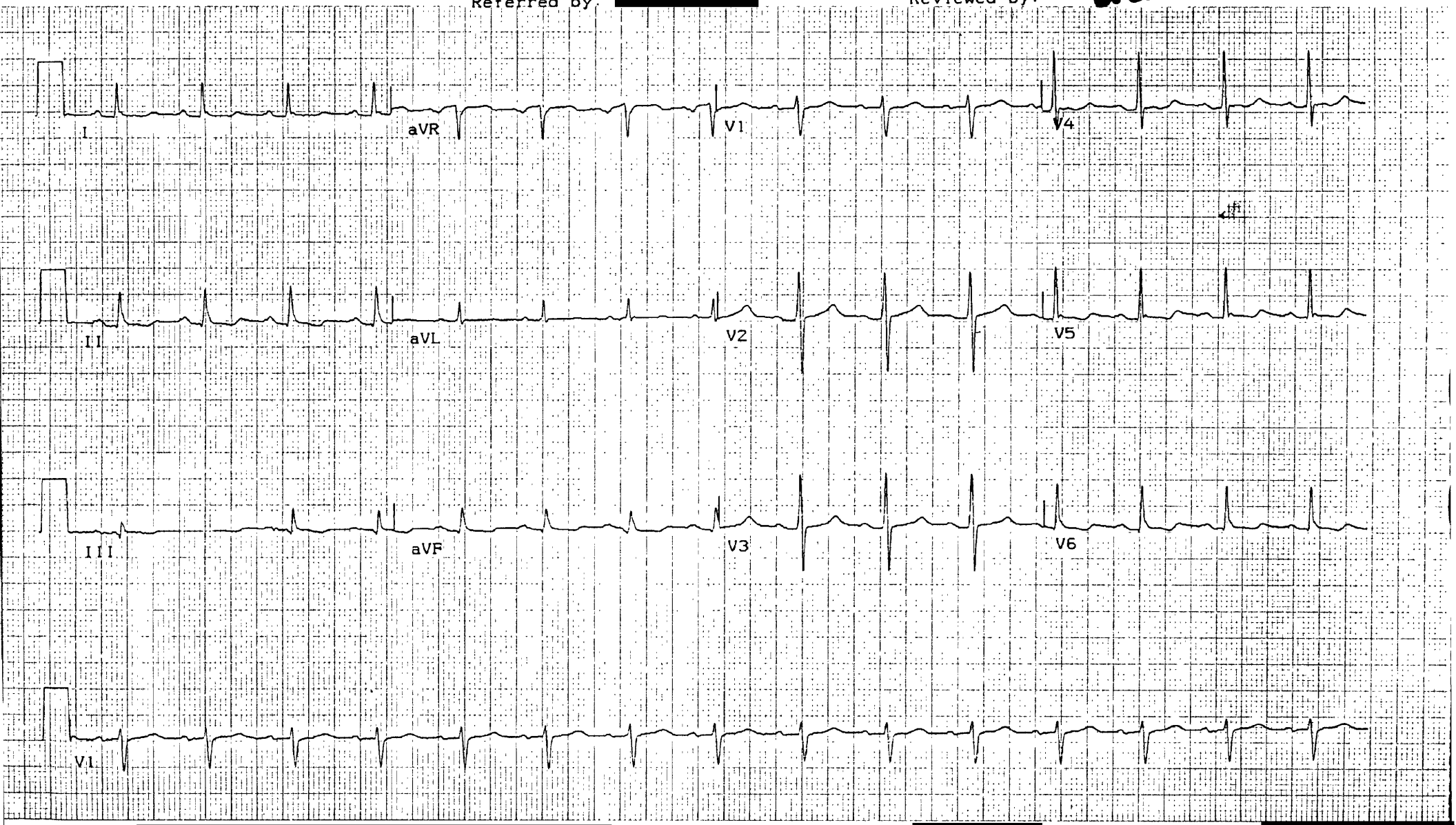
Vent. rate	91	BPM
PR interval	172	ms
QRS duration	80	ms
QT/QTc	384/467	ms
P-R-T axes	47 36 18	

NORMAL SINUS RHYTHM
NONSPECIFIC T WAVE ABNORMALITY
PROLONGED QT
ABNORMAL ECG

INTERPRETATION UNCONFIRMED

000018

Referred by: [redacted] Reviewed by: [redacted]



[redacted]

[redacted] ID: [redacted] [redacted] 07:24 [redacted] EKG DEPT. [redacted]

25mm/s
10mm/mV
40Hz
Pgm 003C
12SL v72

Med:
61yr Ht: Wt:
Sex: F Race: Cauc
Loc: [redacted] Room: [redacted]
Option: BP:

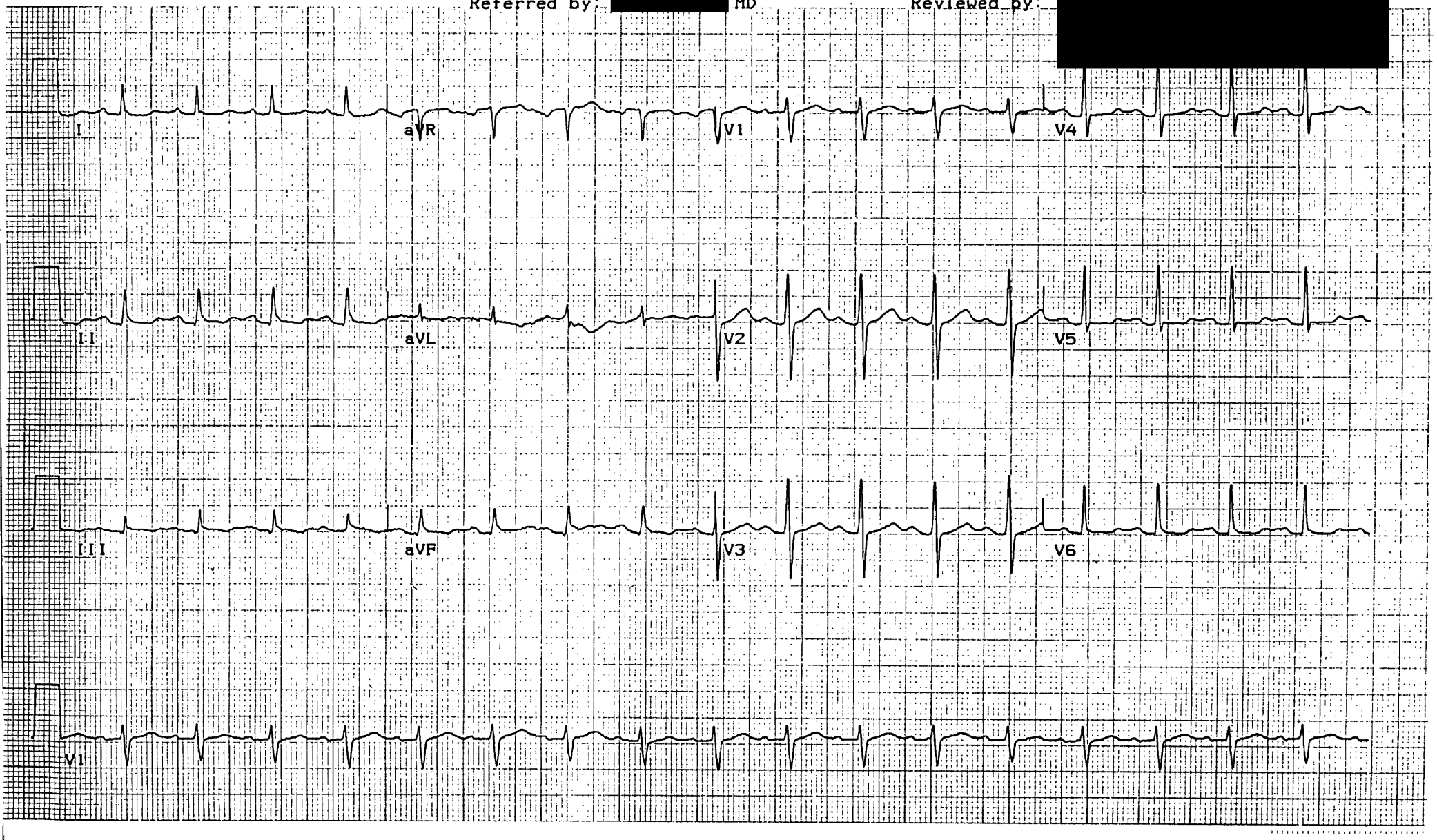
Vent. rate	106	BPM
PR interval	184	ms
QRS duration	84	ms
QT/QTc	344/452	ms
P-R-T axes	53 47	62

SINUS TACHYCARDIA
NONSPECIFIC T WAVE ABNORMALITY
ABNORMAL ECG

SINCE PRIOR TRACING, SINUS TACHYCARDIA NOTED

000019

Referred by: [redacted] MD Reviewed by: [redacted]



[redacted] ID: [redacted] 24-JUN-98 17:26 [redacted]

25mm/s
10mm/mV
40Hz
Pgm 107A
12SLtm v78

000020

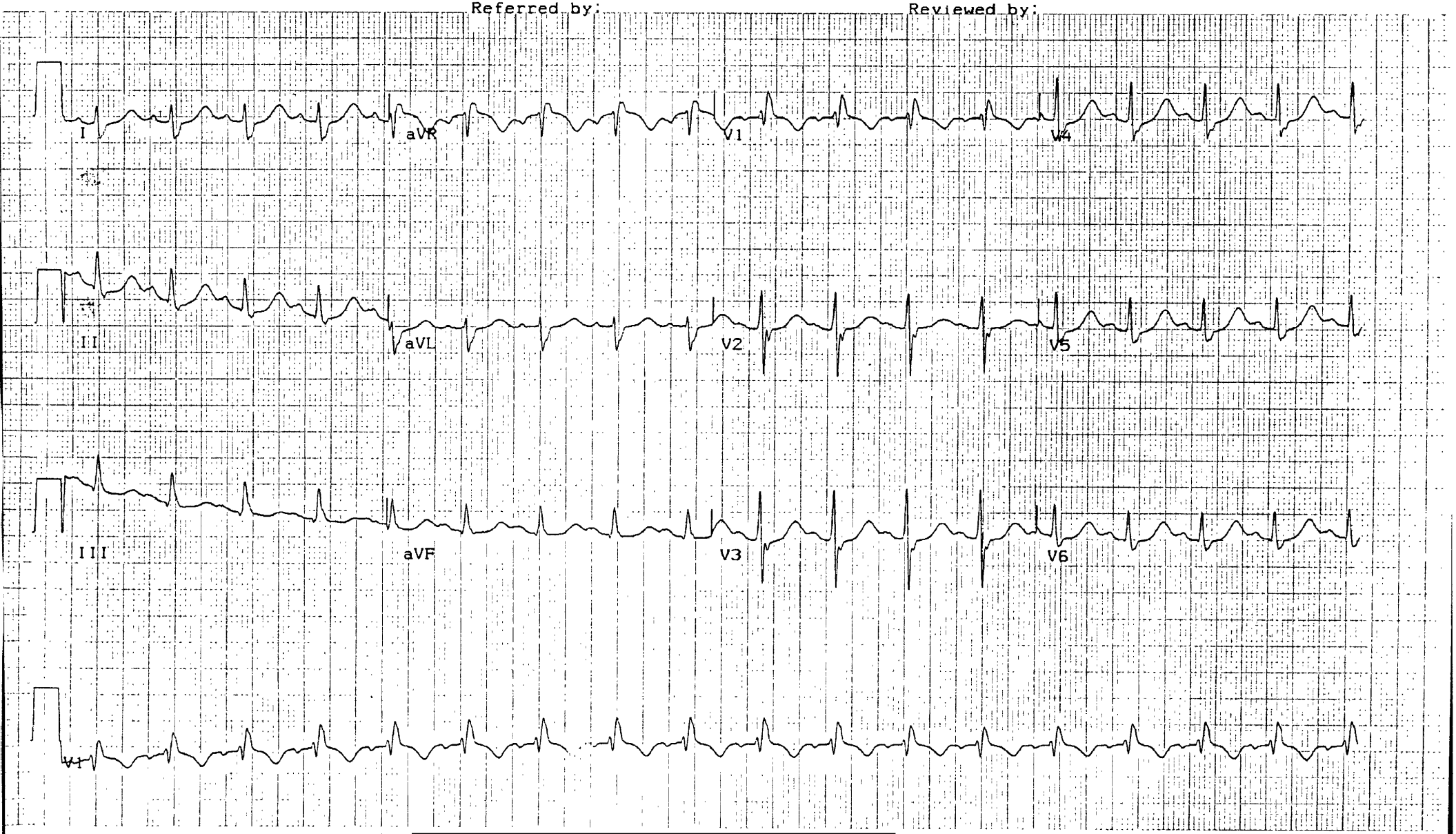
Med:
Age: Ht: Wt:
Sex: F Race:
Loc: [redacted]

SINUS TACHYCARDIA
RIGHT BUNDLE BRANCH BLOCK
ABNORMAL ECG

[redacted]ATION
UNCONFIRMED
BY ECG PANEL

Vent. Rate 105 BPM
PR interval 168 ms
QRS duration 112 ms
QT/QTc 382/516 ms
P-R-T axes 46 90 34

Referred by: Reviewed by:



[redacted]

	DATE	6/24		6/25										
	TIME	1720		0430										
HEMATOLOGY	HGB (12 - 16)	12.8		11.9						BLOOD PRODUCT SUMMARY				
	HCT (37 - 47)	38		35						ALB	PC	FFP	PLT	MISC
	WBC (4.5 - 11,000)	19.0		16.5										
	PT (9 - 12.5)													
	PTT (24 - 44)													
	Platelets (150 - 350,000)	189		189										
	Fibrinogen (170 - 410)													
	DATE	6/24	6/24	6/25/98										
	TIME	1720	2020	0430										
CHEMISTRY	Sodium (134 - 148)	137	140	144										
	Potassium (3.6 - 5.0)	3.5	4.4	4.1										
	BUM (7 - 20)	10	12	12										
	Creatinine (0.7 - 1.2)	0.9	0.9	1.0										
	CO_2 (24 - 34)	25	24	29										
	Glucose (72 - 128)	98	161	152										
	Calcium (8.5 - 10.5)													
	Lidocaine (1.5 - 5.0)													
	Digoxin (0.5 - 2.0)													
	Aminophylline (10 - 20)													
	Pronestyl (4-8) (>12 toxic)													
	DATE			6/25										
	TIME			0430										
HEART	SGOT (5 - 35)													
	CPK (35 - 232)			679										
	HB (0 - 3)			17										
	CPK MG% (0 - 2%)			2.5										
	DATE	6/24												
	TIME	1720	2050											
ABG'S	pH (7.35 - 7.45)	7.48	7.49											
	pCO_2 (35 - 45)	37	30											
	pO_2 (80 - 95)	65	111											
	O_2 Sat. (> 9%)	95	98											
	HCO_3 (22 - 28)	27	22											
	Base (± 2)	3.5	0.1											
	Vt	900												
	FIO_2	75												
	PEEP	0	5											
	MODE	SIMV 8	CPAP											

[redacted]

[redacted]

000021

RUN DATE: 06/24/98
RUN TIME: 1052

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/24/98-0954
Received: 06/24/98-1001
Status: COMP
Req#: [redacted]
Sub Dr: [redacted] MD

Ordered: CHEM 7, CARDIAC
Comments: Campus? [redacted]

Test	Result	Flag	Reference
CHEM 7			
NA	138		137-147 mEq/L
K	3.4		3.4-5.2 mEq/L
CL	101		96-108 mEq/L
CO2	28		20-32 mEq/L
GLU	122	H	70-105 mg/dL
BUN	13		7-22 mg/dL
CREAT	0.8		0.5-1.2 mg/dL
CARDIAC			
CK	107		30-135 U/L
CKMB	2		<5 ng/mL

Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

** END OF REPORT **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

PATIENT: [redacted]
ADM DR: [redacted]
REG DR:
SUBM DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U # [redacted]
REG: 06/23/98
DIS:

*** HEMATOLOGY ***

COMPLETE BLOOD COUNT

Date	Time	WBC (4.5-11.0) K/mm3	RBC (4.2-5.4) M/mm3	HGB (12.0-16.0) gm/dL	HCT (37-47) %	MCV (80-99) fL	MCH (27-32) pg	MCHC (32-36) g/dL	PLT (150-350) K/uL	RDW (11.0-16.0) %
6/23/98	1225	7.5	4.7	14.9	43	92	32	34	246	12.8

Date	Time	NEUT % (50-70) %	LYMPH % (20-40) %	MONO % (0-8) %	EOS % (0-5) %	BASO % (0-2) %
6/23/98	1225	61	29	8	1	1

*** COAGULATION ***

Date	Time	PT (10.5-12.9) sec	INR	PTT (23-35) sec
06/23/98	2115			56 H
06/23/98	1225	12.4	1.0	49 H

*** CHEMISTRY ***

Date	Time	NA (137-147) mEq/L	K (3.4-5.2) mEq/L	CL (96-108) mEq/L	CO2 (20-32) mEq/L	GLU (70-105) mg/dL	BUN (7-22) mg/dL	CREAT (0.5-1.2) mg/dL
06/23/98	1225	141	3.4	101	32	86	12	0.9

CARDIAC PANEL

Date	Time	CK (30-135) U/L	CKMB (<5) ng/mL
06/23/98	1225	139 H	3(A)

(A) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] (Continued)
Reg DR: [redacted]

BLOOD BANK

COLLECTED: Jun 23, 1998 12:25pm

> ABSC	NEGATIVE
> BLOOD TYPE	A POS

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** END OF REPORT **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted] Unit#: [redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
SUBM DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]

LOC:
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

STATUS: ADM IN

*** HEMATOLOGY ***

COMPLETE BLOOD COUNT

Date	Time	WBC (4.5-11.0) K/mm3	RBC (4.2-5.4) M/mm3	HGB (12.0-16.0) gm/dL	HCT (37-47) %	MCV (80-99) fL	MCH (27-32) pg	MCHC (32-36) g/dL	PLT (150-350) K/uL	RDW (11.0-16.0) %
6/25/98	0410	16.5 H	3.8 L	11.9 L	35 L	93	31	34	189	12.9
6/24/98	1720	19.0 H	4.1 L	12.8	38	93	31	34	189	13.2
6/24/98	0954	6.4	4.4	13.9	40	92	32	35	216	13.0
6/24/98	0430	7.1	4.5	14.3	42	94	32	34	232	12.5
6/23/98	1225	7.5	4.7	14.9	43	92	32	34	246	12.8

Date	Time	NEUT % (50-70) %	LYMPH % (20-40) %	MONO % (0-8) %	EOS % (0-5) %	BASO % (0-2) %
6/24/98	0954	66	25	7	2	1
6/23/98	1225	61	29	8	1	1

*** COAGULATION ***

Date	Time	PT (10.5-12.9) sec	INR	PTT (23-35) sec
06/24/98	0430			97 D H
06/23/98	2115			56 H
06/23/98	1225	12.4	1.0	49 H

*** ARTERIAL BLOOD GASES ***

(Performed in [redacted].)

Date	Time	MODE	DELIVERY	FIO2 %	RR VENT /min	RR PAT /min	TEMP C	COR PH (7.35-7.45)	COR PCO2 (26-40) mmHg	COR PO2 (76-80) mmHg
6/24/98	2054	CPAP		40		8	37.6	7.49 H	30	111 H
6/24/98	1722	SIMV	VENT	75	8		36.5	7.48 H	37	65 L

Date	Time	O2SATC (92-98.5) %	HCO3 (22-26) mEq/L	BE (-2.0-2.0) mmol/L	SAO2 % sat	TIDAL VOL cc	PEEP cmH2O	PRES SUP cmH2O	MAP	SITE
6/24/98	2054	98.3	22	0.1	98		5	10		LINE
6/24/98	1722	94.5	27 H	3.5 H	98	900	0	10	10	AL

Date	Time	MINUTE VENT L/min
6/24/98	2054	8.2
6/24/98	1722	6.7

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **

[redacted]

[redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] [redacted] (Continued)

Reg DR: [redacted]

*** CHEMISTRY ***

Date	Time	NA (137-147) mEq/L	K (3.4-5.2) mEq/L	CL (96-108) mEq/L	CO2 (20-32) mEq/L	GLU (70-105) mg/dL	BUN (7-22) mg/dL	CREAT (0.5-1.2) mg/dL
06/25/98	0410	144	4.1	108	29	152 H	12	1.0
06/24/98	2035	140	4.4	107	24	161 H	12	0.9
06/24/98	1720	137	3.5	102	25	98	10	0.9
06/24/98	0954	138	3.4	101	28	122 H	13	0.8
06/23/98	1225	141	3.4	101	32	86	12	0.9

CARDIAC PANEL

Date	Time	CK (30-135) U/L	CKMB (<5) ng/mL	CKMB% (0-2.5) %
06/25/98	0410	679 H	17(A)	2.5

(A) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/24/98	0954	107	2(B)	

(B) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/23/98	1225	139 H	3(C)	

(C) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

BLOOD BANK

COLLECTED: Jun 23, 1998 12:25pm

XMATCH
PC | 84GP47786 PC A POS Compatible? Y
PC | 84GP47794 PC A POS Compatible? Y
> ABSC | NEGATIVE
> BLOOD TYPE | A POS

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** END OF REPORT **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted] Unit#: [redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
SUBM DR:

ACCT #:
AGE/SX: 61/F
DOB:
STATUS: ADM IN

LOC:
ROOM:
BED:

U #:
REG: 06/23/98
DIS:

*** HEMATOLOGY ***

COMPLETE BLOOD COUNT

Date	Time	WBC (4.5-11.0) K/mm3	RBC (4.2-5.4) M/mm3	HGB (12.0-16.0) gm/dL	HCT (37-47) %	MCV (80-99) fL	MCH (27-32) pg	MCHC (32-36) g/dL	PLT (150-350) K/uL	RDW (11.0-16.0) %
6/26/98	0530	15.4 H	2.9 L	9.3 L	27 L	93	32	34	141 L	12.9
6/25/98	0410	16.5 H	3.8 L	11.9 L	35 L	93	31	34	189	12.9
6/24/98	1720	19.0 H	4.1 L	12.8	38	93	31	34	189	13.2
6/24/98	0954	6.4	4.4	13.9	40	92	32	35	216	13.0
6/24/98	0430	7.1	4.5	14.3	42	94	32	34	232	12.5
6/23/98	1225	7.5	4.7	14.9	43	92	32	34	246	12.8

Date	Time	NEUT % (50-70) %	LYMPH % (20-40) %	MONO % (0-8) %	EOS % (0-5) %	BASO % (0-2) %
6/24/98	0954	66	25	7	2	1
6/23/98	1225	61	29	8	1	1

*** COAGULATION ***

Date	Time	PT (10.5-12.9) sec	INR	PTT (23-35) sec
06/26/98	0530			24 D
06/24/98	0430			97 D H
06/23/98	2115			56 H
06/23/98	1225	12.4	1.0	49 H

*** ARTERIAL BLOOD GASES ***

(Performed in [redacted])

Date	Time	MODE	DELIVERY	FIO2 %	RR VENT /min	RR PAT /min	TEMP C	COR PH (7.35-7.45)	COR PCO2 (26-40) mmHg	COR PO2 (76-80) mmHg
6/24/98	2054	CPAP		40		8	37.6	7.49 H	30	111 H
6/24/98	1722	SIMV	VENT	75	8		36.5	7.48 H	37	65 L

Date	Time	O2SATC (92-98.5) %	HCO3 (22-26) mEq/L	BE (-2.0-2.0) mmol/L	SAO2 % sat	TIDAL VOL cc	PEEP cmH2O	PRES SUP cmH2O	MAP	SITE
6/24/98	2054	98.3	22	0.1	98		5	10		LINE
6/24/98	1722	94.5	27 H	3.5 H	98	900	0	10	10	AL

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] (Continued)
Reg DR: [redacted]

*** ARTERIAL BLOOD GASES *** (Continued)
(Performed in [redacted])

Date	Time	MINUTE VENT L/min
6/24/98	2054	8.2
6/24/98	1722	6.7

*** CHEMISTRY ***

Date	Time	NA (137-147) mEq/L	K (3.4-5.2) mEq/L	CL (96-108) mEq/L	CO2 (20-32) mEq/L	GLU (70-105) mg/dL	BUN (7-22) mg/dL	CREAT (0.5-1.2) mg/dL
06/26/98	0530	142	4.0	105	**34 H**	103	**24 H**	1.1
06/25/98	0410	144	4.1	108	29	**152 H**	12	1.0
06/24/98	2035	140	4.4	107	24	**161 H**	12	0.9
06/24/98	1720	137	3.5	102	25	98	10	0.9
06/24/98	0954	138	3.4	101	28	**122 H**	13	0.8
06/23/98	1225	141	3.4	101	32	86	12	0.9

CARDIAC PANEL

Date	Time	CK (30-135) U/L	CKMB (<5) ng/mL	CKMB% (0-2.5) %
06/25/98	0410	**679 H**	17(A)	2.5

(A) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/24/98	0954	107	2(B)	

(B) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/23/98	1225	**139 H**	3(C)	

(C) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] (Continued)
Reg DR: [redacted]

BLOOD BANK

COLLECTED: Jun 23, 1998 12:25pm

XMATCH		
PC	[redacted]	PC A POS Compatible? Y
PC		PC A POS Compatible? Y
ABSC	NEGATIVE	
BLOOD TYPE	A POS	

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** END OF REPORT **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted]

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
SUBM DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

*** HEMATOLOGY ***

COMPLETE BLOOD COUNT

Date	Time	WBC (4.5-11.0) K/mm3	RBC (4.2-5.4) M/mm3	HGB (12.0-16.0) gm/dL	HCT (37-47) %	MCV (80-99) fL	MCH (27-32) pg	MCHC (32-36) g/dL	PLT (150-350) K/uL	RDW (11.0-16.0) %
6/27/98	1056	13.5 H	2.8 L	8.8 L	26 L	94	32	34	161	13.1
6/26/98	0530	15.4 H	2.9 L	9.3 L	27 L	93	32	34	141 L	12.9
6/25/98	0410	16.5 H	3.8 L	11.9 L	35 L	93	31	34	189	12.9
6/24/98	1720	19.0 H	4.1 L	12.8	38	93	31	34	189	13.2
6/24/98	0954	6.4	4.4	13.9	40	92	32	35	216	13.0
6/24/98	0430	7.1	4.5	14.3	42	94	32	34	232	12.5
6/23/98	1225	7.5	4.7	14.9	43	92	32	34	246	12.8

Date	Time	NEUT % (50-70) %	LYMPH % (20-40) %	MONO % (0-8) %	EOS % (0-5) %	BASO % (0-2) %
6/24/98	0954	66	25	7	2	1
6/23/98	1225	61	29	8	1	1

*** COAGULATION ***

Date	Time	PT (10.5-12.9) sec	INR	PTT (23-35) sec
06/26/98	0530			24 D
06/24/98	0430			97 D H
06/23/98	2115			56 H
06/23/98	1225	12.4	1.0	49 H

*** ARTERIAL BLOOD GASES ***

(Performed in [redacted]

Date	Time	MODE	DELIVERY	FIO2 %	RR VENT /min	RR PAT /min	TEMP C	COR PH (7.35-7.45)	COR PCO2 (26-40) mmHg	COR PO2 (76-80) mmHg
6/24/98	2054	CPAP		40		8	37.6	7.49 H	30	111 H
6/24/98	1722	SIMV	VENT	75	8		36.5	7.48 H	37	65 L

Date	Time	O2SATC (92-98.5) %	HCO3 (22-26) mEq/L	BE (-2.0-2.0) mmol/L	SAO2 % sat	TIDAL VOL cc	PEEP cmH2O	PRES SUP cmH2O	MAP	SITE
6/24/98	2054	98.3	22	0.1	98		5	10		LINE
6/24/98	1722	94.5	27 H	3.5 H	98	900	0	10	10	AL

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted] Unit# [redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] [redacted] (Continued)
Reg DR: [redacted]

*** ARTERIAL BLOOD GASES *** (Continued)
(Performed in [redacted])

Date	Time	MINUTE VENT L/min							
6/24/98	2054	8.2							
6/24/98	1722	6.7							

*** CHEMISTRY ***

Date	Time	NA (137-147) mEq/L	K (3.4-5.2) mEq/L	CL (96-108) mEq/L	CO2 (20-32) mEq/L	GLU (70-105) mg/dL	BUN (7-22) mg/dL	CREAT (0.5-1.2) mg/dL					
06/27/98	0500	140	4.4	104	32	97	24 H	1.0					
06/26/98	0530	142	4.0	105	34 H	103	24 H	1.1					
06/25/98	0410	144	4.1	108	29	152 H	12	1.0					
06/24/98	2035	140	4.4	107	24	161 H	12	0.9					
06/24/98	1720	137	3.5	102	25	98	10	0.9					
06/24/98	0954	138	3.4	101	28	122 H	13	0.8					
06/23/98	1225	141	3.4	101	32	86	12	0.9					

CARDIAC PANEL

Date	Time	CK (30-135) U/L	CKMB (<5) ng/mL	CKMB% (0-2.5) %					
06/25/98	0410	679 H	17(A)	2.5					

(A) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/24/98	0954	107	2(B)						

(B) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/23/98	1225	139 H	3(C)						

(C) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **

[redacted]

CUMULATIVE LABORATORY SUMMARY REPORT

Patient: [redacted] (Continued)
Reg DR: [redacted]

*** THERAPEUTIC DRUG MONITORING & TOXICOLOGY ***

Date	Time	DIGOXIN (0.5-2.0) ng/mL					
6/27/98	0500	1.3					

BLOOD BANK

COLLECTED: Jun 23, 1998 12:25pm

XMATCH		
PC	[redacted]	PC A POS Compatible? Y <N/A>
PC	[redacted]	PC A POS Compatible? Y <N/A>
> ABSC	NEGATIVE	
> BLOOD TYPE	A POS	

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** END OF REPORT **
Patient: [redacted] Age/Sex: 61/F Acct#: [redacted]

Patient Care Inquiry *LIVE*

[redacted]

[redacted]

ge/Sex: 61 F

Room [redacted] (Admitted Jun 23, 98) Jun 21, 98 through Jun 24, 98

CHEM	NA	K	CL	CO2	GLU	BUN	CREAT
06/23/98 1225	141	3.4	101	32	86	12	0.9
06/24/98 0954	138	3.4	101	28	***122***	13	0.8

☒ replaced 2:1 to 4.5

HEM	HGB	HCT	RBC	PLT	WBC	a/NE%	a/LY%	a/MO%	a/EO%	a/BA%
06/23/98 1225	14.9	43	4.7	246	7.5	61	29	8	1	1
06/24/98 0430	14.3	42	4.5	232	7.1					
0954	13.9	40	4.4	216	6.4	66	25	7	2	1

COAG	PT	PTT	INR
06/23/98 1225	12.4	***49***	1.0
2114		***56***	
06/24/98 0430		***97D***	

CARD	CK	CKMB	CKMB%
06/23/98 1225	***139***	3	
06/24/98 0954	107	Pend	Pend

000033

Run: Wed - Jun 24 (10:40) for [redacted]

RUN DATE: 06/23/98
RUN TIME: 2142

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR: [redacted] MD
REG DR: [redacted] MD
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/23/98-2115
Received: 06/23/98-2120
Status: COMP
Req#: [redacted]
Sub Dr: [redacted]

Ordered: PTT
Comments: Campus? [redacted]

Test	Result	Flag	Reference
PTT	56	H	23-35 sec

Heparin Bolus 3,000 ↑ 1100 PTT 0400
2150

** END OF REPORT **

Patient: [redacted] Age/Sex: 61/F Acct#: [redacted] Unit: [redacted]

RUN DATE: 06/23/98
RUN TIME: 1300

LABORATORY BROADCAST RESULT REPORT

PATIENT:
ADM DR: MD
REG DR: MD
OTH DR:

ACCT #:
AGE/SX: 61/F
DOB:
STATUS: ADM IN

LOC:
ROOM:
BED:

U #:
REG: 06/23/98
DIS:

Specimen:

Collected: 06/23/98-1225
Received: 06/23/98-1231

Status: COMP
Sub Dr:

Req#:

Ordered: CHEM 7, CARDIAC
Comments: Campus?

Test	Result	Flag	Reference
CHEM 7			
NA	141		137-147 mEq/L
K	3.4		3.4-5.2 mEq/L
CL	101		96-108 mEq/L
CO2	32		20-32 mEq/L
GLU	86		70-105 mg/dL
BUN	12		7-22 mg/dL
CREAT	0.9		0.5-1.2 mg/dL
CARDIAC			
CK	**139**	*H*	30-135 U/L
CKMB	3		<5 ng/mL

Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

** END OF REPORT **

Age/Sex: 61/F Acct#:

RUN DATE: 06/23/98
RUN TIME: 1251

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR: [redacted] MD
REG DR: [redacted] MD
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/23/98-1225
Received: 06/23/98-1231
Status: COMP
Sub Dr: [redacted]
Req#: [redacted]

Ordered: CBC
Comments: Campus? [redacted]

Test	Result	Flag	Reference
CBC			
HEMOGRAM			
WBC	7.5		4.5-11.0 K/mm3
RBC	4.7		4.2-5.4 M/mm3
HGB	14.9		12.0-16.0 gm/dL
HCT	43		37-47 %
MCV	92		80-99 fL
MCH	32		27-32 pg
MCHC	34		32-36 g/dL
RDW	12.8		11.0-16.0 %
PLT	246		150-350 K/uL
NEUT %	61		50-70 %
LYMPH %	29		20-40 %
MONO %	8		0-8 %
EOS %	1		0-5 %
BASO %	1		0-2 %

** END OF REPORT **

RUN DATE: 06/23/98
RUN TIME: 1330

LABORATORY BROADCAST RESULT REPORT

PATIENT:
ADM DR: MD
REG DR: MD
OTH DR:

ACCT #:
AGE/SX: 61/F
DOB:
STATUS: ADM IN

LOC:
ROOM:
BED:

U #:
REG: 06/23/98
DIS:

Specimen:
Wristband

Collected: 06/23/98-1225
Received: 06/23/98-1231

Status: RES
Subm Dr:

Req#:

Ordered: TS, PTR
Comments: Campus?

Test	Result
> BLOOD TYPE	A POS

** END OF REPORT **

Patient: Age/Sex:61/F Acct#

Patient Care Inquiry *LIVE*

[redacted]

[redacted]

Age/Sex: 61 F

Room [redacted] (Admitted Jun 23, 98) Jun 21, 98 through Jun 24, 98

CHEM	NA	K	CL	CO2	GLU	BUN	CREAT
06/23/98 1225	141	3.4	101	32	86	12	0.9

HEM	HGB	HCT	RBC	PLT	WBC	a/NE%	a/LY%	a/MO%	a/EO%	a/BA%
06/23/98 1225	14.9	43	4.7	246	7.5	61	29	8	1	1
06/24/98 0430	14.3	42	4.5	232	7.1					

COAG	PT	PTT	INR
06/23/98 1225	12.4	49	1.0
2114		56	
06/24/98 0430		97D	

CARD	CK	CKMB
06/23/98 1225	139	3

Run: Wed - Jun 24 (06:55) for [redacted]

RUN DATE: 06/24/98
RUN TIME: 1027

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/24/98-0954
Received: 06/24/98-1001
Status: RES
Sub Dr: [redacted] MD
Req#: [redacted]

Ordered: CHEM 7, CARDIAC
Comments: Campus? [redacted]

Test	Result	Flag	Reference
CHEM 7			
NA	138		137-147 mEq/L
K	3.4		3.4-5.2 mEq/L
CL	101		96-108 mEq/L
CO2	28		20-32 mEq/L
GLU	**122**	*H*	70-105 mg/dL
BUN	13		7-22 mg/dL
CREAT	0.8		0.5-1.2 mg/dL
CARDIAC			
CK	107		30-135 U/L

** END OF REPORT **

Patient: [redacted] Age/Sex: 61/F Acct# [redacted]

RUN DATE: 06/24/98
RUN TIME: 1022

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR:
REG DR:
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/24/98-0954
Received: 06/24/98-1001
Status: COMP
Sub Dr: [redacted]
Req#: [redacted]

Ordered: CBC
Comments: Campus? GSH

Test	Result	Flag	Reference
CBC			
HEMOGRAM			
WBC	6.4		4.5-11.0 K/mm3
RBC	4.4		4.2-5.4 M/mm3
HGB	13.9		12.0-16.0 gm/dL
HCT	40		37-47 %
MCV	92		80-99 fL
MCH	32		27-32 pg
MCHC	35		32-36 g/dL
RDW	13.0		11.0-16.0 %
PLT	216		150-350 K/uL
NEUT %	66		50-70 %
LYMPH %	25		20-40 %
MONO %	7		0-8 %
EOS %	2		0-5 %
BASO %	1		0-2 %

** END OF REPORT **

Patient: [redacted] Age/Sex: 61/F Acct# [redacted]

RUN DATE: 06/24/98
RUN TIME: 0546

[redacted]

LABORATORY BROADCAST RESULT REPORT

PATIENT: [redacted]
ADM DR: [redacted] MD
REG DR: [redacted] MD
OTH DR:

ACCT #: [redacted]
AGE/SX: 61/F
DOB: [redacted]
STATUS: ADM IN

LOC: [redacted]
ROOM:
BED:

U #: [redacted]
REG: 06/23/98
DIS:

Specimen: [redacted]
Collected: 06/24/98-0430
Received: 06/24/98-0511
Status: COMP
Sub Dr: [redacted] MD
Req#: [redacted]

Ordered: HEMOGRAM
Comments: Campus? [redacted]

Test	Result	Flag	Reference
HEMOGRAM			
WBC	7.1		4.5-11.0 K/mm3
RBC	4.5		4.2-5.4 M/mm3
HGB	14.3		12.0-16.0 gm/dL
HCT	42		37-47 %
MCV	94		80-99 fL
MCH	32		27-32 pg
MCHC	34		32-36 g/dL
RDW	12.5		11.0-16.0 %
PLT	232		150-350 K/uL

** END OF REPORT **

Patient: [redacted] Age/Sex: 61/F Acct [redacted]

Patient Care Inquiry *LIVE*

Summary of Radiology Results

[redacted]

Sex: 61 F

[redacted] (Admitted Jun 23, 98)

Type: All Exam Types

GD CHEST 1V PORT

Jun 21, 98 through Jun 24, 98

Date	Time	Exam Type	Exam Name	Status	Result Code
Jun 23, 98	UNK	GENERAL DIAGNOS	GD CHEST 1V PORT	Signed	

000042

Ru...

Wed - Jun 24 (10:25) for [redacted]

RUN DATE: 06/24/98
RUN TIME: 0632

LABORATORY BROADCAST RESULT REPORT

PATIENT:
ADM DR: MD
REG DR: MD
OTH DR:

ACCT #:
AGE/SX: 61/F
DOB:
STATUS: ADM IN

LOC:
ROOM:
BED:

U #:
REG: 06/23/98
DIS:

Specimen:
Collected: 06/24/98-0430
Received: 06/24/98-0511
Status: COMP
Req#:
Sub Dr: MD

Ordered: PTT
Comments: Campus?

Test	Result	Flag	Reference
PTT	97	*DH*	23-35 sec

** END OF REPORT **

Patient: Age/Sex:61/F Acct#

[redacted] M.D.
M.D.
.D

[redacted]

[redacted]

DISCHARGE SUMMARY REPORT

Patient [redacted] [redacted] (Continued)

Reg DR: [redacted]

*** ARTERIAL BLOOD GASES *** (Continued)
(Performed in [redacted] - Director: [redacted])

Date	Time	MINUTE VENT L/min								
6/24/98	2054	8.2								
6/24/98	1722	6.7								

*** CHEMISTRY ***

Date	Time	NA (137-147) mEq/L	K (3.4-5.2) mEq/L	CL (96-108) mEq/L	CO2 (20-32) mEq/L	GLU (70-105) mg/dL	BUN (7-22) mg/dL	CREAT (0.5-1.2) mg/dL					
06/28/98	0625	140	4.0	102	32	90	20	0.9					
06/27/98	0500	140	4.4	104	32	97	**24 H**	1.0					
06/26/98	0530	142	4.0	105	**34 H**	103	**24 H**	1.1					
06/25/98	0410	144	4.1	108	29	**152 H**	12	1.0					
06/24/98	2035	140	4.4	107	24	**161 H**	12	0.9					
06/24/98	1720	137	3.5	102	25	98	10	0.9					
06/24/98	0954	138	3.4	101	28	**122 H**	13	0.8					
06/23/98	1225	141	3.4	101	32	86	12	0.9					

CARDIAC PANEL

Date	Time	CK (30-135) U/L	CKMB (<5) ng/mL	CKMB% (0-2.5) %					
06/25/98	0410	**679 H**	17(A)	2.5					

(A) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/24/98	0954	107	2(B)						

(B) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

06/23/98	1225	**139 H**	3(C)						

(C) Normal < 5 ng/mL
Borderline 5-10 ng/mL
Abnormal > 10 ng/mL and CKMB% > 2.5%

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** CONTINUED ON NEXT PAGE **

[redacted]

DISCHARGE SUMMARY REPORT

Patien[redacted] [redacted] (Continued)

Reg DR: [redacted] MD

*** THERAPEUTIC DRUG MONITORING & TOXICOLOGY ***

Date	Time	DIGOXIN (0.5-2.0) ng/mL					
6/27/98	0500	1.3					

BLOOD BANK

COLLECTED: Jun 23, 1998 12:25pm

XMATCH	
PC	[redacted] PC A POS Compatible? Y <N/A>
PC	[redacted] PC A POS Compatible? Y <N/A>
> ABSC	NEGATIVE
> BLOOD TYPE	A POS

LEGEND: * (abnormal) H (high) L (low) P (Panic/Critical) # (Performed off site)

** END OF REPORT **

Patient: [redacted] Age/Sex: 61/F Acct#: [redacted] Unit#: [redacted]

Memorandum to ARMS # 12979

Date: 13Aug99

From: Medical Officer, Clinical Research and Review Staff, Office of Special Nutritionals, HFS-452

Subject: Medical Records Placed in Permanent Storage.

The following types and amounts of records (more than 20 pages total) were place in permanent storage on this date because they were not considered essential for interpretation of this adverse event.

Approx Pages	Type of Records
	Nursing notes
	Dietitian notes
	Respiratory therapy/occupational therapy/physical therapy notes
	Clergy notes
32	Medication records
4	Physician's orders
	Vital signs, fluids, input/output records
	Ventilator records
1	Hospital administrative records (e.g., insurance information, living will, etc)

G. Dixa for L. Lowe