

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

ARMS#

13370



4 - ER URGENT

000001

EMERGENCY PATIENT RECORD

DATE OF VISIT: 01/28/99

CHIEF COMPLAINT:

Foreign body sensation in throat.

HISTORY OF PRESENT ILLNESS:

This is a 19-year-old male who complains of a foreign body sensation over the lower throat over the anterior neck believed to be secondary to possible accidental ingestion of metal shavings. No nausea or vomiting. No voice changes. He is able to speak without difficulty or chest pain.

REVIEW OF SYSTEMS:

Other systems were reviewed and found to be negative.

PAST MEDICAL HISTORY:

None.

MEDICATIONS:

None.

ALLERGIES:

None.

PHYSICAL EXAMINATION:

VITAL SIGNS: Normal.

GENERAL: This is a 19-year-old male. Height is 5'10" and weight is 195 pounds.

HEAD, EYES, EARS, NOSE, AND THROAT: The posterior pharynx shows no evidence of any visual foreign bodies. He has no stridor, hoarseness. No trismus. No laryngeal tenderness to palpation of the neck. Trachea is midline. No respiratory distress. He is able to speak nonstop without difficulty.

CARDIOVASCULAR: Regular rhythm without murmurs or gallops.

RESPIRATORY: Clear and symmetric lungs.

GASTROINTESTINAL: Soft and nontender.

MUSCULOSKELETAL: Normal joints without acute inflammatory process. Normal muscle tone in all four extremities.

NEUROLOGICAL: No gross motor or sensory deficits. Speech is normal.

PSYCHIATRIC: The patient is alert and oriented to person, time and place. The patient carried on a normal conversation.

EMERGENCY ROOM MANAGEMENT, MEDICAL DECISION MAKING:

The patient underwent a chest x-ray as well as a soft tissue x-ray of the neck which were negative per my review. The case was discussed with Dr.

PT. [REDACTED]

M.R.# [REDACTED]

EMERGENCY PATIENT RECORD

PHYSICIAN: [REDACTED] M.D. 1

Job [REDACTED]

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000002 [REDACTED]

[REDACTED]

EMERGENCY PATIENT RECORD [REDACTED]

[REDACTED] ENT specialist, who will see the patient in the office tomorrow.

DISCHARGE INSTRUCTIONS:

Follow up with family doctor. Return if any worsening of symptoms.

IMPRESSION:

Evaluation of ingested foreign body by history.

DISPOSITION:

Home.

The emergency physician provided the initial interpretation for all diagnostic studies including EKGs, rhythm EKGs and x-rays unless otherwise stated.

C:
D:
T:

PT. [REDACTED]

M.R.# [REDACTED]

PHYSICIAN: [REDACTED] M.D.

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AM

EMERGENCY PATIENT RECORD [REDACTED]

Job [REDACTED]

000003 [REDACTED]

RADIOLOGY CONSULTATION

DATE OR ORDER: 01/28/99

PROCEDURE:
CH CHEST 2 VIEW

REASON FOR EXAM:
SOB

EXAM DATE/TIME:
01/28/99 2140

ACCESSION :
[REDACTED]

D 01/29/99 07:28
T 01/29/99 09:03

CHEST, TWO VIEWS:

The cardiac, hilar and mediastinal silhouette is within normal limits. The lungs are clear. The visualized osseous structures are intact.

CONCLUSION:

- 1. NEGATIVE STUDY.

ATTENDING STAFF RADIOLOGIST: [REDACTED] M.D.
(Electronic Signature)

DATE OR ORDER: 01/28/99

PROCEDURE:
NECK SOFT TISSUE

REASON FOR EXAM:
R/O FB

EXAM DATE/TIME:
01/28/99 2140

ACCESSION =
[REDACTED]

D 01/29/99 07:28
T 01/29/99 09:04

NECK SOFT TISSUES:

AP and lateral soft tissues of the neck show the soft tissues to be normal in appearance. There is no evidence of retropharyngeal mass lesion or edema. No foreign body is seen.

CONCLUSION:

- NEGATIVE STUDY.

ATTENDING STAFF RADIOLOGIST: [REDACTED] M.D.
(Electronic Signature)

[REDACTED] policy states Technologist/and/or Radiologist will give explanation of procedures/risks to patient and/or patient family. Also Technologist and/or Radiologist will verify explanation of test for documentation.

Pt.: [REDACTED]
MR#: [REDACTED]
ADM: 01/28/99 Sex: M
Dr: [REDACTED]

Acct.# [REDACTED]
Age: 19 YRS DOB [REDACTED] Loc: [REDACTED]

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RADIOLOGY

Print Date: 01/30/99 1358
Page: END OF REPORT

000004

EMERGENCY PATIENT RECORD

ROOM NO. [REDACTED]

PATIENT NAME	RST	AGE	SEX	HEIGHT	WEIGHT	ME	T	P	R	B/P	
[REDACTED]	[REDACTED]	19	m	5'10"	190					236/98	
ARRIVED	<input type="checkbox"/> CARRIED	LAST TETANUS	LNMP	GPIA	VISUAL ACUITY	OS	OD	OU			
<input type="checkbox"/> HELICOPTER	<input type="checkbox"/> ALS	<input type="checkbox"/> BLS									
<input type="checkbox"/> AMBULATORY	<input type="checkbox"/> WHEELCHAIR	<input type="checkbox"/> POLICE									
TIME	DATE	CURRENT MEDICATIONS <input type="checkbox"/> NONE		DOSE	FREQ.	MEDICAL HISTORY					
0605	2/28/99	Depakote		50mg	BID	Manic Depressive					
CATEGORY		CHIEF COMPLAINT		24 prexa		Tonly HTS					
2		Needs meds regulated according to family. Erratic behavior.		the dose as per finding							
NEUROLOGIC		RESPIRATORY		MUSCULO-SKELETAL		SKIN COLOR		TEMPERATURE		ALLERGIES	
<input checked="" type="checkbox"/> Alert <input type="checkbox"/> Not Alert		<input checked="" type="checkbox"/> Normal		Location		<input checked="" type="checkbox"/> Pink/Brown		<input type="checkbox"/> Warm/Dry		Pen	
Responds to		<input type="checkbox"/> Shallow				<input type="checkbox"/> Pale		<input type="checkbox"/> Hot		Latex	
<input type="checkbox"/> Verbal Stimuli		<input type="checkbox"/> Labored				<input type="checkbox"/> Flushed		<input type="checkbox"/> Cool			
<input type="checkbox"/> Painful Stimuli		Other		<input type="checkbox"/> Pain		<input type="checkbox"/> Jaundice		<input type="checkbox"/> Cold/Clammy			
Oriented GCS				<input type="checkbox"/> Swelling		<input type="checkbox"/> Discoloration		<input type="checkbox"/> Diaphoretic			
<input type="checkbox"/> Deformity				<input type="checkbox"/> Skin Broken							
<input type="checkbox"/> Pulses Present				<input type="checkbox"/> Distal To Injury							
Pain 1 2 3 4 MAX											
TIME	PHYSICIAN ASSESSMENT		[REDACTED]								
HISTORY PRESENT ILLNESS											
pt is bipolar disorder, was hospitalized by his mother after hospital in contact of relatives and cleaners, pt went to his girl friend house and began having the delusions, fighting mother brought her.											
⊕ vomit in time of food contact, pt denies taking any meds											
REVIEW OF SYSTEMS. HEENT: <input checked="" type="checkbox"/> GU: <input checked="" type="checkbox"/> GI: <input checked="" type="checkbox"/> MS: <input checked="" type="checkbox"/> SKIN: <input checked="" type="checkbox"/> CARDIO: <input checked="" type="checkbox"/> RESPIRATORY: <input checked="" type="checkbox"/> NEURO: <input checked="" type="checkbox"/> All other systems negative											
PAST MED HISTORY.											
SOCIAL HX. Tobacco Alcohol Substance Abuse FAM HX: TB DM HTN HEART/LUNG KIDNEY CA											
Persistent Cough (> 2 wks) Bloody Sputum Night Sweats Unexplained Wt. Loss Anorexia Fever Malaise											
Recent close contact with infectious TB Travel / Live in country with high prevalence TB Previous Isoniazid- When- How long-											
PHYS. EXAM:											
[Handwritten notes: long, neck, RCP, 2/28/99 - 50mg NT, 0.35]											
ADMIT PER [REDACTED]											
DISCHARGE TIME		CONDITION ON DISCHARGE		IMPRESSION:							
0730		<input type="checkbox"/> SATISFAC. <input type="checkbox"/> IMPROVED									
LEVEL 400 401 402 403 404 405 406											
TIME ADM CALLED											
TIME BED GIVEN											
ROOM NO											
DATE TO UNIT											
TIME TO UNIT											
<input type="checkbox"/> E <input type="checkbox"/> N											

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000005

EMERGENCY PATIENT RECORD

DATE: 02/28/99

CHIEF COMPLAINT:

Bizarre behavior.

HISTORY OF PRESENT ILLNESS:

The patient is a 19 year-old man, brought by his mother. He has a prior history of bipolar disorder. According to the mother, the patient began to behave in a bizarre way; destroying her property, not following directions, not sleeping for several days. The mother also felt that the patient became delusional. There is no history of any suicidal ideation. The patient was diagnosed with manic-depressive disorder, over a year ago, on Depakote and Zyprexa. Shortly after arrival to the Emergency Department, the patient began to destroy property in the Emergency Department, was found to be bending an IV pole, and subsequently required four extremity restraints.

REVIEW OF SYSTEMS:

A complete review of systems can not be obtained from this patient, who is behaving in a neurotic, bizarre way.

PAST MEDICAL HISTORY:

Manic-depressive disorder.

MEDICATION(s):

Depakote and Zyprexa.

ALLERGIES:

PENICILLIN, LATEX.

FAMILY HISTORY:

Negative for tuberculosis, diabetes mellitus, hypertension, or psychiatric illness.

SOCIAL HISTORY:

There is no history of any substance abuse or use of alcohol.

PT. [REDACTED]

EMERGENCY ROOM ADMIT

M.R.#/RM. [REDACTED]

MEDICAL RECORD

DR. [REDACTED] M.D./

EMERGENCY PATIENT RECORD [REDACTED]

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EMERGENCY PATIENT RECORD

PHYSICAL EXAMINATION:

GENERAL: This is a 19 year-old man who's height is 5'10" and weight is 190 pounds.

VITAL SIGNS: Initial blood pressure was 231/98, repeated down to 176/80. Temperature was 98.2°, pulse was 109, and respiratory rate was 16.

EYES: Pupils equal, round and reactive. Extraocular movements were intact. No conjunctival inflammation.

EARS, NOSE, MOUTH AND THROAT: There is no stridor. There is no drainage from the ears or nose. Pharynx is free of exudates or swelling.

CARDIOVASCULAR: Heart is regular rate and rhythm. No murmurs are auscultated.

RESPIRATORY: The lungs are clear bilaterally. No wheezing or rales are present.

GASTROINTESTINAL: The abdomen is nondistended. Bowel sounds are present. There is no tenderness, guarding or rebound. There are no palpable masses.

MUSCULOSKELETAL: The patient has no joint inflammation. There is no evidence of muscle atrophy.

SKIN: There is no skin rash.

NEUROLOGICAL: The patient has a normal speech pattern. There is no facial asymmetry. The patient has good motor strength in all extremities. There is no evidence of ataxia or incoordination. There is no evidence of seizure activity.

PSYCHIATRIC: The patient is oriented to person, time, and place. He exhibits inappropriate, agitated behavior. He appears to be in a manic state.

HEMATOLOGIC/IMMUNOLOGIC: There is no hepatosplenomegaly. There is no abnormal adenopathy.

EMERGENCY ROOM MANAGEMENT/MEDICAL DECISION MAKING:

Shortly after his arrival to the Emergency Department, the patient required four extremity leather restraints. He was given Haldol 5 mg intramuscularly and Ativan 2 mg intramuscularly. The patient was evaluated by [REDACTED]

PLAN:

The patient will be admitted to the Psychiatric Service.

IMPRESSION:

Bipolar disorder with acute mania.

The emergency room physician provided the initial interpretation for all diagnostic studies, including EKGs, rhythm EKGs and X-rays, unless otherwise stated.

C. [REDACTED], M.D. [REDACTED]
D. [REDACTED]
T. [REDACTED]

PT. [REDACTED]

EMERGENCY ROOM ADMIT

M.R.#/RM. [REDACTED]

MEDICAL RECORD

DR. [REDACTED] M.D./

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EMERGENCY PATIENT RECORD [REDACTED]

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3/24.25.30/99 ARR. Exh [REDACTED]