

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

ARMS#

13256



4 - ER URGENT

000001

EMERGENCY DEPARTMENT/NURSING

PMD: [redacted] WORKER COMP. OCC.HEALTH
DOB: [redacted] SEX: F

NAME [redacted]

SOCIAL SECURITY #: [redacted] ACCOMPANIED BY: [redacted]

Arrival Mode: Ambulance, Carry, Cart, From [redacted] Walk, WC
Arrival Time: 1345 Triage Time: 1345 ET FT Bed # [redacted] Time: 1347 Level: 1 2

Vital Signs: T, P, R, BP
Chief Complaint: [handwritten notes]

Allergies: NK
Meds/Dosage/Frequency: [handwritten notes]

Health History: Td, LMP, Diabetes Yes/No

Body System: Respiratory, Cardiovascular, Neuro, ENT, Eye, GI, GU, Behavioral Crisis, Skin, Reproductive, Musculoskeletal, Communicable Disease Considerations, Infection Control Concerns, Non-specific, Dental

Subjective History: Time: 1400 pt describes onset of pressure to upper sternum, began approx 1000-1030 slight episode diaphoresis, nausea/SOB, weakness/dizziness/light-headedness worsened approx 1315, opting factors requested, feels similar to bronchitis in past but worse, has hyperthyroidism history, admits stress level increasing on work, works station [redacted]

Objective Findings: Time: 1400 AOX3 skin warm & dry pink, peripheral pulses all extremities, lungs clear, sedation to LEs [redacted]

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Cognitive Assessment: Indicate variances and document plan of care. Pain 0-10 10 now 4/7
SocioCultural Assessment: Indicate variances and document plan of care.
Spiritual Assessment: Indicate variances and document plan of care. WDL

Nursing Diagnosis: Activity intolerance, Anxiety, Cardiac output, altered, Coping, ineffective, Fear, Fluid volume excess, Grieving, Infection, potential for, Injury, potential for, Knowledge deficit, Manic behavior, Mobility, impaired physical, Nutrition, alteration in, Pain, Powerlessness, Respiratory insufficiency, Self-care deficit, Self-concept disturbances, Sensory/perceptual alterations, Skin integrity, impairment of, Spiritua, Thought, Tissue, Urinary, Violence

LAB to 1530 EKG 1350 XRAY to 543 from OTHER to from Visual Acuity: R, L, C Correct, S Correct Time: LA RA BP HR Supporting Documentation: IV, Neuro, Mental Health, Plan of Care, Consents, Post Procedure

EMERGENCY DEPARTMENT / NURSING ASSESSMENT AND TREATMENT

EMERGENCY DEPARTMENT/NURSING

PMD: [redacted] WORKER COMP. OCC. HEALTH
DOB: [redacted] SEX: F

NAME

SOCIAL SECURITY #: [redacted] ACCOMPANIED BY: friend

Arrival Mode Ambulance Walk WC Carry Cart Front
Arrival Time 1345 Triage Time 1345 ET FT Bed # [redacted] Time 1347 Level 1 2

Vital Signs T [redacted] P 94 R 20 BP 145/91
Chief Complaint C/o 3-4° hx. of upper chest pain.

Allergies NKA
Meds/Dosage/Frequency propofol
mel

Health History Td N/A LMP 9/4 Diabetes Yes No
Body System Respiratory Cardiovascular Neuro ENT Eye GI GU Behavioral Crisis Skin
 Reproductive Musculoskeletal Communicable Disease Considerations Infection Control Concerns Non-specific Dental

PHYSICIAN NOTES / ORDERS

HISTORY EXAM

MEDICAL ORDERS

TIME O2 Sat. (Y-N): % (Rm Air - O2) LPM O2 at: LPM (C-M) INT.
ECG Monitor (Y-N) Rhythm: Tracked 60 IM IV
IV: Maclox 600 (redacted) - N/A
NTG 0.4 mg
10mg MS IM v.o. b.d.
IMAGING/REASON: CXR PA & LAT
IMAGING/REASON:
EKG
ABG MD RT I-STAT 6 HGC
Hemogram/Diff/Pk NA Urine
BASIC 7 K Qual
CK-MB CL Quant
LD1 BUN RPR
AST Glu CHL
BILI Hgb W-PREP
AMYLASE ESR GM-STAIN
ALK. PHOS. T & C U. UA
LIPASE T & S UC
PT BLD CULTURES U-TOX SCREEN
PTT X Street
ESR Rx
Mg. OTC
Glucometer
* tropinin 1531

DISCHARGE SUMMARY

PLAN INSTRUCTIONS: DISCHARGE ADMIT
Return For: If a pain, SOB, When:
Follow-up: Dr [redacted] For: When: tomorrow
Activity Restriction: patient Diet Restriction:
Instruction Sheet: Ice-Heat Packs q: hrs. for: days

MEDICATIONS:
1. Naproxyn 500mg = po bid #20
2. Vicodin 5mg T # po q 4PRN
3.
4.
 PSYCH ORTHO DAWN EXPIRED
 URO NEURO DR. BLUE AMA
 MEDICAL EYE TRAUMA LWBS
 CV ENT MAJOR CONDITION ON D/C
 ED SURG MINOR Critical
 OB/GYN STD.

DIAGNOSIS
1.
2.
3.
4.
000003
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 Dc 03/02/99
 T-E MME
Physician Notified: [redacted] Signature: [redacted]
Time Called: [redacted]

ED/MD EVALUATION AND TREATMENT

TIME SEEN: _____ ROOM: _____

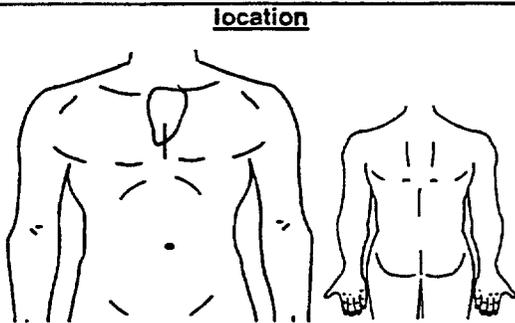
HISTORIAN: patient

HPI
chief complaint- chest pain/discomfort

started- 09 AM

time course
still present better constant "waxing & waning"
gone now intermittent episodes lasting
lasted worse/persistent since
resolved on arrival in E.D.

quality
pressure
tightness
indigestion
burning
dull
like prior MI
sharp
stabbing
"pain"
"numbness"



location

radiation none diagrammed above

associated symptoms
nausea shortness of breath
vomiting sweating
clammy

worsened by
change in position
deep breaths / turning
exertion
nothing

relieved by
sitting up
rest
antacids
nothing
NTG
patient's own supply
given by paramedics
relief: none / partial / complete
transient

onset during
sleep rest light activity
mod. / heavy exertion
emotional upset
cannot recall

severity
maximum
mild moderate severe
when seen in ED
gone almost gone mild moderate severe
residual discomfort in arm (L/R)

Similar symptoms previously

Recently seen/treated by doctor

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MMP

Exhibit 1 pg 5 of 18

fever
chills
cough
sputum
ankle swelling
calf / leg pain

blackouts
EYES/ENT
blurred vision
sore throat
GI and GU
abdominal pain
black / bloody stools
problems urinating
SKIN & LYMPH & MS
skin rash / swelling
joint pain

FEMALE REPRODUCTIVE
LNMP
vaginal discharge
abnormal bleeding

ROS limited due to:

taken Metabolics
SLE 3 pos
⊕ anti cardiolipin Ab

PAST HISTORY negative * = MI risk factors
* high blood pressure emphysema
* diabetes insulin / oral / diet collapsed lung
* high cholesterol stroke
* heart disease peptic ulcer
heart attack (MI) documented? yes no
angina heart failure gall stones
DVT / PE / risk factors other problems

Graves - PTU 2/97
Dr. [redacted] - end
ON PTU

Surgeries/Procedures: none non-contributory
cardiac bypass tonsillectomy
cardiac cath gall bladder surgery
angioplasty appendectomy
pacemaker hysterectomy

Medications none see NAS
ASA ibuprofen acetaminophen
BCP's

Allergies
NKDA see NAS

SOCIAL HX * smoker * drugs
alcohol (recent / heavy / occasional)

FAMILY HX * CAD (<55yo / >55yo) 000004

dad
CAB, Tra
dad - early heart DZ

Nursing Assessment Reviewed. BP, HR, RR, Temp reviewed.

PHYSICAL EXAM Alert Alert Anxious IV
Distress NAD mild moderate severe

HEENT scleral icterus / pale conjunctivae
ENT nml inspection pharyngeal erythema
pharynx nml abnml TM / hearing deficit

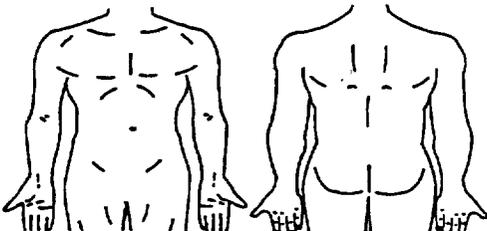
NECK thyromegaly
nml inspection lymphadenopathy (R / L)
thyroid nml

RESPIRATORY respiratory distress
no resp. distress manifests distinct pain on movement
breath sounds nml of R / L arm of trunk
chest non-tender decreased air movement (R / L)
splinting (R / L)
rales
rhonchi
wheezing

CVS irregularly irregular rhythm
regular rate, rhythm extrasystoles (occasional / frequent)
no murmur tachycardia / bradycardia
no gallop PMI displaced laterally
no friction rub JVD present
murmur grade 1/6 sys / dias
cresc / cresc-decreas / decreas

gallop (S3 / S4)
friction rub
decreased pulse(s)
R carotd fem dors ped
L carotd fem dors ped

T = tenderness
G = guarding
R = rebound
m = mild
mod = moderate
sv = severe
(e.g., Tsv = severe tenderness)



ABDOMEN tenderness
non-tender guarding
no organomegaly rebound
abnml bowel sounds
hepatomegaly / splenomegaly / mass

RECTAL black / bloody / heme pos. stool
non-tender tenderness
heme neg stool

SKIN cyanosis / diaphoresis / pallor
color nml, no rash skin rash
warm, dry

EXTREMITIES pedal edema
non-tender, nml ROM calf tenderness
no pedal edema clubbing
no calf tenderness

NEURO/PSYCH disoriented to person / place / time
oriented x3 depressed affect
mood/affect nml weakness / sensory loss
CN's nml as tested facial droop/EOM palsy/anisocoria
no motor/sensory deficit

EKG, LABS, XRAYs, and PROGRESS

EKG- nml abnormal:

Comparison w/ prior EKG-
Repeat EKG- unchanged

Cardiac Monitor- NSR

CBC normal nml except WBC Hgb Hct Platelets segs bands lymphs monos	Chemistries normal nml except Na K CL CO2 BUN Gluc Creat	CK CKMB Troponin LDH PT INR PTT	UA normal nml except WBC RBC's bacteria dip:
--	--	---	---

CXR nml / NAD

Pulse Oximeter time % RA L
Time unchanged improved re-examined

Discussed with Dr. Prior records ordered
will see patient in office / ED / hospital Additional history from:
 family caretaker paramedics
Counseled patient / family regarding
lab results diagnosis need for follow-up
EKG / X-ray examined
Admit orders written Discussed with radiologist

CLINICAL IMPRESSION: EMS Arrival
Chest Pain acute precordial Acute MI
Chest Wall Pain- acute Unstable Angina
Dyspnea- acute Pericarditis- acute
Costochondritis- acute Acute Aortic Dissection
Myofascial Strain- acute Pulmonary Embolism
Viral Syndrome- acute Congestive Heart Failure
Bronchitis- acute Atrial Fibrillation-
Viral Pleuritis (Pleurisy) controlled uncontrolled new-onset chronic
Abnormal EKG Pneumonia

PLAN: home admitted transferred **000005**

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SIGNATURE
Exhibit pg of

Med	Time	Problem/Data	Time	Interventions/Medication (Dose/Route/Initials/Est. Wt. _____)	Patient Response	Time
	1400			on BP oximetry a telemetry monitor, SR 80-90, 9. sets 99%		
	1455			Morlox 600 given 1440	states SA in discomfort	
	1503			O.Hing w/bo given SL	notes gain 5/6 now	
	1504			states SA to pressure anxiety ting slightly edema, Mrs. restlessness - expressing concern of where husband is, blood draw		
	1530			unsquinted for labs, 10mg MS given 4PM to @ ventroperforated muscle		
	1550			returned Xray express more relaxed, states MS began to hurt husband here		
	1600			states pain level now 2/3, more comfortable		
	1645			60mg Toradol given 4PM to @ ventroperforated muscle, notes gain		
	1715			turning to @ side a return to supine. @ incinerations reviewed, states @ positions, signed copy given, @ given will fill self @ frequent vital signs provided		

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Supplied with: Patient SO RT Social Services Assessment & Referral, Dietary Clergy Community Agencies

Transfer/Discharge Narrative
 O2
 Cardiac Monitor
 IV
 Belongings
 Old Records
 Discharge Mode
 Walk Ambulance Cart Wheelchair Private vehicle

Discharge/Transferred With
 RN Paraprofessional Escort
 SO Self

DC Destination
 Discharge MCCC Admit Rm #
 Nurs. Home Clinic Morgue
 CV Lab Other Hospital NH Placement
 OR MCMC

Report To: ANES CPA SS LWBS Thrombo

Acuity Score: _____ DC Time: 1715

Signature: _____ Int: _____

EMERGENCY DEPARTMENT

INSTRUCTIONS

Return to ER if increased pain or shortness of breath

Take Naprosyn + Vicodin as ordered

Your blood pressure today was _____ Diphtheria / Tetanus booster given today.

INSTRUCTION SHEET(S) GIVEN

- Abd. Pain
- Back Care
- Burn Care
- Cast Care
- Diarrhea
- Other _____
- Eye Care
- Fever
- Food/Drug Interactions
- Fractured Ribs
- Head Injury
- Insulin Reaction
- Kidney Stone
- Lice
- Medications Actions
- Medications which Affect Mood
- Nose Bleed
- Sprains
- Td Vaccine Info. Packet
- URI
- UTI
- Vac. Curettage
- Vag. Bld. / Preg.
- Vaginal Infection
- V.D.
- Wound Care

REFERRED TO Dr. [redacted] partner for check-up tomorrow Phone # _____

- Private Physician
- Other _____

- When calling for an appointment, please inform the physician's office you were referred by the Emergency Department.
- Call for an appointment in _____ days weeks.
- If no improvement in _____ hours days, call your private physician or physician / clinic you have been referred to for an appointment.
- If your condition worsens, call your private physician or return to the Emergency Department.
- X-RAY: During your visit to the Emergency Department, x-rays were taken and provisionally read. The final reading will be done by a Board Certified Radiologist and a report will be sent to your private physician. If you have any questions or concerns relevant to your x-rays, please contact your family physician.

I understand that the treatment I have received was rendered on an emergency basis only and is NOT meant to take the place of complete care from a personal physician or clinic. If my condition worsens, I have been instructed to call my family physician or return to [redacted]. I have read and understand the above and received a copy of [redacted] and applicable instruction sheets and I will arrange for follow-up care.

X _____ Patient Relative Friend

WORK / SCHOOL STATEMENT from [redacted]

- Patient was seen by Dr. _____ See Occupational Health Referral Sheet
- May return to work / school WITHOUT restrictions.
- Will require time off work / school. Estimated time _____ days
- May return to RESTRICTED duties for _____ days.

Restrictions _____

- Must be re-evaluated by physician / Occupational Health before returning to work / school.
- Other _____

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Signature RN / MD _____

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Exhibit 12 of 28

NAME: [REDACTED] MR#: [REDACTED] PHYS: [REDACTED]
DOB/AGE: [REDACTED] 38 WARD: [REDACTED]
SEX: F ACCT#: [REDACTED] BED: [REDACTED]

PRINTED 10/01/98 @ 0410
SUMMARY COVERS TESTS ORDERED >= 9/01/98

***** FINAL REPORTS *****

>>>>> CHEMISTRY -- CARDIAC MARKERS <<<<<<

TROPONIN I (NG/ML): <0.6 - NORMAL
0.6 - 2.0 - INDETERMINATE; [REDACTED]
>2.0 - STRONGLY SUSP. FOR CV DIS.; REC. F/U
>2.0 WITH SERIAL RISE C/W ACUTE M.I.

TROPONIN I
0.1-0.5
NG/ML

DATE TIME
9/30D1542* <0.3

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CLINICAL LABORATORIES REPORT - PERMANENT RECORD - DO NOT DESTROY
65-71265



RADIOLOGY EXAM

NAME [REDACTED]
DOS 09/30/98 REQ NO [REDACTED]
READ 09/30/98 TYPED 10/02/98 08:22
RADIOLOGIST [REDACTED]

PAT ID [REDACTED] DOB [REDACTED]
REFERRED BY COURTESY, UNKNOW
TYPED BY [REDACTED] LOCATION [REDACTED]
CONSULT [REDACTED]

CHEST, PA AND LATERAL 9/30/98

CLINICAL INFORMATION: Chest pain.

Cardiac monitors and electrodes overlie the chest. The heart and pulmonary vessels are of normal size and appearance. Both lungs are clear and are fully expanded. There is no evidence of active pulmonary or cardiac disease.

**

CONCLUSION:
Negative PA and lateral chest exam.
##

TECH [REDACTED]
D&T: 9-30:10-2-98

DR [REDACTED]

APPROVED BY [REDACTED]

39years
Female
Caucasian

Vent. rate 85 bpm
PR interval 134 ms
QRS duration 68 ms
QT/QTc 342/407 ms
P-R-T axes 70 30 41

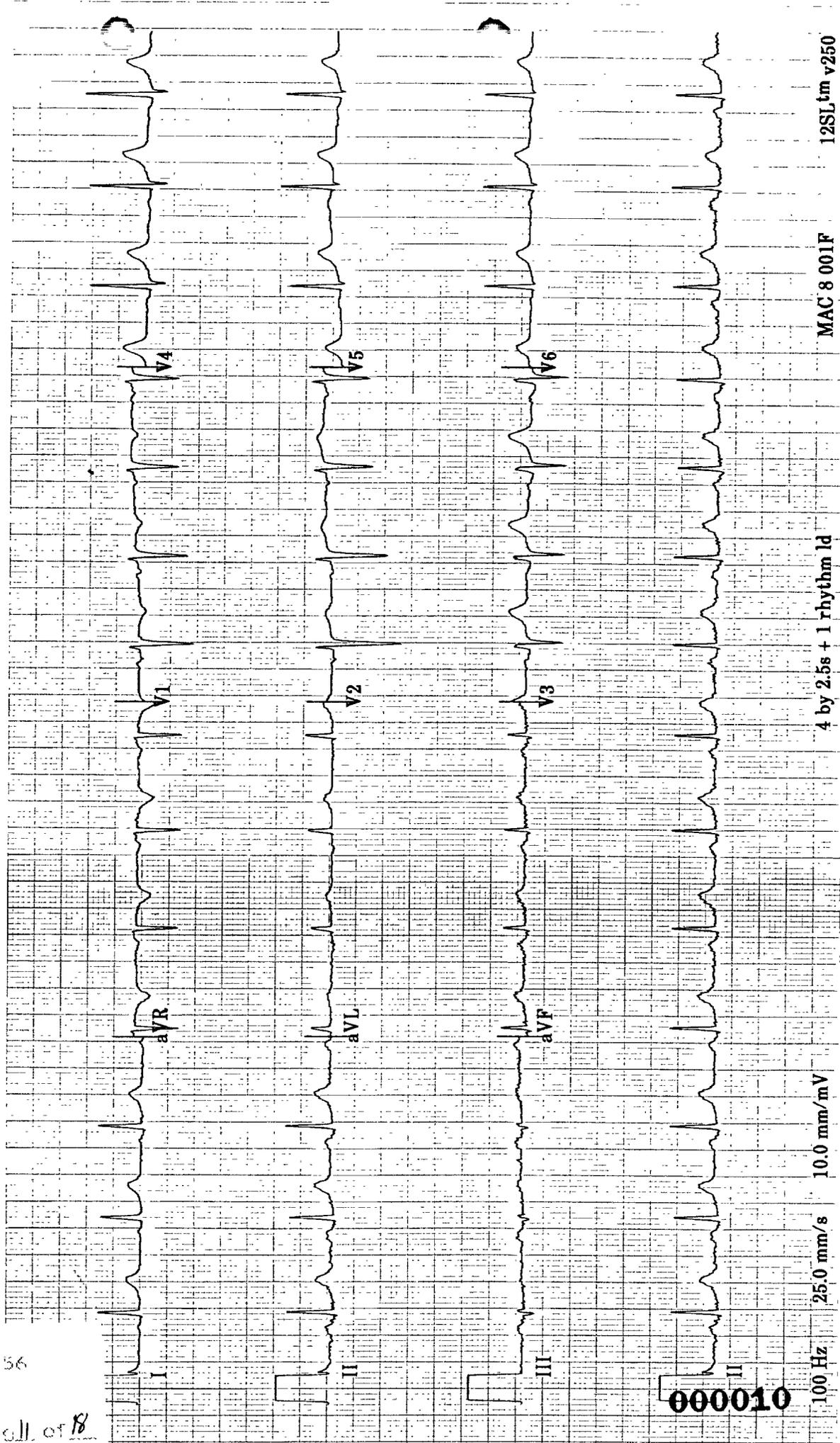
Room: [redacted]
Loc: [redacted]

Technician: [redacted]

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Exhibit A poll of 18

Unconfirmed



000010

100 Hz 25.0 mm/s 10.0 mm/mV

4 by 2.5s + 1 rhythm ld

MAC 8 001F

12SL™ v250

**SPECIAL DIAGNOSTICS
DOPPLER-ECHOCARDIOGRAM REPORT**

OP
A:
O:
I:
DATE: 10/07/98

F

Transthoracic: XX Transesophageal:

Refer: **Attend: Dr.** [REDACTED]

Address: Fax [REDACTED] /

Preliminary Diagnosis: Pericarditis

Age: 38 **HT:** **WT:** **BP:** **Tape:** [REDACTED] **Begins:** 22:28 **Tech:** [REDACTED]

Codes: WNL = Within Normal Limits, AB = Abnormal, NO = Not Obtained, VR = Valve Replacement, SB = See Below, P = Peak, M = Mean, A = Area

3.0	Aorta (3.7 cm)	SB	Aortic Valve	Doppler	WNL
3.9	LA (4.0 cm)	WNL	Mitral Valve	Doppler	Mild MR
2.7	RV (3.0 cm)	WNL	Tricuspid Valve	Doppler	2.7 m/s
4.3	LVd (5.6 cm)	WNL	Pulmonic Valve	Doppler	WNL
3.0	LVs (variable)	WNL	LVF	DIASTOLIC FUNCTION:	
1.1	IVSd (1.2 cm)	64	% EF = Cubed	DT insp (ms)	199±32: 155
1.2	IVSs (variable)	60	% Est. EF	IVRT (ms)	76±13 > 40 yo: 100
0.8	LVPWd (1.2 cm)		Planimetered EF	E Vel (cm/s)	86±16: 114
1.4	LVPWs (vari)	SB	Pericardial Eff	A Vel (cm/s)	56±13: 671.
95	LVOT diameter			E-A Ratio	1.6±.5: 1.7:1
				Ma (ms)	<0.4: 120
				PVa (ms):	85

Heart Rate
Quality:

Rhythm
Other:

INTERPRETATION:

INDICATION: Pericarditis; rule out pericardial effusion or tamponade.

Transthoracic two-dimensional, M-mode, color and Spectral Doppler images were performed.

INTERPRETATION: Left ventricular size and systolic performance were normal. Estimated ejection fraction was 60% and there were no regional wall motion abnormalities. Left ventricular wall thickness was normal.

Right ventricular size was at the upper limits of normal. Right ventricular systolic performance appeared to be normal.

The aortic valve was trileaflet with mild nonspecific thickening of

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the leaflets. Leaflet excursion was normal and there was no evidence of aortic stenosis or insufficiency.

The mitral valve was structurally normal with Doppler evidence of mild mitral regurgitation, into a left atrium which was at the upper limits of normal in size.

The tricuspid valve was within normal limits structurally normal and there was trace to mild tricuspid insufficiency, into a normal sized right atrium. The peak velocity of the tricuspid regurgitant jet was 2.7 m/s, yielding an estimated right ventricular and pulmonary artery systolic pressure of 29 mmHg plus right atrial pressure.

The pulmonic valve was structurally normal and there was no pulmonic insufficiency. The pulmonary artery was normal in dimension.

The aortic root was normal.

Doppler parameters of left ventricular diastolic function were normal. Mild respiratory variation was seen on the mitral inflow Doppler velocity of the E wave but this was less than 25%.

There was no significant pericardial effusion. A small fluid collection was seen posterior to the left atrium and in the left atrioventricular groove, in some views. This amount of fluid was probably within normal limits.

The inferior vena cava and interatrial septum were poorly visualized from subcostal views.

- IMPRESSION:
1. Normal left ventricular systolic function, without regional wall motion abnormalities and ejection fraction of 60%.
 2. Trace pericardial fluid, probably within normal limits.
 3. No echocardiographic evidence of tamponade physiology.
 4. Structurally normal intracardiac valve with trace to mild mitral and trace tricuspid insufficiency.
 5. Upper normal to mildly elevated pulmonary artery pressure.

10-12-98

M.D.

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