Hoffman, Jeanne Leonie

MRN: U8170135

Barnes, James Irvin, MD
Physician
Internal Medicine

Discharge Summary
Signed

Date of Service: 3/8/2025 8:29 AM

Discharge Summary

Jeanne Leonie Hoffman ("Jeanne") - DOB: 1/6/1925 (100 year old female)
Gender Identity: Female Pronouns: she/her/hers
PCP: Navalurkar, Reema, MD
Code Status: DNR DNR/DNI

DATE OF ADMISSION: 1/9/2025
DATE OF DISCHARGE: 03/08/25
DISCHARGE TEAM & ATTENDING: Medicine E Gen Adults & Barnes, James Irvin, MD

ADMISSION DIAGNOSIS: acute limb ischemia
DISCHARGE DIAGNOSIS: acute limb ischemia, now s/p L AKA. Course complicated by post-operative bradycardia and new intermittent Mobitz II heart block requiring temporary TVP, now s/p PPM 1/13.

PROBLEMS ADDRESSED DURING THIS HOSPITALIZATION:
Principal Problem:
 Acute lower limb ischemia
Active Problems:
 Bradycardia
 Abdominal pain
Resolved Problems:
 * No resolved hospital problems. *

DISCHARGE FOLLOW-UP VISITS/APPOINTMENTS:
Upcoming appointments at UW Medicine:

Future Appointments

Date	Time	Provider	Department	Center
3/21/2025	1:00 PM	EP APP	U3HEART	UWMC CARD
4/3/2025	2:30 PM	Smith, Matthew C, MD	UVASC	UWMC SURGICA
5/12/2025	8:30 AM	Kawaguchi, Lauren Y, AUD	U3AUDIOL	UWMC OTOLARY
5/14/2025	8:05 AM	UWMC CARDIAC DEVICE REMOTE-MONTLAKE	U3HEART	UWMC CARD
1/16/2026	10:00 AM	Akoum, Nazem Walid, MD	U3HEART	UWMC CARD

Additional follow-up:
Navalurkar, Reema, MD
1959 NE Pacific St
Box 359755
Seattle WA 98195
206-744-8513

Follow up

PENDING RESULTS THAT REQUIRE FOLLOW-UP (*as of this summary*):

Pending Labs

Order	Current Status
1st Extra Urine Tube	In process

F/U recommended
- Ongoing goals of care discussion
- f/u with cardiology EP
- f/u with rehab medicine
- f/u with orthopedics surgery
- f/u with vascular surgery

THERAPEUTIC RECOMMENDATIONS:
- we have recommended limited interventions, as below. Remains on lovenox for dvt prophylaxis and other meds as below. Some meds such as asa and atorvastatin have been stopped at this point and if she can tolerate po this may need to be revisited depending on GOC, Rectal tylenol and high concentration oxycodone PO for pain

ALLERGIES:
Adhesives, Aspirin, Nitrofurantoin, Penicillins, and Sulfa antibiotics

DISCHARGE MEDICATIONS:
Current Discharge Medication List

START taking these medications

	Details
acetaminophen 650 MG suppository	Unwrap and insert 1 suppository (650 mg) rectally every 6 hours as needed for mild pain, moderate pain or severe pain.
atropine 1% ophthalmic solution (for oral use)	Place 2 drops under the tongue every 4 hours as needed for secretions.
bisacodyl 10 MG suppository	Unwrap and insert 1 suppository (10 mg) rectally daily as needed for constipation.
buprenorphine 5 MCG/HR patch	Place 1 patch on the skin every 7 days. *Qty:* 2 patch, *Refills:* 0
camphor-menthol 0.5-0.5 % lotion	Apply topically 2 times a day as needed for itching.
carboxymethylcellulose 0.5 % ophthalmic solution	Place 1 drop in each EYE every hour as needed for dry eyes.
enoxaparin 30 MG/0.3ML prefilled syringe	Inject 0.3 mL (30 mg) under the skin at bedtime.
magnesium hydroxide 400 MG/5ML suspension	Take 30 mL by mouth 2 times a day as needed for constipation.
oxyCODONE CONCENTRATED 100 MG/5ML concentrate solution	2.5-5mg Oral, Every 4 hours PRN For pain *Qty:* 30 mL, *Refills:* 0
phenol 1.4 % mouth/throat spray	Place 1 spray to the mouth or throat every 2 hours as needed for sore throat.
psyllium 51.7 % packet	Take 1 packet by mouth 2 times a day. Mix in 8 oz of juice or water and drink.
saliva substitute (Biotene Dry Mouth) liquid oral rinse	Swish and spit 15 mL 3 times a day.
scopolamine 1 MG/3DAYS patch	Place 1 patch on the skin every 72 hours as needed for other (for secretions if atropine, glycopyrrolate are insufficient). Apply to hairless area behind 1 ear.

white petrolatum gel	Apply topically as needed for dry skin.

CONTINUE these medications which have NOT CHANGED

	Details
lidocaine 4 % patch	Apply 1 patch onto the skin every 24 hours. Apply to painful area for up to 12 hours in a 24 hour period. *Qty:* 15 each, *Refills:* 0

STOP taking these medications

atorvastatin 10 MG tablet	*Comments:* *Reason for Stopping:*
Cholecalciferol 1000 units Oral Tab	*Comments:* *Reason for Stopping:*
Cyanocobalamin (VITAMIN B-12 OR)	*Comments:* *Reason for Stopping:*
MULTIPLE VITAMIN OR	*Comments:* *Reason for Stopping:*
pentoxifylline ER 400 MG ER tablet	*Comments:* *Reason for Stopping:*
timolol maleate 0.5 % ophthalmic solution	*Comments:* *Reason for Stopping:*
Wound Dressings (medihoney) topical gel	*Comments:* *Reason for Stopping:*
Wound Dressings (medihoney) topical gel	*Comments:* *Reason for Stopping:*

HOSPITAL COURSE:
Brief Admission History:
Per 1/9 admit note by Dr. Schwarz: *"100F w/h/o hx of HTN, T2DM, HLD, prior DVT (previously on warfarin), chronic venous disease (s/p prior saphenous stripping), and known PAD without known history of arterial intervention. She lives with her son, who notes that the chronic wounds at her LLE blackened ~2 days ago and she endorses increased pain in the leg around this time period. Subsequent symptom progression is unclear but her son notes that he noticed the leg was normal at around 6AM but had grown acutely discolored at 0730. He brought her directly to the ED. On arrival is bradycardic to the low 40s with EKG showing new RBBB but normal troponins. Normal range BP and mentating at baseline - able to answer questions appropriately. Labs notable for Cr 1.1, WBC 13.8, venous lactate 1.6; normal range trops, INR 1.1. On initial ED evaluation was noted to have no pulses so got CTA and consulted our service for evaluation.*
The CTA demonstrated acute occlusion of the L EIA through the entire axial arterial system to the foot - PFA remains open via collaterals through the hypogastric. There is no occlusion of the RLE. She has no sensation from toes through mid/upper shin, foot is in fixed plantar-flexion, skin is cold and mottled. She has tenderness to palpation of the upper calf region."

Hospital Course:
100 year old female with a PMH notable for HTN, T2DM, HLD, prior DVT, PAD who initially presented to the hospital on 1/9/25 with acute limb ischemia, now s/p L AKA. Course complicated by post-operative bradycardia and new intermittent Mobitz II heart block requiring temporary TVP, now s/p PPM 1/13 with course c/b delirium.

Pt was admitted as above. She initially underwent L AKA on 1/9/25 with vascular surgery. She subsequently developed symptomatic bradycardia w/ 2nd degree heart block necessitating TVP and eventual PPM placement on 1/13.

Post-operatively, she developed significant acute pain related to her AKA. Her pain was initially managed by APS w/ nubain patch and nalbuphine + PRN tylenol.

She unfortunately developed progressive encephalopathy with at least a component of delirium. This waxed and waned throughout her hospitalization but overall worsened. Related to this, she had ongoing dysphagia and high aspiration risk. As a result, she developed aspiration pneumonitis. It is felt that her ongoing aspiration likely worsened her delirium, which in turn increased her aspiration risk. Because of this, she was made NPO initially. Palliative care was consulted for assistance with assessing goals of care for Jeanne. This primarily occurred through discussion with her son, Louis, who is her POA. He felt that Jeanne would want everything because she is a fighter. There was ongoing push to do everything possible to extend Jeanne's life despite high risks. After multidisciplinary meetings between providers involved in her care including ethics, it was determined that Louis is likely acting in accordance with Jeanne's wishes, as she had previously noted she would want to be full code, have enteral nutrition, etc.

Given the aforementioned aspiration risk, Jeanne was NPO. However, after a GOC conversation, Louis felt that Jeanne would want to continue to eat by mouth. She continued to have ongoing aspirations and worsening respiratory status until she was made NPO again after being placed on high flow oxygen. At this point, Louis felt that the team should do everything to pursue an NG tube. Multiple attempts with bedside nursing were made to place an NG tube, but Jeanne became very agitate and resisted all attempts. She was given minimal sedation with low-dose ativan and had attempted placement under fluoroscopy, which failed. At this point, the team was able to place a peripheral IV and the decision was made to trial ~48 hours of IV fluids with dextrose to see if this helped her perk up.

Over the time she was receiving IV fluids, Jeanne developed pulmonary edema and worsening respiratory status again. This was likely multifactorial related to pulmonary edema and aspiration. She required high flow. Louis was adamant that was must get a feeding tube in her to address her nutrition. This was discussed with GI who agreed that she was too high risk to undergo anesthesia to have an endoscopically placed NG tube. After multiple prolonged goals of care discussions with Louis, she was ultimately made comfort care. We expressed to him that we are unable to place an NG tube due to tenuous clinical status and that overall, even if we could, this may even lead to more harm than benefit regardless due to aspiration risk of tube feeds. Louis intermittently continued to request aggressive treatments despite risks being too high, stating "she's going to die anyway", and so felt that we might as well try even if she were to "die on the table". We expressed that this would be doing harm and would not be offered.

Despite the transition to comfort measures only, patient continued to do well. She was eventually transitioned only to blow-by oxygen and even that became no longer necessary. She would rapidly desaturate with movement however her oxygen monitoring remained only intermittent. Multiple conversations were had with her son regarding the appropriate course of care. Discussions included transitioning the patient back to full care and treatment however many aspects of this treatment plan were not in line with with the care team thought was appropriate and ethical for the patient as well as what Luis thought she could tolerate. Aggressive inpatient management including daily IV draws and having to address patient's feeding were not likely to be of benefit to her quality of life. While the patient did show some improvement over the last several days, her overall prognosis is still poor to fair and it was agreed upon with the healthcare team and with the patient's son that her best interest is found in staying a comfort measures only patient with some "out of the box "comfort measures care. As such, she became a modified comfort measures patient with a general approach of minimum necessary escalation of care. For example, while systemic antibiotics would be contraindicated, patient developed what appeared to be a infected left parotid gland likely from poor p.o. intake and a dry oral mucosa. It was reasonable within the goals of care to prescribe 5 days of oral antibiotics to treat this. She also had a very mild erythema present at a picked off the scab from her left AKA site and it was reasonable to provide basic wound care. DVT prophylaxis also was a reasonable minimal necessary escalation of care. Patient's son began requesting more and more things that were starting to borderline on some care package between comfort measures and full care and so each of these issues need to be dealt with on an as needed and as provider determined appropriate basis. This happened in conjunction with nursing staff. Due to patient's incredibly high aspiration risk, it was made clear to Lewis on a near daily basis that we did not recommend feeding her anything at all however, as long as Lewis excepted the risk, we stated that it was okay if he were to feed her, and so he has done so. In fact, it is likely Luis is persistent fluid administration 2 water bottles and straws that the patient managed to do so well. Ultimately, her plan was Bainbridge rehab and this was agreed upon by all parties.

 # By problem

 # Right hip fracture
- fall in hospital on 3/5 with R hip fracture, non -op management decided upon based on very high operative risks.
- patient's son reported he internally rotated her leg to "set it" and we will repeat 2V femur xray - d/w orthoi and looks

like there is no intervention needed after this manipulation by son
- I have reiterated that he should not do this. If he does this again I think we need to have a discussion about him not being in her room. He reported he would not do this again.
- brace placed by orthotics on 3/7 at request of son and with guidance from orthotics and ortho.
- NWB on Right leg
- Should limit motion of leg (ideally no ROM of R leg)
- abduction pillow
- log rolls for turning
- hip-spica brace now in place settings 0-60, slight abduction, can take off if uncomfortable and when needed (was not strictly recommended at this point by ortho, patient and son prefer it to be on)
- referral to NW ortho trauma clinic made, 2 view femur xray to be performed 3/13/25 (ordered as outpatient in case it needs to be done here vs at SNF)
- concentrated oxycodone for pain (low dose 2.5 - 5 mg)
- will continue lovenox for now

#Superficial infection of left stump site
#Mild parotitis
Will provide patient with 5-day course of crushable p.o. antibiotic to cover for parotitis infection which is limiting patient's quality of life at this time (completed). Also will instruct nursing staff to perform basic wound care on left stump site such as Betadine antiseptic and bandage care. Adhering to minimum necessary escalation of care

#Aspiration risk, ongoing
#malnutrition, protein-calorie, worsening since admission
SLP has been following & coordinating with son. Had a risk:benefit discussion, explained the patient will always be an aspiration risk. TF are not within GOC and son understands the challenge of her nutrition status in setting of delirium and aspiration risk. He acknowledges the aspiration risk and would like to continue PO nutrition with strict aspiration precautions. PO intake has been overall low since admission with contributors including delirium and need for 1:1 feeding, poor appetite.
- continues on 1:1 feeding with minced diet with thin liquids and strict aspiration precautions; son has been feeding her.

#Acute pain 2/2 recent L above knee amputation
#new back pain 2/7, presumed MSK related to sling transfer
APS signed off on 1/18 given significant improvement in pain. Will engaged PRN. Note she initially had difficult to control pain which improved with buprenorphine patch and was able to DC PRN nalbuphine. Still having some pain on mobilization of stump but otherwise seems pretty comfortable. There was c/f withdrawal/pain when patch was accidentally stopped/fell off MAR on 1/24. s/p Ropivacaine
- APAP Q8H
-Buprenorphine patch 5mcg q7 days

#PAD, c/b
#Acute limb ischemia
#S/p L AKA (1/9/25, Smith)
Seen by vascular surgery weekly, last 2/10 with well approximated incision.
- No activity restrictions from AKA standpoint for PT/OT. Fall risk.
- Dressing management in orders. Betadine paint, dry dressing, ACE wrap for compression. Nursing doing this daily.
- NWB LLE per Vascular Surgery
- has outpatient f/u 4/2/25
- was on ASA 81 mg daily, atorvastatin 10 mg daily which was dc'd during transition to modified comfort care, may require ongoing discussions with son . Previously was on pentoxifylline at home, but was not recommended by vascular surgery at this point
<u>Per PMR</u>
- nutrition and proper wound care in the recovery of the residual limb.
- Agree with physical therapy consult to work on functional transfer, therapeutic exercise, appropriate wheelchair fit recommendations and other equipment needs such as shower bench, commode chair.
- Recommend supine left lower extremity hip extension exercises, as tolerated, to prevent left hip flexion contractures.
- Consider mirror therapy or visualization techniques to help with phantom limb sensation (ie feeling that the left foot or ankle are in uncomfortable positions).
- Possible **follow-up in rehab amputee clinic after discharge depending on GOC, referral placed**

#bilateral pleural effusions
Present since admission with some increase from mild on 1/9 to moderate on 1/27 and stable since then. Concurrent presence of pulmonary edema indicates extracellular volume overload as likely cause. While her BNP 2/4 was

elevated, her cardiac function appeared normal on 1/10 (albeit while bradycardic). Her albumin has been downtrending so she may have third spacing related to low protein and malnutrition. Currently she does not have respiratory symptoms (SOB or hypoxia). In this setting I think direct intervention (either diuresis or thoracentesis) would be more harmful than beneficial; I reviewed this with her son on 2/4 and he was in agreement. Overall improving her nutrition (and subsequently her albumin) may help, see nutrition section above.

#Mild normocytic anemia, stable
-thought 2/2 chronic disease and recent surgery, no changes while inpatient

#Symptomatic bradycardia
#2nd degree AV block
#S/p Transvenous pacemaker placement (1/10)
#S/p PPM placement (1/13)
Noted to be bradycardic to the 20-30's post-operatively, asymptomatic and hemodynamically stable. Became symptomatically bradycardic on 1/10 despite dopamine gtt and atropine pushes; taken to cath lab for TVP placement with interventional cardiology. PPM placement on 1/13. Paced at 70bpm, hemodynamically stable off pressors.
-Added to EP follow up list and will be called to schedule an appointment.
Device care instructions:
- May shower, gently clean wound with soap and water without scrubbing; do not soak/immerse until incision is fully healed
- scheduled for f/u in EP clinic 3/21/25

#T2DM
BG in low 100s, discontinued SSI since not triggering insulin

Prior to admission, was on:
- timolol 0.5% opth 1 drop both eyes bid (glaucoma)
- b12 PO daily (unckear dose)
- Vitamin d 2000 units daily
- multivitamin

GOC note from palliative care discussion:
"INTERVAL HISTORY:
-Discussed case with Dr. Barnes. Jeanne had R femur fracture in the setting of a fall. No surgical intervention, is non-weightbearing. Plan was for Jeanne to d/c to SNF today for rehab, however, she required SQ hydromorphone overnight. Is now transitioned to an oral regimen.
-Per discussion with Dr. Barnes, son Louis expressed desire for Jeanne to be full code upon discharge. This topic came up with completing POLST. Dr. Barnes and I made plans to follow up for further discussion. Jeanne has been more somnolent this morning.
-Dr. Barnes and I discussed case with bedside RN Rosalie and charge RN Alex. Rosalie shared that Louis has been requesting a brace for Jeanne's leg to help stabilize it. Per discussion with Dr. Barnes, Louis manipulated Jeanne's leg trying to "set it".

Dr. Barnes, Rosalie Puleo RN, and I met bedside with Louis. Initially, Louis shared a desire for his mom to have a brace placed to stabilize her leg. He had done some research on is own and had some ideas about possible options. Louis shared worry that if her leg is not stabilized she will have severe pain with turns, which she will need to have for things such as toileting. He shared that she is quite sensitive to pain medications. If she becomes sedated from pain medications then she will not eat and then will eventually starve to death. I reflected to Louis that we were facing her decreased intake weeks ago and that it seems like this has been up and down. Louis shared that he wants to give his mom a chance to recover.

We shared worry with Louis that Jeanne will continue to have complications and may not be able to recover and may be close to EOL. He shared that he knows that she will survive and will be able to get better.

We discussed with Louis standard of care and ortho recs for no brace, log roll turns. Louis shared how important it is to him for Jeanne to have her leg as stable as possible to have the best chance at recovery. We discussed that pain management will still be necessary as part of her care plan. He was accepting of this and expressed a desire to minimize opioids as much as possible.

We then addressed code status. Shared with Louis our perspective that providing interventions such as CPR or a breathing tube are unlinely to be helpful to Jeanne given her comorbidities and current clinical situation. Louis shared a hope for peace at EOL and also does not want to take things off of the table when she leaves the hospital. Shared that a peaceful EOL for Jeanne would not involve CPR. We asked Louis what his plan would be if his mom does not

improve and continues to worsen. Louis shared taht eh would be willing to re-evaluate in the moment and make the decision.

...

IMPRESSION: *Jeanne remains hospitalized and has been stable on comfort care for the past few weeks. She recently sustained a femur fracture which has increased her pain. Her son Louis has concerns about ongoing pain and has requested a brace to support her leg. At this time his is hoping for recovery and would like for his mom to remain full code. If things chance and his mom is clearly declining, then he is willing to consider changing her code status to DNR/ DNI. At this time Louis hopes for rehab oriented care for his mom.*

RECOMMENDATIONS:
-Continue with current level of care. Louis would like code status changed to full code upon discharge from the hospital. Will leave code status as DNR/DNI and continue with comfort oriented care. Dr. Barnes and I are in agreement that full code status would not be medically appropriate at this time.
-Appreciate orthotics support with getting a brace for Jeanne if possible.
-Recommend trial of scheduled tylenol suppository (recommend Q8 hour dosing with turns).
-Recommend oxycodone 2.5-5mg PO Q8 hours PRN pain. Will be helpful to premedicate before turns.
-Louis is willing to reconsider POLST and changing code status in the future should Jeanne continue to clinically declline or not tolerate rehab oriented care.

Patient discussed with nursing and Discussed with primary team"

Key Diagnostic Studies:
XR Femur 2 Vw Right
Final Result by Rehwald, Christine Marie, MD (03/07 1805)
Redemonstration of the peri-implant femur fracture with decreased angulation. Similar shortening and anterior translation by one half shaft width. Prior ORIF of the right femoral neck and plate and screw fixation of the right femoral shaft. Prominent screw head of the proximal most lateral femoral plate. Diffuse osseous demineralization. Vascular calcifications.

I have personally reviewed the images and agree with the report (or as edited).

XR Femur 2 Vw Right
Final Result by Rich, Natalie, MD (03/06 1011)
PELVIS: Acute comminuted impacted peri-implant right femur fracture with varus angulation. Prior ORIF of the right femoral neck and plate and screw fixation of the right femoral shaft. Moderate left hip osteoarthritis. Diffuse osseous demineralization limits evaluation for nondisplaced fractures. Vascular calcifications.

RIGHT FEMUR: Acute comminuted peri-implant femur fracture with varus angulation and up to 8 cm of impaction. Prior ORIF of the right femoral neck and plate and screw fixation of the right femoral shaft. Diffuse osseous demineralization. Vascular calcifications. Limited evaluation of the contralateral left lower extremity demonstrates an above knee amputation.

XR Pelvis 1-2 Vw
Final Result by Rich, Natalie, MD (03/06 1011)
PELVIS: Acute comminuted impacted peri-implant right femur fracture with varus angulation. Prior ORIF of the right femoral neck and plate and screw fixation of the right femoral shaft. Moderate left hip osteoarthritis. Diffuse osseous demineralization limits evaluation for nondisplaced fractures. Vascular calcifications.

RIGHT FEMUR: Acute comminuted peri-implant femur fracture with varus angulation and up to 8 cm of impaction. Prior ORIF of the right femoral neck and plate and screw fixation of the right femoral shaft. Diffuse osseous demineralization. Vascular calcifications. Limited evaluation of the contralateral left lower extremity demonstrates an above knee amputation.

XR Chest 1 View
Final Result by Chalian, Hamid, MD (02/23 1201)
FINDINGS AND IMPRESSION:

Support apparatus: No significant interval change in position.

Heart and mediastinum: Cardiomediastinal silhouette is obscured

Lungs and pleura: Interval increase in bilateral pleural effusions and findings suggestive of pulmonary edema. Superimposed infection or aspiration cannot be excluded. No pneumothorax

Bones/soft tissue: Unchanged.

XR GI Tube Intro W Fluoro
Final Result by Dhyani, Manish, MD (02/20 1710)
Using guide wire and fluoroscopy, a weighted 10 French feeding tube was placed transnasally, however despite multiple attempts and lack of patient's cooperation, repeated attempts resulted in tracheal placement. After multiple attempts, and patient's inability to cooperate, the study was stopped without placement of tube.

Fluoroscopy time was 214 seconds.

PRESENCE STATEMENT:
I, Manish Dhyani, was present during the entire procedure, reviewed the images and agree with the report above.

CT Abdomen And Pelvis wo Contrast
Final Result by Dighe, Manjiri Kiran, MD (02/19 1314)
* Gallbladder distention without pericholecystic inflammation. Gallbladder ultrasound could be helpful for further evaluation, if clinically indicated.
* New bilateral moderate-volume pleural effusion and new reticular pulmonary parenchymal changes, which could suggest pneumonia in proper clinical settings.

I have personally reviewed the images and agree with the report (or as edited).

XR Abdomen 1 View
Final Result by Bhargava, Puneet, MD (02/18 1552)

Weighted enteric tube tip is in the lower third of the esophagus. Tube could be advanced further by 10 cm.

Lung findings are unchanged.

XR Chest 1 View
Final Result by Santos Lima, Ana Paula, MD (02/16 1033)

Lines and tubes: Unchanged.

Lungs: Decreased lung volume with bibasilar and perihilar consolidations likely atelectasis or aspiration. Superimposed edema is also conceivable.

Pleura: Increased bilateral small pleural effusions. No pneumothorax.

Heart and mediastinum: Unchanged.

XR Chest 1 View
Final Result by Gulhane V, Avanti, MD (02/03 1440)

Lines and tubes: Pacemaker electrode is unchanged in position.

Lungs: Pulmonary edema and bibasilar atelectasis persists.

Pleura: Moderate bilateral pleural effusions persist. No pneumothorax.

Heart and mediastinum: Unchanged.

XR Chest 1 View
Final Result by Godwin II, J David, MD (01/27 1008)
Compared to 1/25/2025, lung volume is even lower. Consolidation persists in midlungs and bases.

There are bilateral pleural effusions.

Heart size is unchanged. Pacemaker electrode position is unchanged, given different rotation.

XR Chest 1 View
Final Result by Cham, Matthew D, MD (01/25 1037)

Compared to 1/19/2025, lung volumes remain low. Increased bilateral mid and lower lung consolidation, likely edema superimposed with is basal atelectasis or aspiration.

Increased small pleural effusions. No pneumothorax.

Heart and mediastinum are unchanged.

I have personally reviewed the images and agree with the report (or as edited).

Vascular US Venous Duplex for DVT or Venous Obstruction Lower Extremity Right
Final Result by Zierler, Robert Eugene, MD (01/22 0921)

XR Chest 1 View
Final Result by Ordovas, Karen Gomes, MD (01/19 1218)

Lung volumes remain low with similar mild diffuse lung disease. Superimposed basal atelectasis or aspiration persists, but aeration of the bases is slightly improved.

Small pleural effusions persist. No pneumothorax.

Heart and mediastinum are unchanged.

I have personally reviewed the images and agree with the report (or as edited).

XR Chest 1 View
Final Result by Santos Lima, Ana Paula, MD (01/17 1314)

Lines and tubes: Right IJ central venous catheter has been removed

Lungs: Similar low lung volume with bibasilar atelectasis or aspiration.

Pleura: Small bilateral pleural effusions. No pneumothorax.

Heart and mediastinum: Unchanged.

XR Chest 2 View
Final Result by Godwin II, J David, MD (01/14 1056)
Compared to 1/13/2025, pacemaker electrode position is unchanged. Heart size is unchanged.

Lung volume is lower. Basal atelectasis or aspiration and bilateral pleural effusions persist.

XR Chest 1 View
Final Result by Godwin II, J David, MD (01/14 1003)
Compared to 1/12/2025, a pacemaker has been placed from the left subclavian vein with electrode in the right ventricular apex, as expected.

Heart size is normal and unchanged. Aorta is calcified, indicating atherosclerosis.

Lung volume is low. There is basal atelectasis or aspiration and there are bilateral pleural effusions.

No pneumothorax.

Electrophysiology procedure
Final Result by Akoum, Nazem Walid, MD (01/13 2118)

XR Chest 1 View
Final Result by Chalian, Hamid, MD (01/12 1322)
FINDINGS AND IMPRESSION:

Support apparatus: No significant interval change in position.

Heart and mediastinum: Cardiomediastinal silhouette is unchanged.

Lungs and pleura: Slight interval increase in left pleural effusion. Findings suggestive of pulmonary edema with a slight interval increase. Trace right pleural effusion. No pneumothorax.

Bones/soft tissue: Unchanged.

TransTHORACIC echo (TTE) complete
Final Result by Otto, Catherine M, MD (01/10 1826)

Cardiac catheterization
Final Result by Ayyoub, Alaa Samih, MD (01/10 1710)

Electrophysiology procedure
Final Result by Ayyoub, Alaa Samih, MD (01/10 1716)

XR Chest 1 View
Final Result by Santos Lima, Ana Paula, MD (01/10 1601)

Lines and tubes: Transvenous pacing wire tip terminates in the right ventricle.

Lungs: The lung volumes persist. Similar bibasilar consolidations, likely atelectasis or aspiration.

Pleura: Small left pleural effusion. No pneumothorax.

Heart and mediastinum: Unchanged.

I have personally reviewed the images and agree with the report (or as edited).

Cardiac catheterization
Final Result by Ayyoub, Alaa Samih, MD (01/10 1323)

CTA Abdomen Angio
Final Result by Hartman, Jason Brett, MD (01/09 1228)

Occlusion of the left lower extremity vasculature beginning at the left external iliac artery. There is associated skin thickening/swelling of the distal left lower extremity which likely represents edema. No associated subcutaneous emphysema or definitive evidence of necrotizing soft tissue infection.

XR Chest 1 View
Final Result by Hartman, Jason Brett, MD (01/09 1102)

Lines and tubes: None.

Lungs: Clear.

Pleura: No effusion. No pneumothorax.

Heart and mediastinum: Unremarkable.

Bones: No acute or suspicious abnormality.

XR Femur 2 Vw Bilat (Results Pending)

Procedures/Dates:
L AKA amputation 1/19/2025
Transvenous pacer 1/10/2025
Pacemaker placement 1/13/2025

Tube/Line/Drain Care Orders / Instructions:
none

Consults:
PT
OT
MICU
Ortho
Cardiology, Electrophysiology
Vascular Surgery
Nutrition
Speech & Language Pathology
Pain Medicine
Palliative Care
Physical Medicine & Rehabilitation
Prosthetics
SW

DISPOSITION:
03 SNF-SKILLED NURSING FACILITY [03]

CONDITION: stable

CONSULTS COMPLETED:
IP CONSULT TO PAIN MANAGEMENT
IP CONSULT TO CARDIOLOGY
IP CONSULT TO NUTRITION SERVICES
IP CONSULT TO SOCIAL WORK
INPATIENT CONSULT TO WOUND THERAPY
IP CONSULT TO PALLIATIVE CARE
IP CONSULT TO NUTRITION SERVICES
IP CONSULT TO NUTRITION SERVICES
IP CONSULT TO NUTRITION SERVICES
IP CONSULT TO NUTRITION SERVICES

IP CONSULT TO PHYSICAL MEDICINE REHAB
IP CONSULT TO PROSTHETICS AND ORTHOTICS
IP CONSULT TO NUTRITION SERVICES
INPATIENT CONSULT TO VASCULAR ACCESS TEAM
INPATIENT CONSULT TO VASCULAR ACCESS TEAM
INPATIENT CONSULT TO VASCULAR ACCESS TEAM
IP CONSULT TO NUTRITION SERVICES
IP CONSULT TO SPIRITUAL CARE
IP CONSULT TO SPIRITUAL CARE
IP CONSULT TO SPIRITUAL CARE
IP CONSULT TO PROSTHETICS AND ORTHOTICS

Discharge Orders

XR Femur 2 Vw Bilat

Standing Status: Future *Standing Exp. Date:* 04/07/26

Reason for exam (include signs, symptoms, diagnosis, and medical history)? — 3/13/25 Femur fracture f/u imaging as requested for this date by orthopedic surgery team
Does the patient require sedation or anesthesia? — None
Release Result to Patient — Immediate

Referral to Fractures/Trauma

Standing Status: Future
Referral Priority: Routine
Referral Type: Specialty Visit
Number of Visits Requested: 1

Referral to Rehabilitation Medicine

Standing Status: Future
Referral Priority: Routine
Referral Type: Rehab
Number of Visits Requested: 1

Discharge Summary: Enclosed

Patient Aware of Diagnosis: Yes

Activity (specify)

Order Comments:
- brace placed by orthotics on 3/7 at request of son and with guidance from orthotics and ortho.
- NWB on Right leg
- Should limit motion of leg (ideally no ROM of R leg)
- abduction pillow
- log rolls for turning
- hip-spica brace now in place settings 0-60, slight abduction, can take off if uncomfortable and when needed (was not strictly recommended at this point by ortho, patient and son prefer it to be on).
- referral to NW ortho trauma clinic made, 2 view femur xray to be performed 3/13/25 (ordered as outpatient in case it needs to be done here vs at SNF)
- NWB on Left leg

Adult Discharge Diet (Specify)

Order Comments: As tolerated, aspiration risk

Diet type: Regular
Carbohydrate level: Carbohydrate managed

DISCHARGE PHYSICAL EXAM:

Vitals (Most recent in last 24 hrs)
T: (not recorded) **BP:** (not recorded) **HR:** (not recorded) **RR:** (not recorded) **SpO2:** (not recorded) Room air **T range:** No data recorded Admit weight: 45.5 kg (100 lb 6.4 oz) (01/09/25 1033)

Last weight: 45.7 kg (100 lb 12 oz) (02/21/25 0749)

Physical Exam

NAD, comfortable appearing; sitting up in bed,
EOMI, edentulous. Left parotid gland appears to be improved and is no longer erythematous.
No increased WOB, Decreased air movement. Crackles bilaterally mild.
Abd soft, NTND
No pretibial edema
no rash or concerning lesion of exposed skin. Incision site medial aspect with scab that appears picked off. No discolored drainage though there is some superficial white slough and 1-2mm of erythema.
Alert, no gross focal deficits, +dysarthria, seems to respond to question (though not intelligible) but interactive and able to prompt when wants something, interactive
Mood/affect congruent
RLE- wwp, pulses palpable

ATTENDING TIME STATEMENT:
I spent more than 30 minutes on hospital discharge day management.

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Electronically signed by Barnes, James Irvin, MD at 3/8/2025 9:57 AM

Revision History

Date/Time	User	Provider Type	Action
3/8/2025 9:57 AM	Barnes, James Irvin, MD	Physician	Sign
3/8/2025 8:44 AM	Barnes, James Irvin, MD	Physician	Share