Duke Eye Center

PADDOCK, KAREN
Appt : 12/7/2012 10:45 AM
DOB : 9/3/1969

Friday, December 07, 2012

DUKE EYE CENTER AT PAGE ROAD

To whom it may concern;

Mrs Karen Paddock is currently 43 yr 3 mo old, and comes today for vision going completly black in both eyes for 10-15 minutes this morning. Pt states her vision gradually came back but if she moves either her head or eyes too quickly it will go black again. Pt recently has a lumbar puncture on 12/3/12 to remove fluid. Pt was in a MVA 23 yrs ago and had headaches ever since. 6-7 weeks ago Dr. Grey patched leaks in her spinal colum and since then she has had too much fluid on her brain which she has had 2 LP's done. She has been dizzy, nauseated, states her mouth is very dry. opening pressure on Monday 15mm Hg, and on Wednesday 20mmHg
CHIEF COMPLAINT: black vision ou x 10-15 minurtes

Patient History
PAST MEDICAL HISTORY:
1) ? psuedo tumor)
SURGICAL HISTORY:
1) Lumbar puncture

PAST OCULAR HISTORY:
1) None
NEUROPSYCHIATRIC:
ALERT AND ORIENTED TO PERSON- PLACE- AND TIME
MOOD AND AFFECT APPROPRIATE

Medications/Allergies
CURRENT MEDICATIONS: HCTZ, Diamox 250 mg (5 x daily) , Amitriptyline, Phenergan, Benadryl, Zomig, Neurontin, Klor-con, Morphine(prn), Oxycodone(prn)
OCULAR MEDICATIONS: None
DRUG ALLERGIES: Pcn

REVIEW OF SYSTEMS
On review of systems, Mrs Paddock's general health, HENT, respiratory, cardiovascular, gastrointestinal, genital/urinary, musculoskeletal, skin, neurologic, psychiatric, and endocrine systems were unremarkable

VISUAL ACUITY
VISUAL ACUITY: (with current correction)
DISTANCE:
OD: 20/20
OS: 20/20

ANCILLARY TESTING
INTRAOCULAR PRESSURE:
Applanation: **OD:** 8 mm Hg - 11:30 AM
OS: 9 mm Hg - 11:30 AM
MOTILITY TESTING: Full, pain w/ mvmt

RAPD: NO

CONFRONTATION FIELDS:
OD: ftcf **OS:** ftcf

PUPILLARY EXAM:
OD: 3mm -> 2mm
OS: 3mm -> 2mm

Duke Eye Center

PADDOCK, KAREN
Appt : 12/7/2012 10:45 AM
DOB : 9/3/1969

ADDITIONAL TESTING

OCT:

OD: rnfl: central thickness 122

OS: rnfl: central thickness 116

HUMPHREY VISUAL FIELD:

OD: not reliable, poor head position with blind spot located inferiorly ou

OS: not reliable, poor head position with blind spot located inferiorly ou

COLOR VISION (HARDY-RAND-RITTLER):

OD: 9 out of 10 **OS:** 10 out of 10

SLIT LAMP EXAM:

	OD:	OS:
EXT:	wnl	wnl
L & L:	wnl	wnl
CJ/SC:	wnl	wnl
K:	clear	clear
IRIS:	wnl	wnl
AC:	Deep and quiet	Deep and quiet
LENS:	clear	clear
AV:	clear	clear
TF:	normal tear meniscus	normal tear meniscus

FUNDOSCOPIC - dilated: Duke Mix % (11:30 AM OU)

	OD:	OS:
VIT:	Clear	Clear
O:	C:D =0.2, mild nasal disc edema normal rim color	C:D =0.2, trace nasal disc edema vs no disc edema normal rim color
M:	wnl	wnl
V:	wnl	wnl
P:	wnl	wnl

DIAGNOSIS IMPRESSION:

Right Eye	Left Eye	Systemic
1. Papilledema, UNSP - 377.00	**1. Papilledema, UNSP - 377.00**	**1. HEADACHE - 784.0**

PROCEDURES:

Procedures
1. 99244 - Comp. - moderate - 99244 -
2. 92083 - Extensive visual field - 92083 -
3. 92250 - Fundus photos - 92250 -
4. 92133 - OCT - Optic Nerve - 92133 -

RECOMMENDATIONS:

Headaches/ increased intracranial pressure with transient vision loss ou x 10-15 minutes
-cause for vision loss is unclear as mild disc edema would not account for this. may be orthostasis as pt reports getting up and losing vision ou
-mild disc edema OD and minimal disc edema OS vs physiologic OS
-OCT rnfl indices are within the normal range ou and vision is stable
-rec. fu with Dr. Gray
-HVF was unreliable today due to poor head position and displaced blind spot
-Recommend repeat HVF 24-2 ou with correct head positioning in 1-2 weeks (will need to be done locally as pt is returning home today) and if abnormal, recommend fu with neuro-ophthalmology asap locally or at duke
-if HVF is normal, then fu with duke neuro-ophthalmology in 6 months

-disc photos done today

RETURN: as above

Thank you for allowing me to participate in the care of this patient. If you have any questions or concerns regarding your patient's ocular care, please don't hesitate to contact me.

Sincerely,

ANNA HONG BORDELON MD
Attending Physician

cc:
Dr. LINDA GRAY LEITHE

,
Fax:

HEIDELBERG ENGINEERING

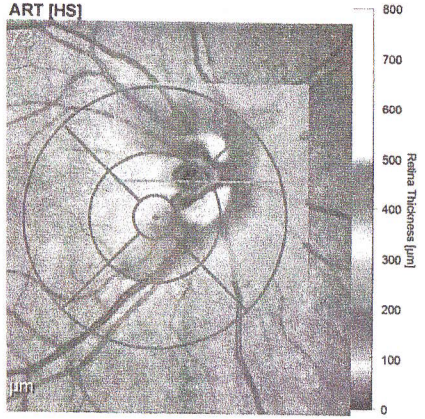
nt: PADDOCK, KAREN
nt ID: KP2481

DOB: Sep/3/1969
Exam.: Dec/7/2012

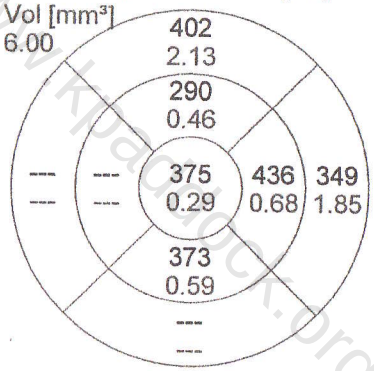
Sex: F

OD

ART [HS]



Average Thickness [µm]

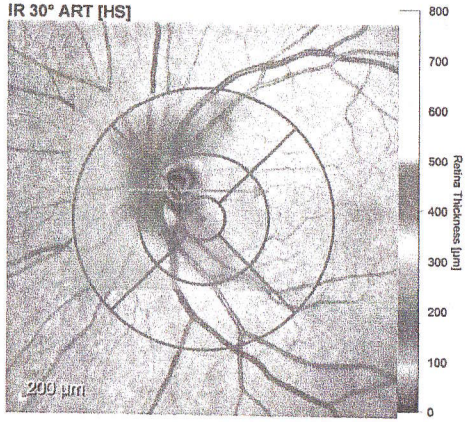


Center: 375 µm
Central Min: 311 µm
Central Max: 463 µm
Circle Diameters: 1, 3, 6 mm ETDRS

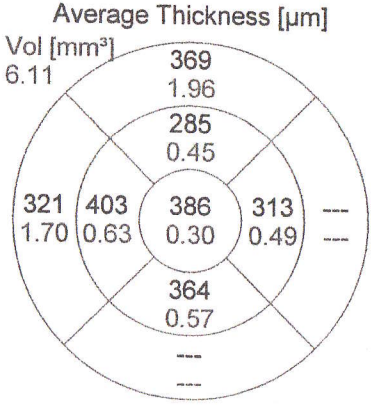
OCT 15° (4.5 mm) ART (7) Q: 27 [HS]

OS

IR 30° ART [HS]



Average Thickness [µm]



Center: 404 µm
Central Min: 308 µm
Central Max: 477 µm
Circle Diameters: 1, 3, 6 mm ETDRS

OCT 15° (4.5 mm) ART (10) Q: 27 [HS]

RNFL Single Exam Report OU with FoDi™

SPECTRALIS® Tracking Laser Tomography

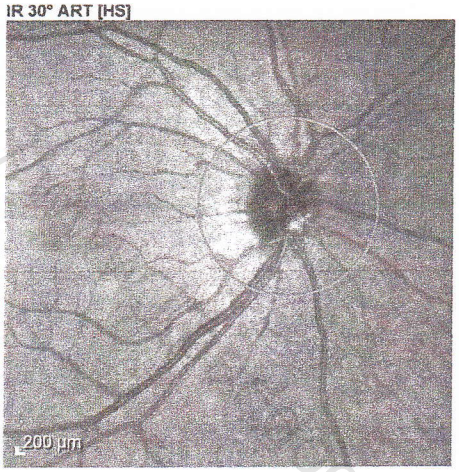
HEIDELBER ENGINEERING

kpaddock_000050

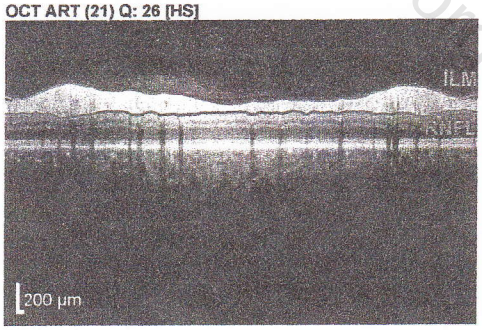
Patient:	PADDOCK, KAREN	DOB:	Sep/3/1969	Sex:	F
Patient ID:	KP2481	Exam.:	Dec/7/2012		

OD

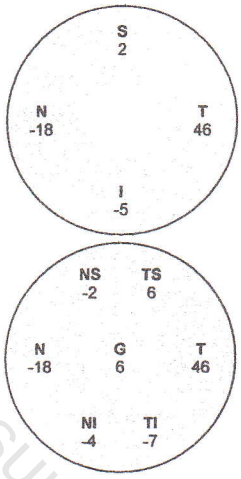
IR 30° ART [HS]



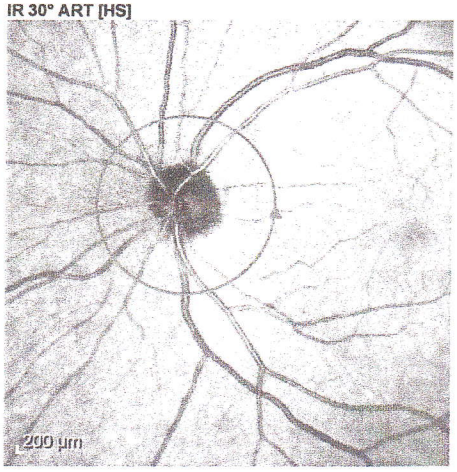
OCT ART (21) Q: 26 [HS]



Asymmetry OD - OS

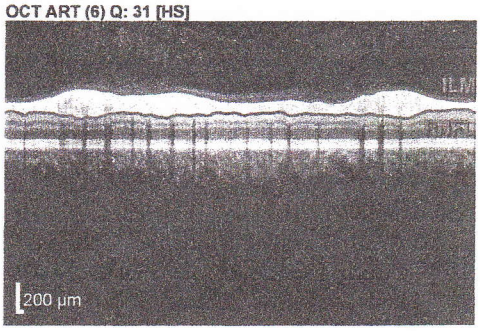


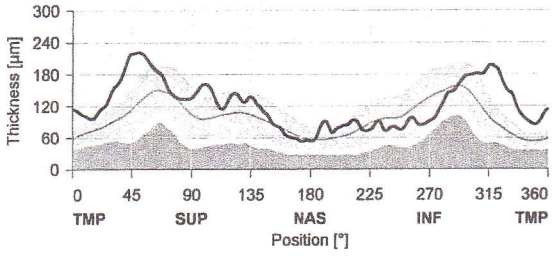
IR 30° ART [HS]



OS

OCT ART (6) Q: 31 [HS]

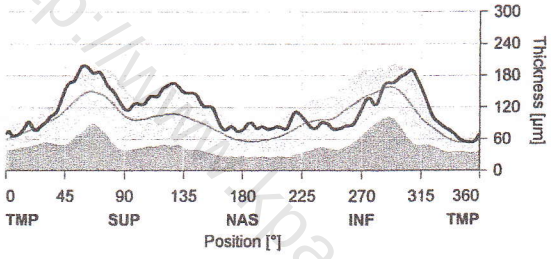


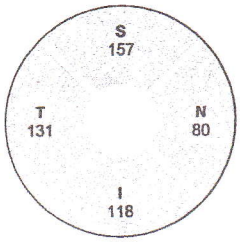


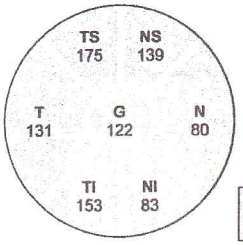
Within Normal Limits (p>0.05)

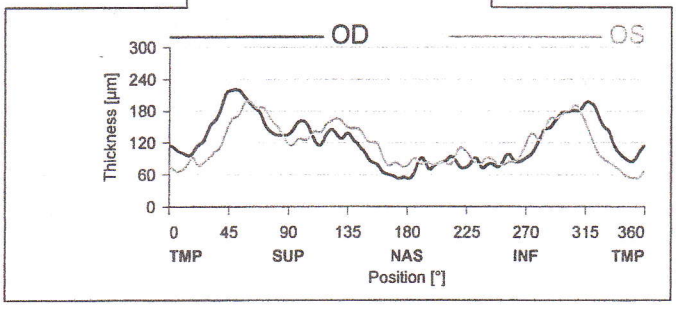
Borderline (p<0.05)

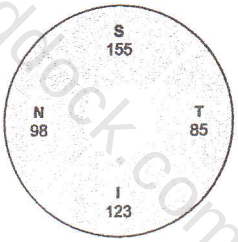
Outside Normal Limits (p<0.01)

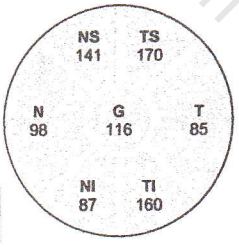












Classification OD

Within Normal Limits

Classification OS

Within Normal Limits

SINGLE FIELD ANALYSIS

EYE: RIGHT

NAME: [redacted] ,KAREN

kpaddock_000051

DOB: 09-03-1969

ID: KP2481

CENTRAL 24-2 THRESHOLD TEST

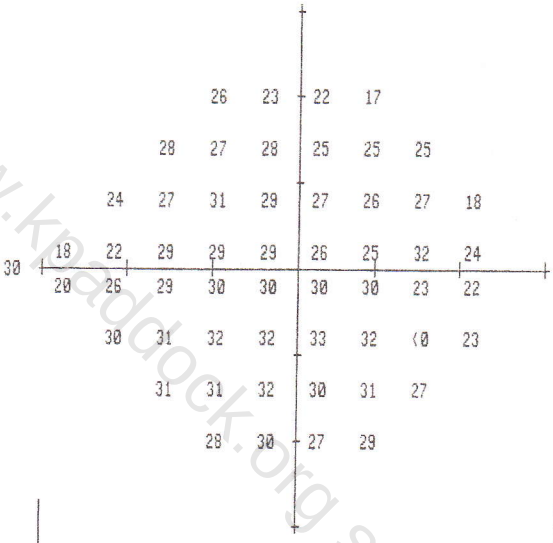
FIXATION MONITOR: GAZE TRACK
FIXATION TARGET: CENTRAL
FIXATION LOSSES: 0/0
FALSE POS ERRORS: 0 %
FALSE NEG ERRORS: 0 %
TEST DURATION: 04:23

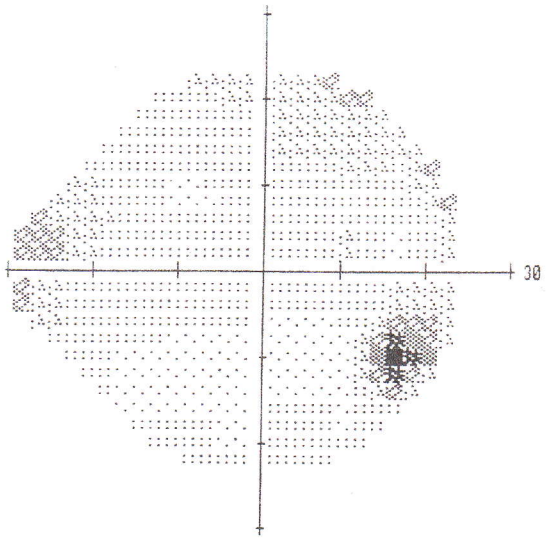
FOVEA: 35 DB

STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST

PUPIL DIAMETER: 7.3 MM
VISUAL ACUITY:
RX: +0.00 DS OC X

DATE: 12-07-2012
TIME: 11:36 AM
AGE: 43





			-3	-5	-6	-10			
		-2	-4	-3	-5	-5	-4		
	-6	-4	-1	-4	-6	-6	-3	-12	
-10	-8	-3	-4	-5	-7	-7		-6	
-9	-4	-3	-3	-4	-3	-3		-9	
	-1	-1	-1	-1	0	-1	-34	-8	
		0	-1	0	-2	-1	-5		
			-2	-1	-3	-2			

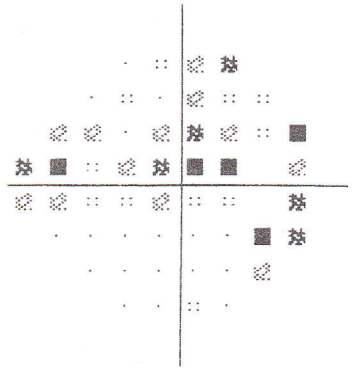
			-2	-5	-6	-10			
		-2	-3	-2	-4	-4	-4		
	-5	-3	0	-3	-5	-5	-3	-11	
-10	-8	-3	-3	-4	-6	-6		-6	
-8	-4	-3	-2	-3	-2	-2		-9	
	0	0	0	0	0	0	-33	-7	
		1	0	0	-1	0	-4		
			-2	0	-3	-1			

GHT
OUTSIDE NORMAL LIMITS

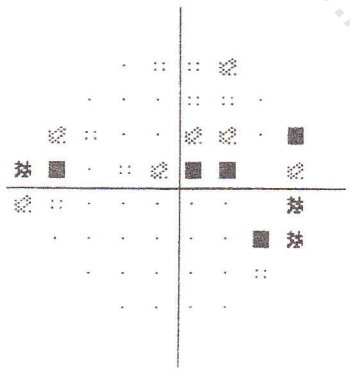
VFI 90%

MD -3.66 DB P < 1%
PSD 2.82 DB P < 2%

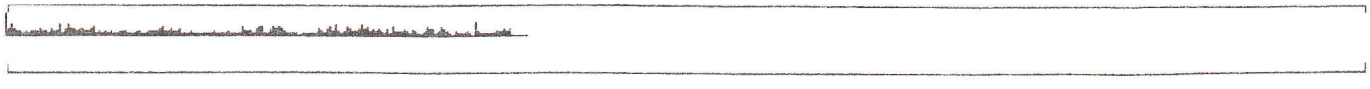
TOTAL DEVIATION



PATTERN DEVIATION



:: < 5%
▨ < 2%
▩ < 1%
■ < 0.5%



HFA II 750-30022-5.1.1/5.1.1

SPECTRALIS® Tracking Laser Tomography

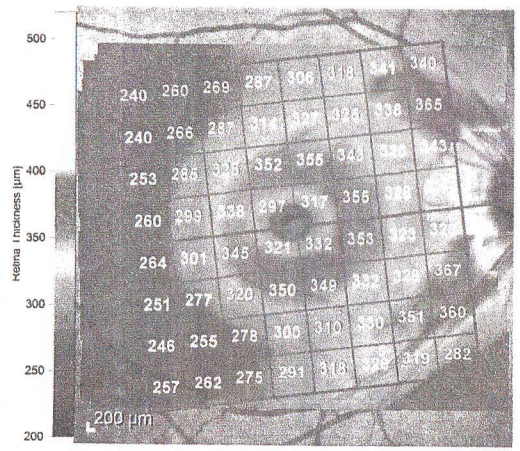
kpaddock_000052

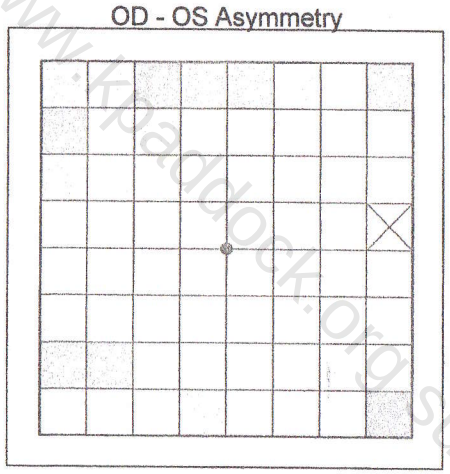
HEIDELBERG ENGINEERING

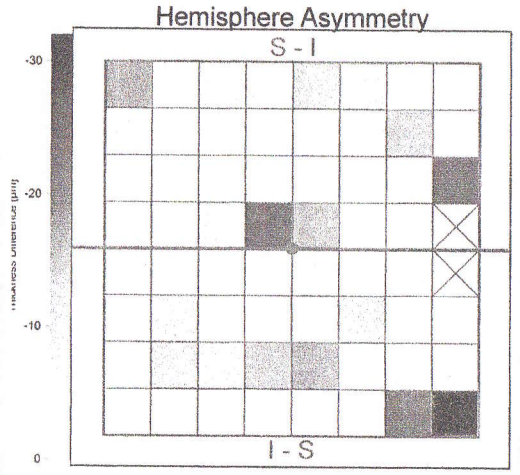
Patient: PADDOCK, KAREN **DOB:** Sep/3/1969 **Sex:** F

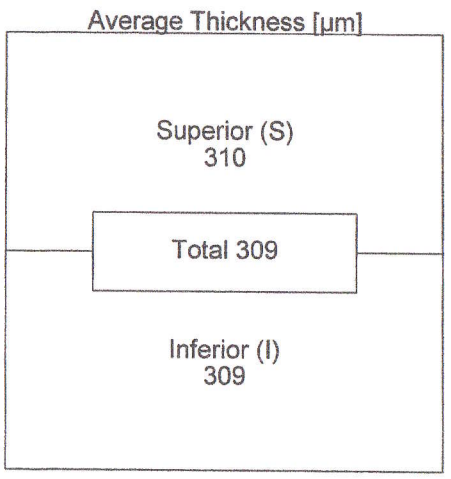
Patient ID: KP2481 **Exam.:** Dec/7/2012

OD









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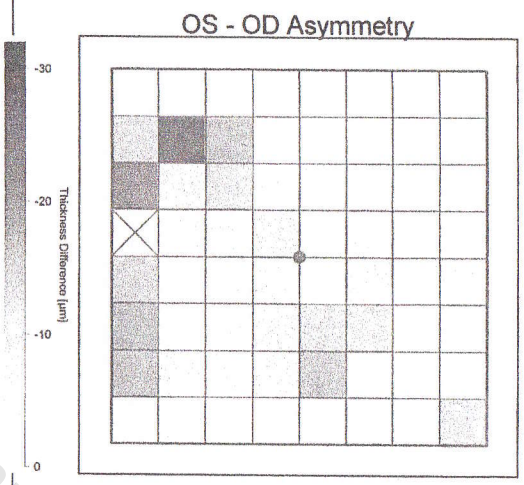

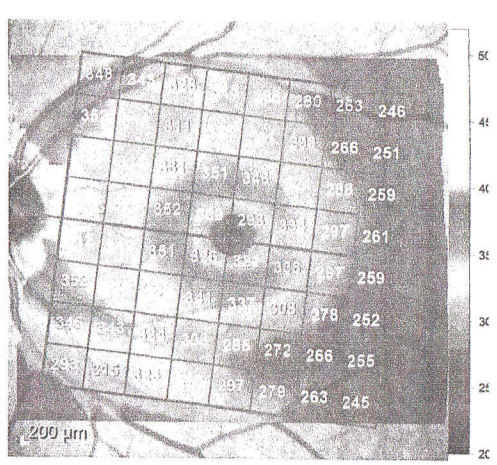

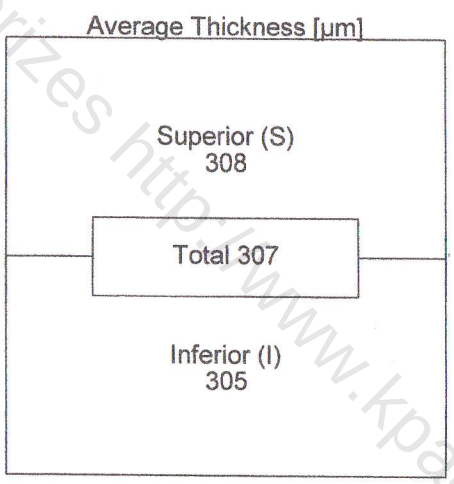

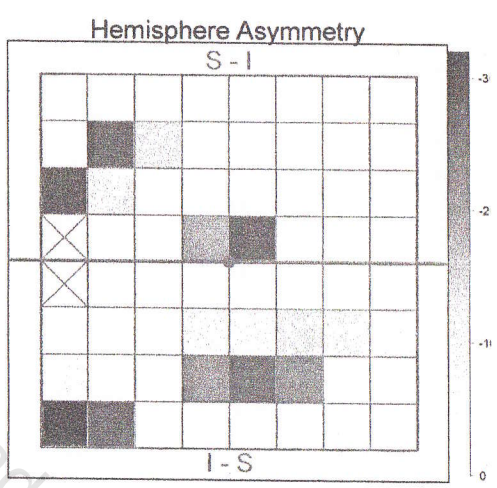

kpaddock_000053

Patient: PADDOCK, KAREN KP2481

Dictated Rpt: Final 09/18/2012 00:00

Orthopaedic Clinic Note

KP2481

PADDOCK, KAREN
9/18/2012
DOB: 9/3/1969 Age: 43
Orthopaedic Clinic Note
Christopher R Brown, MD
Duke Case Number 684NNW

Orthopaedic Clinic Note
DUKE UNIVERSITY MEDICAL CENTER
Division of Orthopaedics

REQUESTING PHYSICIAN: LEITHE,LINDA GRAY

HISTORY OF PRESENT ILLNESS:
Ms. Paddock is a 43 year old female who comes in for evaluation of headaches. She has positional headaches. When she stands up she gets headaches and when she lays down she gets relief. She had a blood patch a week ago with Dr Gray that helped for a short period of time. She as an MRI that shows spondylosis at 6-7 and she had an ESI at that level that didnkt help with any of her pain or her headaches. She has no radicular symptoms, no myelopathic complaints, and no numbness or tingling. She exercises every day. She doesnkt smoke.

Ms. Paddock is a 43 year old Caucasian female here for evaluation of neck pain. The patient reports her problem is a chronic problem that started in 1989. The injury occurred in a motor vehicle accident. The patient has received previous treatment (physical therapy and surgery and injections and chiropractic and massage therapy) for this problem.

PAIN MANAGEMENT
This pain is continuous. She reports that her pain has been present for more than 5 years. She describes her pain as aching, gnawing, exhausting, tiring, penetrating, nagging, miserable. Pain occasionally awakens her from sleep and prevents her from sleeping. Reported alleviating factors: lying down. Reported aggravating factors: sitting, standing.
Neck Pain: 8/10
Right Arm Pain: 0/10
Left Arm Pain: 0/10
Back Pain: 6/10
Right Leg Pain: 0/10
Left Leg Pain: 0/10

Outcomes Instruments:
Oswestry Survey: Ms. Paddock reports that pain killers provide very little relief from pain. She states that pain does not interfere with her sleep. She states pain

has restricted her social life and she does not go out as often.
Neck Disability Survey: The patient rates her neck today as 50 percent of normal (0-100 with 100 percent being normal). Ms. Paddock reports fairly severe pain at the moment. She reports a fair degree of difficulty in concentrating and claims to be able to only do usual work, but no more. Ms. Paddock reports no trouble sleeping.

SF-36: In general, Ms. Paddock feels that her health is fair. In the past four weeks, she was limited a little in moderate activities. She accomplished less than she would like in the past four weeks, due to physical health. Emotional health (feeling depressed or anxious) did not interfere with her ability to accomplish daily activities during the past four weeks. Pain interfered with the patient's normal work (including both work outside the home and housework) moderately, during the past four weeks.

Medical History:
1. Depression
2. GERD

Surgeries:
1. Appendectomy 1985
2. C2 nerve root decompression 1994

Allergies:
1. PENICILLIN
2. FLUROQUINOLONE (TENDONITIS)

Medications:
1. Indomethacin 75 mg b.i.d. p.r.n.
2. Zomig 5 mg b.i.d. p.r.n.
3. Prilosec 20.6 mg b.i.d.
4. Amitriptyline 50 mg q.day
5. Neurontin 600 mg t.i.d.
6. Multivitamin q.day
7. Calcium + Vitamin D 1200 u q.day

She reports a history of taking Advil, Aleve, Celebrex, Ibuprofen, Indocin, Naprelan, Naproxen, Ultram. There is a positive history of adverse reaction to anti-inflammatories (nausea).

Family History:
Family health history positive for cancer (other than breast or prostate), diabetes. Father is alive at age 80 with heart disease, osteoarthritis. Mother is alive at age 73 with heart disease, stroke, osteoarthritis.

Social History:
She is married. She exercises daily. Ms. Paddock is are disabled by back/neck. She denies ever using alcohol. She does not use and has never used tobacco.

ROS:
10 System Review of Systems is positive for depression, joint pain, joint stiffness, muscle pain, back pain, headaches and specifically negative for chest pain, shortness of breath, gross hematuria and melena. In order to insure proper and comprehensive care, the patient was directed to follow-up with her primary care physician for any and all medical problems and concerns noted here.

PHYSICAL EXAMINATION:
Vital Signs: Ht:5ft.11in. Wt:185lbs.
General:
Healthy female appearing her stated age, . Respiratory rate within normal limits.
General neurologic:

Oriented x 3 demonstrating normal mood and affect.
Lymphatics:
There is no evidence of adenopathy in affected extremity.
Skin:
Head, neck, and extremity skin is intact without rashes or lesions.

Comprehensive Spine Examination
Leg lengths are equal. Grossly normal hip exam. The patient walks with a normal gait. Patient has normal alignment with no decompensation. There is no tenderness examining their spine. Normal spine and bilateral extremity motion. Light touch and pin prick are normal throughout arms and legs.

Right Strength Exam
Deltoid strength is 5/5.
Biceps strength is 5/5.
Triceps strength is 5/5.
Wrist flexors strength is 5/5.
Wrist extensors strength is 5/5.
Grip strength is 5/5.
Instrinsics strength is 5/5.
Hip flexor strength is 5/5.
Hip extensor strength is 5/5.
Hip abduction strength is 5/5.
Hip adduction strength is 5/5.
Proas strength is 5/5.
Quadriceps strength is 5/5.
Hamstrings strength is 5/5.
DF strength is 5/5.
PF strength is 5/5.
EHL strength is 5/5.

Left Strength Exam
Deltoid strength is 5/5.
Biceps strength is 5/5.
Triceps strength is 5/5.
Wrist flexors strength is 5/5.
Wrist extensors strength is 5/5.
Grip strength is 5/5.
Instrinsics strength is 5/5.
Hip flexor strength is 5/5.
Hip extensor strength is 5/5.
Hip abduction strength is 5/5.
Hip adduction strength is 5/5.
Proas strength is 5/5.
Quadriceps strength is 5/5.
Hamstrings strength is 5/5.
DF strength is 5/5.
PF strength is 5/5.
EHL strength is 5/5.

Right Reflex Exam
Biceps reflex is 2+.
Triceps reflex is 2+.
Brachioradialis reflex is 2+.
Quadriceps reflex is 2+.
Achilles reflex is 2+.
Hoffman's sign is negative.
Clonus is negative.

IBR is negative.

Left Reflex Exam
Biceps reflex is 2+.
Triceps reflex is 2+.
Brachioradialis reflex is 2+.
Quadriceps reflex is 2+.
Achilles reflex is 2+.
Hoffman's sign is negative.
Clonus is negative.
IBR is negative.

Right Vascular Exam
No edema noted.
Posterior tibial pulse is 2+.
Dorsalis pedis pulse is 2+.

Left Vascular Exam
No edema noted.
Posterior tibial pulse is 2+.
Dorsalis pedis pulse is 2+.

ASSESSMENT:
Primary Spine Diagnosis: Cervical Spondylosis w/o myelop (721.0)

PLAN:
I donkt feel like her cervical spondylosis is leading to any the headache symptoms. She is going to follow up with Dr. Gray.

Medical Decision Making: Level 4: Number of Diagnoses or management options: 8 extensive (2 new, additional work-up), Amount and complexity of reviewed data: (radiology, independent visualization) 3 moderate. Level of Risk: Moderate. Moderate complexity medical decision involved.

Christopher R. Brown, MD
Department of Orthopaedics
ELECTRONICALLY SIGNED ON
September 25, 2012 AT 8:56:13 AM

CRB/CRB
Dictated on: 9/18/2012
Transcribed on: 9/18/2012

LINDA GRAY LEITHE
DUKE UNIVERSITY MEDICAL CENTER
DUMC 3808
DURHAM NC 27710

kpaddock_000057

Patient: PADDOCK, KAREN KP2481

ED Department Visit: Revised Final 12/02/2012 16:25

Emergency Dept Patient Chart

Acct. No.:719T6R
Age/DOB:9/3/1969 Age:43yr Sex:F MRN:Kp2481

========== MD Chart ==========
MD ED Initial:Borawski, Joseph M.D. MD ED:Borawski, Joseph M.D.
Res/PA/NP Initial:Ward, Michael M.D. Res/PA/NP:Ward, Michael M.D.

E/M Level:3 Action Code:FR

CC/Cur Imp:Headache
Pt Weight:/72.6kg

Home Medications (Review)

Medication	Dose	Freq	MD Review
Amitriptyline			Keep taking & ask your doctor
Zomig			Keep taking & ask your doctor
Neurontin			Keep taking & ask your doctor
Morphine			Keep taking & ask your doctor
Percocet			Keep taking & ask your doctor
Prilosec OTC			Keep taking & ask your doctor
Klor-Con 10			Keep taking & ask your doctor
Phenergan			Keep taking & ask your doctor

Drug Allergy:PCN V, Levaquin

Borawski, Joseph M.D. Created: 12/2/2012 1654 Last Entry: 1753

MD Note: I have personally interviewed and examined the patient. I discussed the findings, interventions and diagnostic testing with the Ward, Michael M.D.. I agree with the findings and treatment plan as presented with

exceptions in our respective documentation.

12/2/2012 1752 - SPoke with Dr Gray who confirmed her appoointment tomorrow and that she is scheduled for LP to evaluated for possible increased pressures.

Ward, Michael M.D. Created: 12/2/2012 1708 Last Entry: 1744

HPI: 43 year old female with a history of chronic headaches after a car accident s/p LPs and blood patches here for worsening headache, a sensation that she can't smell or taste anything, and a sensation that she cannot sit still. She says she had some of these symptoms in the past but some of them also started after taking phenergan. She is scheduled for an outpatient LP and blood patch tomorrow with Dr. Gray. She is here since she has been unable to sleep the last 4 days due to her symptoms.

(-)prior hx of similar problem.

PMH: (-)DM, (-)HTN.

SH: (-)tob,(-)alcohol, (-)drug use
FH: (-)DM
ROS: (-)fever, (-)visual changes, (-)sore throat, (-)chest pain, (-)SOB, (-)vomiting, (-)dysuria, (-)MSK complaints, (-)rash, (-)LOC, (-)bleeding, (+)all other systems reviewed and neg.

PHYSICAL EXAM:
VITALS: (+)nurses notes reviewed
GENERAL: (+)alert, (-)obvious discomfort.
HEAD: (-)trauma
EYES: (+)PERRL, EOMI
NOSE: (-)nasal discharge.
MOUTH: (-)decreased moisture.
THROAT: (-)erythema, (-)exudate
NECK: (-)palpable LN.
LUNGS: clear to auscultation, (+)good air exchange.
HEART: normal rate, normal rhythm.
ABDOMEN: (-)abd tenderness, (-)distension, (+)bowel sounds.
BACK: (-) CVAT, (-)no spinal tenderness.
EXTREMITIES: (+)pulses in all extremities, (+)brisk cap refill, (-)edema.
SKIN: (-)rash, (-)jaundice.
NEURO:
CNs (-)deficit. CN 2-12 intact
Motor: (-)strength deficit.
Sensory: (-)sensation deficit.
Reflexes: not tested
Gait: normal.
MENTAL STATUS: (-)deficit.

INITIAL DDX: Phenergan Side Effect, Worsening Chronic Headache

INITIAL PLAN: Benadryl, Discharge with instructions to use benadryl and stop taking phenergan until seen in follow up, instructions to see Dr. Gray as scheduled tomorrow for an LP.

DATA REVIEWED:
(+)Nurses notes reviewed.
(+)Recent eBrowser notes reviewed.
(+)Labs which have returned reviewed.

kpaddock_000059

(+)Radiology studies which have returned reviewed.

SUMMARY/DISPOSITION: The patient was given benadryl and told to stop using phenergan. She was told to follow up with Dr. Gray tomorrow.

Results Reviewed:

Form:

========== Dx/Instr ==========

Dx 1:Headache
Dx 2:

Misc Instr 1:
Surg/Proc/Tst 1:
Other Instructions:Return of worse in anyway. Use benadryl for symptoms of feeling like you cant sit still (this may be a side effect of Phenergan). Consider switching anti nausea meds. Follow up tomorrow with Dr. Gray as scheduled.
Follow-up 1:Linda Gray
F/U MD Ph:
Specialty:
F/U Address:
Address:
City: State: Zip:
Follow-up 1 Date:Tomorrow ------(Call For An Appointment)

Follow-up 2:
F/U 2 MD Ph:
Specialty:
F/U 2 Address:
Address:
City: State: Zip:
Follow-up 2 Date:

PMD: PMD Ph:
PMD Specialty:

========== Disposition ==========

Disposition:Tar-Treated/Released
Mode of Departure:Ambulatory

Dispo Summary Printed:12/2/2012 1739
CEU Assigned at:
CEU Bed (initia
Pt Left ED/CEU at:12/2/2012 1751

Dispo Status:Stable

Discharged With Whom:husband

Patient Belongings:

Admitted by:
Admitting MD:
Admitting Service:
Admission Type:

Admit by ED MD at:
Admitting MD Phone
IP Bed Asgn:

Admitting Dx
Assigning Condition:

kpaddock_000060

========== Prescription / Rx ==========

Rx 1:
Dose/Conc:
Freq/Rte:
Disp: Refill:

Rx 2:
Dose/Conc:
Freq/Rte:
Disp: Refill:

---------- Work/School Excuse ----------
==========

May return to work/school:

Restrictions:

========== RN/Triage ==========
Mode of Arrival:Walk Arrival:12/2/2012 1625
Arrival (HIS):12/2/2012 1625

Precautions:None Identified

Priority:2 Trauma Alert Level:

Discharge RN:Leslie K. Dispo RN Name Entered:12/2/2012 1751

Houser, Kristin R.N Created: 12/2/2012 1637 Last Entry: 1642

NURSING TRIAGE (Adult)
TRIAGE VITALS: 152/82, left arm, 109, 18, 37.2 (99.0) tympanic temp, SaO2 98 % on RA.
HPI: Pt states she had spinal fluid leak patched 5-6 weeks ago. Pt states "I feel like my pressure in my head is high". Husband states pt has not been sleeping, c/o headaches and "hearing a rushing sound in her ears"
PMH: CSF leak, tendonitis.
Surgeries: appendectomy.
TRIAGE DATA:
Pain Scale: Unable to quantify- headache
LMP: Not Applicable.
WEIGHT(metric): 72.6kg.
PREHOSPITAL CARE: None
NURSING INTERVENTION: None.
TRIAGE PRIORITY: Level 2.

Keck, Leslie R.N. Created: 12/2/2012 1648 Last Entry: 1651

RN Note: Nursing Assessment (Adult):
HPI: Pt said she has had "low level" headaches and then her doctor did a blood patch 6wks ago. Pt said for the past 6wks her headaches have been getting steadily worse. Feels better sitting up but then feels too weak if she sits up too long.
PMH: see above
SCREENING SUMMARY: (-)latex allergies, (-)communicable disease,

kpaddock_000061

(-)tuberculosis
(-) Patient screened for Domestic Violence/Elder/Disabled Adult abuse
(-)Domestic Violence/Elder/Disabled Adult disclosed by patient (if disclosed, contact Social Worker).
(-)Domestic Violence/Elder/Disable Adult abuse suspected (if suspected, contact Social Worker)
PHYSICAL EXAM
GENERAL APPEARANCE: well nourished, cooperative, no acute distress, no obvious discomfort
EYES: Conjunctiva clear, Sclera white
VISION: Baseline
NECK: no airway obstruction. (-) JVD
CHEST Wall: no chest tenderness, (+) symmetrical
LUNGS: no wheezing, no crackles, no Rhonchi, (-) accessory muscle use, good air exchange bilateral
CAPILLARY REFILL: <2 seconds.
ABDOMEN: normal BS, soft, no abd tenderness, (-)guarding.
EXTREMITIES: no swelling\tenderness in the extremities, no edema.
SKIN: warm, dry, good color, no rash, no abrasions\lacerations
MENTAL STATUS: speech clear, oriented X 4, normal affect, responds appropriately to question
FALL RISK: (+)Patient screened for fall risk. (-) fall risk intervention needed: (-)unable to stand without assistance, (-)uses an assistance device for ambulation, (-)recent fall within 3 months, (-)current symptoms including AMS, dementia, weakness, dizziness, or loss of balance. (-) currently on medication that alters mental status or alertness, (-) has problems with elimination, (-) has sensory deficit: hearing or vision, (-) other reasons for risk:
Fall Interventions: Stretcher placed in lowest postion and brake locked. Call bell within reach.

Keck, Leslie R.N. Created: 12/2/2012 1706 Last Entry: 1706

Order(s) performed:
- 12/2/2012 1706 - BENADRYL Cap (Diphenhydramine) 50mg PO once - Gave 50mg

---

Keck, Leslie R.N. Created: 12/2/2012 1751 Last Entry: 1751

RN Note:
DISCHARGE - Plan of care discussed with patient. Patient discharged with printed English instructions. Patient verbalized understanding and ability to comply. The personal belongings were returned to ( ), the patient.
Other Discharge Instructions Included: None.

POCT:

Core Measures:

==========

Clinical Decision Support

==========

Alert	Compliance	PQRC	Reviewer
No Entries			

==========

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kpaddock_000062

Medication Orders

Order	Req D/T	Comp D/T
BENADRYL Cap (Diphenhydramine) 50mg PO once - Gave 50mg, ~ Adult_Only	201212021658	201212021706

========== Signatures ==========

MD/PA E-SgnBorawski, Joseph M.D. 12/2/2012 1654
Resident/Intern/NPWard, Michael M.D. 12/2/2012 1736
RN E-Sgntr:Keck, Leslie R.N. 12/2/2012 1653

=== (C) 2000 Wellsoft Corp, Price/Stern/Sloan ====== THIS IS THE LAST PAGE ===

kpaddock_000063

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 09/10/2012 11:03 Req# 7512283 Acct# 679CKD

CT GUIDED NEEDLE PLACEMENT

Verified

CT Guided Lumbar Puncture, Myelogram and Autologous Blood Patch Treatments 09/10/2012

Indication: This this 43-year-old female presents today with C/O headache occipital pain when she gets out of bed in the morning, bilateral tinnitus N diminished hearing in the right ear, cognitive issues including difficulty with verbal conversations. Patient has a history of left-sided head trauma from a rear end and side collision (MVA) in 1989, after which her symptoms began.

Procedure: The risks and benefits were discussed and informed consent was obtained from the patient. Consent was also obtained from the patient for administration of Moderate Sedation PRN, (Fentanyl and Versed), for management of pain/anxiety throughout the procedure and recovery period.

The patient was placed in the left lateral decubitus position and a limited CT scan of the lumbar spine was obtained. The lower back was prepped, draped, and locally anesthetized in the usual sterile fashion.

Under CT fluoroscopic guidance and using a right posterior oblique approach, a 24-gauge atraumatic Gertie-Marx spinal needle was advanced into the subarachnoid space at L3-L4, until return of CSF was obtained.

CSF appearance: clear and colorless
Opening pressure = 14.5 cm of water

Provocative Tests:

A. Elliots B solution x 10.0 mL was injected into the thecal sac. Patient's symptoms improved.

Myelogram: Isovue-M 300 contrast media x10.0 mL was injected into the thecal sac and the needle was withdrawn. Hemostasis was obtained using direct pressure at the injection site.

The patient was then placed in the supine position, helped to do a pelvic raise and then rolled 540 degrees, returning to the prone position. A limited CT fluoroscopic image was then taken in the cervical region to assure that contrast media was distributed to that level. This was immediately followed by a CT scan of the cervical, thoracic and lumbar spine. Review of the CT myelogram images revealed extravasation of contrast media in the transforaminal regions @ left T1-T2, bilateral T3-T4, bilateral T4-T5 and bilateral L1-L2.

Total = 7

The patient's back was then prepped, draped and locally anesthetized in the usual sterile fashion. Again, under CT fluoroscopic guidance, and

using a posterior oblique approach, 22-gauge spinal needles were advanced into the central epidural space locations @ T4-T5 and L1-L2 (covering the bilateral transforaminal regions at the same levels) and transforaminal epidural locations @ left T1-T2 and bilateral T3-T4, where extravasation of contrast media was seen to have occurred. In addition, a blood patch was placed in the epidural space @ L3-L4, to cover the site of the lumbar puncture. The loss of resistance technique was used for all central epidural needle placements. Approximately 0.2 mL of Isovue-M 200 was injected at each site, immediately followed by 3 mL of autologous blood. After each injection the needle was withdrawn, and hemostasis was achieved using direct pressure at the injection site.

Total = 6

The patient tolerated the procedure well, was placed supine on a bed and sent to the Radiology Observation Area. Orders were written for 2 hours strict bedrest, administration of Normal Saline IV x500 mL , Zofran 4mg. IV for nausea. After a full recovery, the patient was discharged to home with a driver, contact information and follow-up instructions.

Impression:
1. Successful CT guided Lumbar Puncture and Myelogram @ L3-L4.

CSF appearance: clear and colorless
Opening pressure = 14.5 cm of water

Provocative Tests:

A. Elliots B solution x 10.0 mL was injected into the thecal sac.
Patient's symptoms improved.

B. Myelogram: Isovue-M 300 contrast media x10.0 mL was injected into the thecal sac.

2. Review of CT myelogram images reveals CSF Leaks/Dural Diverticula seen in the transforaminal regions @ left T1-T2, bilateral T3-T4, bilateral T4-T5 and bilateral L1-L2.

Total = 7

3. Successful CT guided Autologous Blood Patches placed in the central epidural space @ T4-T5 and L1-L2 (covering the bilateral transforaminal regions at the same levels) and L3-L4 (LP site); transforaminal regions @ left T1-T2 and bilateral T3-T4.

Total = 6

Linda Gray, M.D. performed this procedure and Jeff Taylor, PA-C was present.

I have reviewed the films and concur with the above findings.

Electronically Reviewed by: Jeffrey N Taylor PA
Electronically Reviewed on: 09/12/2012 14:54:40

Electronically Signed by: Linda Gray Leithe MD
Electronically Signed on: 09/18/2012 11:56:46

kpaddock_000065

Result ID: 5435883

ATTENDING MD: LEITHE,LINDA GRAY
ORDERING MD: LEITHE,LINDA GRAY
ORDER REASON: 784.0 HEADACHE-PRESSURE CHECK, POSSIBLE BLOODPATCH

kpaddock_000066

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 09/13/2012 16:53 Req# 7527026 Acct# 683YJM

CT GUIDED NEEDLE PLACEMENT

Verified

CT Guided Translaminar Approach Central Epidural Steroid Injection
9/13/2012

Indication: This 43-year-old female presents today with C/O left neck, shoulder and upper extremity pain. The patient rates the preprocedural pain at 5-7/10.

Procedure: The risks and benefits of the procedure were discussed and written informed consent was obtained from the patient. With the patient in the prone position, a limited preprocedure CT scan of the cervicothoracic spine was obtained.

The cervicothoracic neck area was prepped, draped, and locally anesthetized.

Under CT fluoroscopic guidance, a 22-gauge spinal needle was inserted into the central epidural space at the C6-C7 level using a left translaminar, posterior oblique approach and loss of resistance technique. Needle position in the central epidural space, was confirmed with injection of 0.2 mL Isovue-M 200 contrast media, in a 50% dilution with sterile Normal Saline. Injection was then made with a mixture of 2.0 mL Celestone and 0.5 mL Lidocaine 2.0%. The needle was withdrawn and hemostasis achieved using direct pressure at the injection site.

The patient tolerated the procedure well and rated the immediate postprocedural pain at 0/10. After a short period of observation, the patient was discharged to home with driver, contact information, and follow-up instructions.

Impression:
1. Successful CT guided left translaminar approach central epidural steroid injection at C6-C7.
2. Patient rated the preprocedure pain at 5-7/10 and postprocedural pain at 0/10.

Linda Gray, M.D. performed this procedure and Jeff Taylor, PA-C was present.

I have reviewed the films and concur with the above findings.

Electronically Reviewed by: Jeffrey N Taylor PA
Electronically Reviewed on: 09/14/2012 13:47:49

Electronically Signed by: Linda Gray Leithe MD
Electronically Signed on: 09/18/2012 11:57:01

kpaddock_000067

Result ID: 5435884

ATTENDING MD: LEITHE,LINDA GRAY
ORDERING MD: LEITHE,LINDA GRAY
ORDER REASON: 723.1 CERVICALGIA-CERVICAL ESI PER DR GRAY

kpaddock_000068

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 09/13/2012 17:35 Req# 7527288 Acct# 683YJM

SPINE-CERV/LAT FLEX EXT

Verified

Three views of the cervical spine

Indication: 43-year-old woman with cervicalgia

Comparison: None

Findings: Seven cervical appearing vertebral bodies are visualized in anatomic alignment. There is no spondylolisthesis within the cervical spine, unchanged in flexion and extension. There is mild loss of the normal cervical lordosis. No fracture or dislocation. Tiny posterior disc osteophytes are seen at C5 and C6; the joint spaces and intervertebral disc spaces are otherwise preserved. The soft tissues are unremarkable.

Impression:
1. Minimal DDD at C5-C6.
2. Mild loss of the normal cervical lordosis.

I have reviewed the images and concur with the above findings.

Electronically Reviewed by: Christopher Yurko MD
Electronically Reviewed on: 09/14/2012 09:14:16

Electronically Signed by: Charles E Spritzer MD
Electronically Signed on: 09/14/2012 17:29:24

Result ID: 5431640

ATTENDING MD: LEITHE,LINDA GRAY
ORDERING MD: MD.LEITHE
ORDER REASON: 723.1 CERVICALGIA-NECK PAIN

kpaddock_000069

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 10/23/2012 14:21 Req# 7582864 Acct# 699HMV

CT GUIDED NEEDLE PLACEMENT

Verified

CT Guided Lumbar Puncture and Autologous Blood Patch Treatments
10/23/2012

Indication: This 43-year-old female presents today with C/O occipital headache and posterior neck pain which improves with supine positon. She had a prior patch would did not cause any substantial improvement in her symptoms.

Procedure: The risks and benefits were discussed and informed consent was obtained from the patient. Consent was also obtained from the patient for administration of Moderate Sedation PRN, (Fentanyl and Versed), for management of pain/anxiety throughout the procedure and recovery period.

The patient was placed in the left lateral decubitus position and a limited CT scan of the lumbar spine was obtained. The lower back was prepped, draped, and locally anesthetized in the usual sterile fashion.

Under CT fluoroscopic guidance and using a right posterior oblique approach, a 24-gauge atraumatic Gertie-Marx spinal needle was advanced into the subarachnoid space at L3-L4, until return of CSF was obtained.

CSF appearance: clear and colorless
Opening pressure = 15.5 cm of water

Myelogram: Review of a previous CT myelogram (September 10, 2012) was used to plan treatment sites in the central epidural space @ T12-L1 and L5-S1; transforaminal locations@ bilateral L1-L2.

Total = 4

The patient's back was then prepped, draped and locally anesthetized in the usual sterile fashion. Again, under CT fluoroscopic guidance, and using a posterior oblique approach, 22-gauge spinal needles were advanced into the central epidural space locations @ T12-L1 and L5-S1 and transforaminal epidural locations @ bilateral L1-L2, where extravasation of contrast media was previously seen to have occurred. In addition, a blood patch was placed in the epidural space @ L3-L4, to cover the site of the lumbar puncture. The loss of resistance technique was used for all central epidural needle placements. Approximately 0.2 mL of Isovue-M 200 was injected at each site, immediately followed by 3 mL of autologous blood. After each injection the needle was withdrawn, and hemostasis was achieved using direct pressure at the injection site.

Total = 5

The patient tolerated the procedure well, was placed supine on a bed and

sent to the Radiology Observation Area. Orders were written for 2 hours strict bedrest, administration of Normal Saline IV x500 mL , Zofran 4mg. IV for nausea. After a full recovery, the patient was discharged to home with a driver, contact information and follow-up instructions.

Impression:
1. Successful CT guided Lumbar Puncture @ L3-L4.

CSF appearance: clear and colorless
Opening pressure = 15.5 cm of water

2. Review of previous CT myelogram images reveals CSF Leaks/Dural Diverticula seen @ central epidural T12-L1 and L5-S1; transforaminal epidural bilateral L1-L2.

Total = 4

3. Successful CT guided Autologous Blood Patches placed in the central epidural space @ T12-L1, L3-L4 (LP site) and L5-S1; transforaminal regions @ bilateral L1-L2.

Total = 5

Linda Gray, M.D. performed this procedure and Jeff Taylor, PA-C was present.

I have reviewed the films and concur with the above findings.

Electronically Reviewed by: Jeffrey N Taylor PA
Electronically Reviewed on: 11/13/2012 9:28 PM

Electronically Signed by: Linda Leithe, MD
Electronically Signed on: 11/13/2012 9:37 PM

Result ID: 5480557

ORDERING MD: BROWN,CHRISTOPHER ROBERT
ORDER REASON: 784.0 HEADACHE-BLOODPATCH REPEAT

kpaddock_000071

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 10/25/2012 12:10 Req# 7594653 Acct# 699HMV

SPINE-LUMBAR/LAT FLEX EXT

Verified

Lumbar spine AP and lateral with flexion and extension

Indication: Pain

Comparison: None

Findings and impression:
5 lumbar type vertebral bodies.
Vertebral body heights and disc space are maintained. No acute fractures or dislocations. Soft tissues are unremarkable. Mild L5-S1 facet arthropathy.

Electronically Signed by: Naveed Khan, MD
Electronically Signed on: 10/25/2012 4:51 PM

Result ID: 5482572

ATTENDING MD: BROWN,CHRISTOPHER ROBERT
ORDERING MD: GRAY MD,
ORDER REASON: 784.0 HEADACHE-HEADACHE

kpaddock_000072

Patient: PADDOCK, KAREN KP2481

Rad Rpt: Final 12/03/2012 07:54 Req# 7652127 Acct# 719NMN

CT GUIDED NEEDLE PLACEMENT

Verified

CT Guided Lumbar Puncture and Provocative Test 12/03/2012

Indication: This 43-year-old female presents today with C/O headache, confusion, burning facial pain, nausea and loss of appetite.

Procedure: The risks and benefits of the procedure were discussed and informed consent was obtained from the patient.

With the patient in the left lateral decubitus position, a limited CT scan of the lumbosacral spine was obtained and the L3-L4 subarachnoid space was localized. The lower back was prepped, draped, and anesthetized in the usual sterile fashion. Under CT fluoroscopic guidance, a 24-gauge Gertie Marx spinal needle was advanced to the localized level, until CSF return was achieved.

CSF description: Clear and colorless
Opening pressure = 15.75 cm of water

Provocative Tests:

CSF collected: 23.0 mL
Result: Patient's symptoms improved.

The needle was then removed and hemostasis achieved with direct pressure at the site. The patient was placed supine on a bed and sent to the Radiology Observation Area with orders for strict bedrest x1 hour. After a full recovery, the patient was discharged to home with a driver, contact information and follow-up instructions.

Impression:
1. Successful CT guided Lumbar Puncture at L3-L4.

CSF description: Clear and colorless
Opening pressure = 15.75 cm of water

Provocative Tests:

CSF collected: 23.0 mL
Result: Patient's symptoms improved. The implication is that although her pressure is not extraordinarily high, her volume maybe too high.

The patient was treated previously with diamox 2000mg per day without substantial relief. She is now taking 50mg HCTZ BID and we will add diamox 250mg q6hrs. If her symptoms continue we will create a small hole in her dura.

Linda Gray, M.D. performed this procedure and Jeff Taylor, PA-C was present.