CHAPTER 8

Diseases and Disorders of the Musculoskeletal System and Connective Tissue

BASIC HEALTH RECORD

Discharge Summaries

Discharge Summary Notes

All notes

Author	Service	Author Type	Filed	Note Time
ı, MD	(none)	PHYS- Fellow	09/30/2008 0921	09/30/2008 0920

HOSPITAL DISCHARGE SUMMARY

Patient Name:
Date of Birth: Age: 40 y.o.
Medical Record Number:
Primary Physician: 1, MD
Phone:
Admission Date: 9/11/2008
Discharge Date: 9/12/2008

He will be discharged from . ı Hospital to home.

PRINCIPAL DIAGNOSIS CAUSING ADMISSION: HERNIATION

DISCHARGE MEDICATIONS
This patient isn't currently admitted.

FOLLOW-UP:
He should return to clinic in 6 weeks or as scheduled

Additional followup: None

Special instructions: None

BRIEF HOSPITAL COURSE: This 40 y.o. male was admitted to the ward s.p. Procedure(s):
DISCECTOMY SPINE 01. The patient had a stable post operative course. Standard prophylactic antibiotics were administerd for 24 hours post surgery and the patient received DVT prophylaxis per service protocol. The patient's pain was initially controlled on intravenous pain medications and then weaned to oral medications prior to discharge. The patients pain was well controlled and the patient had met all physical therapy goals prior to discharge.
On his exam today sensation was intact in all dermatomes and motor examination demonstrated 5/5 strength in quadriceps, hamstrings, tibialis anterior, extensor hallucis longus, and gastrocsoleus muscle groups. The patient has normal bowel and bladder function. his incision is clean dry and intact.

PROCEDURES PERFORMED DURING HOSPITALIZATION: Procedure(s):
DISCECTOMY SPINE 01

COMPLICATIONS IN HOSPITAL: None

IMPORTANT PENDING TEST RESULTS: None

PERTINENT FINDINGS/RESULTS AT DISCHARGE: None

Total time spent for discharge on date of discharge: 20 minutes

Date of Pre-operative Exam: 9-9-0? — Date of Surgery: 9-11-0?

Surgeon: [illegible]

Procedure/Indication: Bilateral discectomy L4-5

Age: 40

Gender: X Male ☐ Female

Height: 6'0" Weight: 241 / 252

PMHx/Major Medical Problems:

1.
2.
3.
4.

Past Surgery Hx/Anesthesia – Bleeding – or other complications:

1. knee surgery - 2004
2. Wisdom teeth
3. Pyloric stenosis as infant
4.

Medications & dosages (including OTC's):

1. NONE
2.
3.
4.

HISTORY AND PHYSICAL
Please STAT Scan

Allergies:

1. ⊘
2.

Intolerance:

1. ⊘
2.

Habits/Miscellaneous Medical Hx:

ETOH: 9-10 / wk

Tobacco: ⊘

IV drug/Street drug use: ⊘

NSAID/ASA use: was taking Ibuprofen - stopped

History of Hepatitis or Jaundice: ⊘

Bleeding Tendency: ⊘

Transfusion Hx: ⊘

Steroid Use (within past year): N/A

LMP/Pregnancy status: N/A

Family Hx (Mother, Father, Siblings):

DAD - HTN

Social Hx:

Code Status: Full Code

Surgical Waiver Discussed

04

REVIEW OF SYSTEMS	
Directions: Circle pertinent / pos out negatives	
CONST	fever/chills / sweats / fatigue / appetite change / temperature intolerance / weight change
EYES	double vision / blurry vision / pain / redness
NOSE & SINUSES MOUTH & THROAT	drainage / congestion / nosebleeds / sinus problems / sores on lips, mouth, tongue, throat / dental work / change in voice
RESP	cough / sputum / SOB / wheezing
BREAST	lumps / pain / discharge
CVS	chest pain / heart murmur / DVT / PE / edema / palpitations Chest tenderness
GI	swallowing difficulties / heartburn / abdominal pain / nausea / vomiting / diarrhea / constipation / black or bloody stools / hemorrhoids
URINARY	painful urination / frequent urination
REPRODUCTIVE	STD / sexual problems
Male	penile sore, discharge / testicular pain, mass
Female	abnormal bleeding, discharge / mass / pregnancies / post menopausal, hysterectomy / contraception
SKIN	sores / rash
MUSCULO SKELETAL	joint pain / swelling / stiffness / back pain / neck pain
NEURO	headache / head injury / blackout / confusion / seizure / difficulty with vision, speech, walking / weakness in arm, leg, face - R / L

LABS/DX STUDIES DATE OF FINDING:

X-RAY
EKG: WNL - See enclosed

IMPRESSION (DIAGNOSIS):
40 y/o - Good General health
Chest wall tenderness (L) side - normal EKG
OK for Surgery

PHYSICAL EXAM

Directions: ☐ Check appropriate box and explain if indicated.

VS: T 97.5 BP 110/60 P 80 R 20 Wt.
General: Wt 250 Ht 6'0" O₂ Sats ___

	NML/NEGATIVE	ABNL/COMMENTS
EYES	☑ pupils, EOMI	☐
	☑ fundus, conjunctiva	☐
ENT	☑ TM	☐
	☑ teeth, pharynx	☐
	☑ nares	☐
NECK	☑ tenderness, ROM	☐
	☑ thyroid, lymph nodes	☐
RESP	☑ breath sounds	☐
	☑ chest wall motion	☐
	☑ percussion	☐
CVS	☑ RRR	☐
	☑ heart sounds	☐ S1, S2 ∅m
	☑ carotids	☐
	☑ peripheral pulses	☐
ABD	☑ BS	☐
	☑ tender	☐
	☑ masses, organomegaly	☐
BACK	☑ inspection	☐
	☑ ROM	
EXT	☑ edema	☐
	☑ cyanosis, clubbing	☐
	☑ joints	☐
NEURO	☑ orientation	☐
	☑ motor	☐
	☑ gait	☐
	☑ CN's, reflexes	☐
	☑ sensory/motor	☐
	☑ cerebellar test	☐
BREAST	☑	☐
GU	☐	☐

HISTORY AND PHYSICAL
Please STAT Scan

Date of Pre-operative Exam: 9/9/08
Examining Physician Signature
Printed Name
Pager #
Phone #

Please include PI Name with middle initial and birthdate

Procedure Notes

Procedure Notes

All notes

Author	Service	Author Type	Filed	Note Time
, , ;, MD	(none)	Physician	09/30/2008 0916	09/11/2008 0000

Transcription ID ---   Transcription Status Unavailable

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DATE OF SERVICE: 09/11/2008

ATTENDING:

SURGEON: ;

PREOPERATIVE DIAGNOSES
1. Herniated nucleus pulposus, L4-L5.
2. Lumbar spinal stenosis, L4-L5.
3. Bilateral lower extremity radicular pain.

PROCEDURE
Bilateral hemilaminotomy, partial medial fasciectomy, foraminotomy and partial discectomy L4-L5.

ASSISTANT
......, ...), spine fellow.

COMPLICATIONS
None.

INDICATIONS
The patient has a history of bilateral lower extremity radiculopathy related to large disc herniation and spinal stenosis at the L4-L5 level. After failure of nonoperative treatment attempts, he has elected to proceed with a surgical intervention. Risks, benefits, and expected outcomes of the procedure were discussed in detail. Informed consent was provided.

DESCRIPTION OF PROCEDURE
The patient was brought to the operating room after placement of intravenous antibiotics. General endotracheal anesthesia was induced without apparent complications. He was positioned prone on the Jackson table with the bony prominences well padded. The skin of his back was prepped and draped in the usual sterile manner. Midline incision was placed over the presumed L4-L5 level using anatomical landmarks. Sharp dissection was carried out to the deep fascia. A metallic marker was placed and intraoperative crosstable x-ray was obtained. After positively identifying the intended surgical level, a subperiosteal dissection was carried out bilaterally over the L4-L5 intralaminar space. The hemilaminotomy were then performed using Kerrison rongeurs and a high-speed bur. The underlying ligamentum flavum and hypertrophied capsular tissue was then removed and Kerrison rongeurs. After

Procedure Notes continued

confirming satisfactory subarticular decompression, the traversing nerve roots were gently retracted medially to reveal a herniated disc on the floor of the spinal canal, this was consistent with the preoperative imaging. Discectomy was then performed by incising the protuberant annulus over the disc herniation. Herniated nuclear material was then retrieved with pituitary rongeurs and blunt nerve hooks. The wound was then irrigated. Hemostasis was observed. Satisfactory decompression was observed bilaterally.

The wound was then closed in layers. The deep fascia was closed with a #1 Vicryl in a running manner. Subcutaneous tissues were closed with 2-0 Vicryl and skin edges were reapproximated using a 3-0 Monocryl in a running subcuticular manner. Steri-Strips and sterile bandages were applied. The patient was returned to the supine position, awakened, extubated and transported to the postanesthesia care unit in stable condition. All sponge and needle counts were correct.

, MD

Author	Service	Author Type	Filed	Note Time
, MD	(none)	PHYS- Fellow	09/12/2008 0639	09/12/2008 0637

Spine Surgery Progress Note

9/12/2008
POD #: 1
S/P: Procedure(s):
DISCECTOMY SPINE 01
L4-5 decompression, congenital stenosis
Subjective:
Leg pain resolved. Straight cath x 1 overnight. Patient felt urge but was unable to void. Denies perineal or perianal numbness

Objective:
BP 130/72 | Pulse 92 | Temp 98.2 °F (36.8 °C) | Resp 16 | Ht 1.829 m (6') | Wt 112.9 kg (248 lb 14.4 oz) | SpO2 95%

Intake/Output Summary (Last 24 hours) at 09/12 0637
Last data filed at 09/12 0000

	Gross per 24 hour
Intake	1800 ml
Output	1505 ml
Net	295 ml

+I/O+ Urine: 300 ml

Hemovac #1
No data found.

Patient +I/O+ Hemovac Drain # 1 Vol (ml) in the past 24 hrs:

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09/11/08	80 ml

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All Progress Notes continued

2200

Physical Examination:
Incision covered

BLE Quad/Tib Ant/Gastroc Soleus/EHL 5/5
BLE L4-S1 intact to light touch
Sens intact and normal to LT in perineum and perianal.

Labs:

S/P Procedure(s):
DISCECTOMY SPINE 01 on 09/11/2008
HERNIATION

Plan:
Mobilize
Change dressing prior to discharge
Home today if spont voiding

M.D.

All Progress Notes

Progress Notes

All notes

Author	Service	Author Type	Filed	Note Time
, RN	(none)	NURS-Registered Nurse	09/12/2008 1535	09/12/2008 1534

Discharge Note

Data:
l has been discharged home at 1515 via ambulatory accompanied by Significant Other.

Action:
Discharge/follow-up instructions were provided to patient and Significant Other. Prescriptions were filled and sent with patient.. Belongings sent with patient and Significant Other. Equipment none .

Response:
Patient and Significant Other verbalized understanding of discharge instructions, reason for discharge, and necessary follow-up appointments.