CHAPTER 11

Diseases and Disorders of the Kidney and Urinary Tract

INTERMEDIATE HEALTH RECORD

Discharge Summaries

Discharge Summary Notes

All notes

Author	Service	Author Type	Filed	Note Time
PA	(none)	PHYS-Physician Assistant	06/02/2008 1055	06/02/2008 1048

Related Notes
Cosigned by :

Discharge Summary

Admit date: 5/30/08
Discharge date: 6/1/08

Diagnosis: Bilat Kidney stones
Procedure: R PCNL

Hospital course: Uneventful. CT shows 5 mm residual R stone.

Discharge instructions: Pt D/Cd home with Neph tube. Cipro and Percocet scripts.
Follow up: Nephrostogem and neph tube removal Wednesday.

PREOPERATIVE CLEARANCE

Date of Exam: 5/23/2008

is a 74 y.o. male ( ) who presents for preop evaluation undergoing open removal of kidney stones for treatment of nephrolithiasis.

Date of Surgery: 5/30/08

Surgeon: Dr.

Hospital/Surgical F:

Primary Physician:

HPI:

is a 74 y.o. male with recurrent kidneys, gross hematuria, and recurrent UTIs. He is now scheduled for open stone removal by Dr.

Problem List:

Patient Active Problem List

Diagnoses	Date Noted
• CHRONIC KIDNEY DISEASE, UNSPECIFIED [585.9]	10/15/2007

10/07 Creatinine 1.7 est. GLOMERULAR FILTRATION RATE 42

4/08 Creatinine 1.7

History and Physical continued

- HYPERTENSION [401.9] 08/16/2007
- ARTHROPATHY SITE UNSPECIFIED [716.90] 08/16/2007

severe rt. ankle

- SPINAL STENOSIS OF LUMBAR REGION [724.02] 08/16/2007

MRI 5/04 severe

- GOUTY ARTHROPATHY [274.0] 08/16/2007
- OBESITY [278.00] 08/16/2007

TSH 1.2 (4/06)

BMI >45

- NONSPECIFIC REACTION TO TUBERCULIN TEST [795.5] 08/16/2007

1970's

- ATRIAL FIBRILLATION [427.31] 08/16/2007

Coumadin intolerance

Treated with ASA

- BPH W URINARY OBSTRUCTION AND OTHR (LUTS) [600.01] 08/16/2007

11/05 PSA 4.6

- ALLERGIC RHINITIS CAUSE UNSPECIFIED [477.9] 08/16/2007
- DIVERTICULOSIS COLON [562.10] 08/16/2007
- ASTHMA [493.90] 08/16/2007
- SLEEP APNEA [780.57] 08/16/2007

CPAP intolerance, not using

- EDEMA [782.3] 08/16/2007
- DISC DISORDER [722.90] 08/16/2007

Septic lumbar discitis 2006

- HYPERCHOLESTEROLEMIA [272.0] 08/16/2007

11/05 Chol 242 HDL 68 LDL 146

4/08 Cholesterol 184 HDL 45 LDL 122 TG 184

- SCREENING MALIGNANT NEOPLASMS COLON [V76.51] 08/16/2007

Flex 12/1999

Histories:

No past medical history on file.

Past Surgical History

Procedure	Date

- Esophagogastroduodenoscopy 11/9/2006

  duodenal ulcer, prepyloric ulcer on nsaid;check HP bx on coumadin

- Nasal polypectomy
- Lumbar decompression 2006

- Hx turp 2006
- Pr total knee arthroplasty 5/2006

  left

History

Social History

- Marital Status: Married

  Spouse Name: N/A

  Number of Children: N/A

- Years of Education: N/A

Occupational History

- Not on file.

History and Physical continued

Social History Main Topics

- Tobacco Use: Quit

  Quit date: 01/01/1990

- Alcohol Use: Yes

  couple/day

- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics	Concern
• Not on file	

Social History Narrative

- No narrative on file

No family history on file.

Allergies: Shellfish and Warfarin

Latex Allergy: no

Current Medications:

Current outpatient prescriptions

Medication	Sig	Dispense	Refill

• ATENOLOL 50 MG TAB	one daily		0
• FUROSEMIDE 40 MG TAB	1 tablet daily		0
• LISINOPRIL 5 MG TAB	one daily		0
• MULTIVITAMIN TAB	one tab daily		0
• TUMS 500 MG CHEWABLE TAB	prn for heartburn		0
• VIAGRA 50 MG TAB	1-2 po before sex as needed	20	0

Recent use of: no recent use of aspirin (ASA), NSAIDS or steroids

HABITS:

History

Substance Use Topics

• Tobacco Use:	Quit
Quit date:	01/01/1990
• Alcohol Use:	Yes

couple/day

Tetanus up to date yes

Anesthesia Complications: None

History of abnormal bleeding : None

History of Blood Transfusions: Yes - Date: 11/06

Health Care Directive or Living Will: yes

REVIEW OF SYSTEMS:

The patient denies cough, chest pain, dyspnea, wheezing or hemoptysis. The patient denies abdominal or flank pain, anorexia, nausea or vomiting, dysphagia, change in bowel habits or black or bloody stools or weight loss.

History and Physical continued

EXAM:

BP 134/82 | Pulse 60 | Temp (Src) 97.7 °F (36.5 °C) (Oral) | Ht 1.93 m (6' 4") | Wt 171.46 kg (378 lb)

General Appearance: Pleasant, alert, appropriate appearance for age. No acute distress

Head Exam: Normal. Normocephalic, atraumatic.

Eye Exam: Normal external eye, conjunctiva, lids, cornea. PERL.

Ear Exam: Normal TM's bilaterally. Normal auditory canals and external ears. Non-tender.

Nose Exam: Normal external nose, mucus membranes, and septum.

OroPharynx Exam: Dental hygiene adequate. Normal buccal mucosa. Normal pharynx.

Neck Exam: Supple, no masses or nodes.

Thyroid Exam: No nodules or enlargement.

Chest/Respiratory Exam: Normal chest wall and respirations. Clear to auscultation.

Cardiovascular Exam: Irregular rate and rhythm. S1, S2, no murmur, click, gallop, or rubs.

Gastrointestinal Exam: Soft, nontender, no abnormal masses or organomegaly.

Lymphatic Exam: Non-palpable nodes in neck, clavicular, axillary, or inguinal regions.

Skin: no rash or abnormalities, chronic dermatitis of the hands

Neurologic Exam: Nonfocal; symmetric DTRs, normal gross motor movement, tone, and coordination. No tremor.

Psychiatric Exam: Alert and oriented, appropriate affect.

DIAGNOSTICS:

1. EKG: EKG FINDINGS - atrial fibrillation, rate 46-66 and normal axis, normal intervals, no acute ST/T changes c/w ischemia

2. CXR: not indicated

3. Labs: CBC and basic metabolic panel, results pending.

IMPRESSION:

592.0 CALCULUS OF KIDNEY (primary encounter diagnosis)

Comment: staghorn calculus

Plan: CBC AND DIFFERENTIAL

Open removal of stones

V72.83 PREOP EXAM SPECIFIC OTHER

Comment: stop aspirin and resume postoperatively

Plan: consider enoxaparin for VTE prophylaxis postoperatively, 40 mg twice daily.

401.9 HYPERTENSION

Comment: well controlled

Plan: CBC AND DIFFERENTIAL, BASIC METABOLIC PANEL

Continue usual medications perioperatively.

585.9 CHRONIC KIDNEY DISEASE, UNSPECIFIED

Comment: stable

Plan: BASIC METABOLIC PANEL

278.00 OBESITY

Comment: Body mass index is 46.01 kg/(m^2).

Plan:

427.31 ATRIAL FIBRILLATION

Comment: rate is well-controlled, dveloped rash on coumadin

Plan:

780.57 SLEEP APNEA

Comment: does not tolerate his CPAP machine

Plan: oxygen at night as needed.

607.84 IMPOTENCE OF ORGANIC ORIGIN

Comment:

Plan: VIAGRA 100 MG TAB

Refill given.

For above listed surgery and anesthesia:

Patient is moderate risk for perioperative complications.

RECOMMENDATIONS: discontinue aspirin (ASA) 7 days prior to reduce bleeding risk and resume all medications post-operative or per surgeon

Electronically Signed by:

Total visit 40 minutes, 25 minutes of counseling and coordination of care.

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/29/2008 1552	05/30/2008 0000

Related Notes
Original Note : at 06/03/2008 1520
Transcription ID Transcription Status
Available

DATE OF SERVICE: 05/30/2008

ATTENDING:

SURGEON:

PREOPERATIVE DIAGNOSIS
Right staghorn calculus.

POSTOPERATIVE DIAGNOSIS
Right staghorn calculus.

PROCEDURE
Right percutaneous stone removal.

PREOPERATIVE STATUS
is a 74-year-old male with bilateral staghorn calculi. The right kidney on renogram showed partial obstruction. We therefore will proceed with treatment of the right kidney. The patient is morbidly obese and discussed a percutaneous stone removal. The patient does understand that it may require more than sitting to completely remove the stone. The risks and benefits of the procedure were discussed and the patient has elected to proceed.

DESCRIPTION OF PROCEDURE
Earlier in the day, the patient underwent percutaneous puncture into the right middle calix and a 7-French angiographic catheter was placed in the radiologist's suite. The patient was now brought to the operating room. After adequate general anesthesia, a Foley catheter was placed. The patient was then placed in the prone position and prepped and draped in the usual manner. Through the existing angiographic catheter, a guidewire was placed and the tract was dilated and a 30-French Amplatz sheath was placed by Dr. The access was right at the stone. I then performed rigid nephroscopy. The stone was readily visualized. I then proceeded to use the ultrasonic lithotriptor and proceeded to disintegrate the stone and the fragments were aspirated at the same time. The stone was noted to be fairly hard. The stone in the calix and subsequently the stone in the renal pelvis to the UPJ and then partly to the lower calix, all these stones were completely removed using the ultrasonic lithotripter. At the end of the procedure nephroscopy showed no other stone fragments. Patient had a generous renal pelvis. A 22-French council-tipped Foley catheter was then placed as a nephrostomy tube and nephrostogram showed no significant extravasation. Under fluoroscopy no residual stone fragments were noted. I think we have completely removed all of the stone from his kidney. The patient will be scheduled to have a CT scan in followup. The nephrostomy tube was secured to the back with a silk stitch and connected to drainage. The patient tolerated the procedure well and was sent to the recovery room in stable condition.

All Progress Notes continued

BP 138/72 | Pulse 70 | Temp 97.7 °F (36.5 °C) | Resp 16 | Ht 1.87 m (6' 1.62") | Wt 171.5 kg (378 lb 1.4 oz) | SpO2 96%
Temp (24hrs), Avg:97.2 °F (36.2 °C), Min:96.3 °F (35.7 °C), Max:97.9 °F (36.6 °C)

Patient Wt. in the past 72 hrs:

	Wt.
05/30/08 0700	171.5 kg (378 lb 1.4 oz)

Intake/Output Summary (Last 24 hours) at 05/31 1219
Last data filed at 05/31 0600

	Gross per 24 hour
Intake	3500 ml
Output	830 ml
Net	2670 ml

Feeling ok, urine output a little sluggish overnight, but better after lasix today.

Urine lt pink.

Lab ok.

A/P: stable post-op, will get ct today or tomorrow, prob home with neph tube tomorrow, and rtc mid week for nephrostogram and tube removal.

Author	Service	Author Type	Filed	Note Time
, MD	(none)	PHYS-Anesthesiologist	05/30/2008 1352	05/30/2008 1352

Anesthesia Postoperative Note

BP 145/98 | Pulse 60 | Temp 96.3 °F (35.7 °C) | Resp 12 | Ht 1.87 m (6' 1.62") | Wt 171.5 kg (378 lb 1.4 oz) | SpO2 97%

Patient without complaints. No nausea. Pain adequately controlled. Hemodynamics acceptable.

Author	Service	Author Type	Filed	Note Time
, MD	(none)	PHYS-Anesthesiologist	05/30/2008 1258	05/30/2008 1255

All Progress Notes continued

ANESTHESIA ASSESSMENT/HISTORY AND PHYSICAL
5/30/2008 12:55 PM
74 y.o. male

CC: renal stones.

Procedure(s):
REMOVAL PERCUTANEOUS KIDNEY STONE
Surgeon(s):

PAST MEDICAL HISTORY:
Past Medical History

Diagnosis	Date
• CHRONIC KIDNEY DISEASE, UNSPECIFIED	
• HYPERTENSION	
• ARTHROPATHY SITE UNSPECIFIED	
• SPINAL STENOSIS OF LUMBAR REGION	
• GOUTY ARTHROPATHY	
• ATRIAL FIBRILLATION	
• BPH W URINARY OBSTRUCTION AND OTHR (LUTS)	
• DIVERTICULOSIS COLON	
• ASTHMA	
• SLEEP APNEA *not using Cpap, cannot tolerate*	
• EDEMA	
• HYPERCHOLESTEROLEMIA	

PAST SURGICAL HISTORY
Past Surgical History

Procedure	Date
• Esophagogastroduodenoscopy *duodenal ulcer, prepyloric ulcer on nsaid;check HP bx on coumadin*	11/9/2006
• Nasal polypectomy	
• Lumbar decompression	2006
• Hx turp	2006
• Pr total knee arthroplasty *left*	5/2006

ALLERGIES
Shellfish and Warfarin

MEDICATIONS
Current hospital medications

Medication	Dose	Route	Frequenc	Provider	Last Rate

All Progress Notes continued

• cefazolin 2 g in D5W 50 mL (ANCEF, KEFZOL)	2 g	Intravenous	PRE
• gentamicin 80 mg in NaCl 50mL (GARAMYCIN)	80 mg	Intravenous	PRE

Prescriptions prior to admission

Medication	Sig	Dispense	Refill
• ATENOLOL 50 MG TAB	one daily		0
• FUROSEMIDE 40 MG TAB	1 tablet daily		0
• LISINOPRIL 5 MG TAB	one daily		0
• MULTIVITAMIN TAB	one tab daily		0
• TUMS 500 MG CHEWABLE TAB	prn for heartburn		0
• VIAGRA 100 MG TAB	1 as needed for sex	18	1 year

Recent Labs

Basename	5/30/08 0813
• HGB	14.2
• PLT	177
• PTT	--
• INR	1.1
• SODIUM	--
• POTASSIUM	--

Pre-op EKG a fib, rate controlled
SOCIAL HISTORY:
History
Substance Use Topics

• Tobacco Use:	Quit
Quit date:	01/01/1990
• Alcohol Use:	Yes
couple/day	

ROS: NPO. denies GERD. unable to tolerate coumadin, asa for a fib--denies pulm, heme, heaptic ror DM problems.
ANESTHESIA COMPLICATIONS: None
BLEEDING TENDENCIES: None

PHYSICAL EXAM:
DENTITION: Native, in tact
RESPIRATORY: Normal
CARDIOVASCULAR: Normal
BP 112/78 | Pulse 64 | Temp 97.2 °F (36.2 °C) | Resp 18 | Ht 1.87 m (6' 1.62") | Wt 171.5 kg (378 lb 1.4 oz) | SpO2 97%

All Progress Notes continued

Body mass index is 49.04 kg/(m^2).

AIRWAY CLASSIFICATION: II

ASA: III

ANESTHETIC PLAN: General

I acknowledge that I have provided this patient with the understandable and current information including risks, benefits, alternatives related to the anesthetic care I am recommending. Risks for the following include but are not limited to: general anesthesia (dental damage). The patient was given the opportunity to ask questions and I have answered them.

..... 5/30/2008 1255

Insititute Preoperative and Postoperative Excellian Orders per patient type - inpatient, surgeryadmit, or ambulatory. (Order set #3055, 30286, 30556, 30557).

Author		Service	Author Type	Filed	Note Time
	RN	(none)	NURS-Registered Nurse	05/30/2008 1017	05/30/2008 1006

Interventional Radiology:
0915 Pt arrived to room for right nephrostomy tube placement. Site marked, procedure explained, pt has no questions or concerns at this time and consent on chart. Pt prone, prepped, draped on monitors and vss. Pause for the cause completed upon Dr. arrival into the room. Sedation given with good effect. 10:15 Procedure completed without complications, pt ready to transport to and report given to RN

Author		Service	Author Type	Filed	Note Time
	MD	(none)	Physician	06/01/2008 1204	06/01/2008 1200

Urology POD2

BP 169/98 | Pulse 67 | Temp 97.3 °F (36.3 °C) | Resp 18 | Ht 1.87 m (6' 1.62") | Wt 171.5 kg (378 lb 1.4 oz) | SpO2 95%
Temp (24hrs), Avg:97.8 °F (36.6 °C), Min:97.3 °F (36.3 °C), Max:98.3 °F (36.8 °C)

Patient Wt. in the past 72 hrs:

	Wt.
05/30/08 0700	171.5 kg (378 lb 1.4 oz)

Intake/Output Summary (Last 24 hours) at 06/01 1201
Last data filed at 06/01 0600

	Gross per 24 hour
Intake	4200 ml
Output	2650 ml
Net	1550 ml

Feels well, urine clearing and CT shows 5mm residual stone rt side, so ok for tube removal alter this week. Will need to address possible ESWL after left perc neph stone removal is done.

A/P: stable, will d/c home with neph tube, return for nephrostogram and tube removal Weds.

Progress Notes

All notes

Author	Service	Author Type	Filed	Note Time
, RN	(none)	NURS-Registered Nurse	06/01/2008 1524	06/01/2008 1524

Discharge Note

Data:

as been discharged home at 1345 via wheelchair accompanied by Nursing Assistant and Family.

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

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

Result Summary for IR PERC NEPHROSTOLITHOTOMY continued

Result Narrative

NEPHROSTOMY TUBE PLACEMENT TRACT DILATATION & WORKING SHEATH PLACEMENT, [5/30/2008 1:21:03 PM -
CLINICAL HISTORY: Large right renal stone.

PROCEDURES PERFORMED:
(1) Placement of a 7-French sheath via right lower pole posterior calyx for percutaneous nephrostomy access in angiographic suite.

(2) Removal of existing ureteral sheath over a guidewire in operating room.

(3) Dilatation of tract with 10 mm diameter Track Master balloon and placement of a 5-French safety catheter into ureter.

(4) Placement of a 30-French working sheath into infundibulum for subsequent percutaneous stone removal.

(5) Placement of Councill catheter in renal pelvis after stone removal.

RADIOGRAPHIC FINDINGS:
Initial fluoroscopic inspection of the right kidney shows a stone to be within the renal pelvis. Following placement of the working sheath, the working sheath tip is within the infundibulum directed at the renal pelvis. Following complete stone removal by Dr. a 22-French Councill catheter was placed through the working sheath into the renal pelvis and a balloon inflated with 3 cc of dilute contrast. The working sheath was then removed. Final nephrostogram shows the 22-French Councill to be in good position with no residual stone fragments seen fluoroscopically. The 5-French nephroureteral catheter was left terminating in the distal ureter.

Result Impression

Successful percutaneous nephrostomy and tract dilatation for right percutaneous stone removal through working sheath by Dr. Councill catheter left in renal pelvis and 5-French ureteral catheter left in place following stone removal.

OPERATIVE REPORT:
The patient was brought to the angiographic suite, and the right flank was prepped, draped and anesthetized with 1% lidocaine. Following placement of a 22-gauge needle onto the stone, contrast and CO2 were injected to identify posterior calyces. A posterior lower pole calyx was then punctured with an 18 gauge needle and a 7 French vascular sheath placed into the ureter. In the operating room, this was exchanged for a safety 5 French catheter directed into the distal ureter and a stiff guidewire. The tract was subsequently dilated using a 10 mm diameter, 10 mm long angioplasty balloon. A 30 French working sheath was then advanced over the balloon into the renal pelvis. Following percutaneous stone removal by Dr. , a 22-French Councill was replaced through the working sheath into the renal pelvis and the balloon inflated with 3 cc of contrast was injected to document its position. The catheters were sutured in place and attached to drainage. The site was dressed with sterile dressing. The patient tolerated the procedure well without immediate complication. The patient received the planned minimal intravenous sedation using 3 mg of Versed and 200 mcg of fentanyl over a 30 minute period for placement of the 7 fr working sheath access while being continuously monitored by the radiology nurse. The patient then

Result Summary for IR PERC NEPHROSTOLITHOTOMY continued

went to the operating room and the tract dilation and stone removal performed under general anesthesia. There was no immediate complication.

Lab and Collection IR PERC NEPHROSTOLITHOTOMY (Order #138594418) on 5/30/08 - Lab and Collection Information

Result Summary for IR PERC TUBE PLACEMENT

Result Information	Status		Provider Status
	Normal	Final result (5/30/2008 1:30 PM)	Open

Result Narrative Please see report for a2212930.

Lab and Collection IR PERC TUBE PLACEMENT (Order #138594430) on 5/30/08 - Lab and Collection Information

Result Summary for CT Abd/Pelvis wo IV Contrast *

Result Information	Status		Provider Status
	Normal	Final result (6/2/2008 11:07 AM)	Reviewed

Result Narrative

CT OF THE ABDOMEN AND PELVIS WITHOUT ORAL OR IV CONTRAST, 5/31/08

CLINICAL INFORMATION: 74-year-old male with bilateral renal stones presenting for CT to follow up removal of right kidney stone reportedly percutaneously. Evaluate for stone.

TECHNIQUE: Multidetector helical CT of the abdomen and pelvis was performed without oral or IV contrast using 2.5 mm collimation. Scan was interpreted on a computer workstation including evaluation of axial, coronal and sagittal images.

FINDINGS: No comparison CTs. Moderate degenerative hypertrophic changes in the spine. Rod and pedicle screw fixation from L3 to L5 posteriorly. Osteopenia. Pedicular screws at L3 and L4 course very close to the superior endplates on the right. Moderate degenerative arthritis both hips. Patchy bibasilar atelectasis and/or fibrosis. Tiny subpleural nodule left lower lobe should be benign. Very small right pleural effusion. Mild amount of opacity in the left lower chest posteriorly has some calcification associated with it and may be related to some pleural thickening. Heart is mildly enlarged. Irregular-shaped 1.8 cm stone seen in the left mid intrarenal collecting system with tiny stone in a left lower calyx. Larger stone seen in the left renal pelvis measures 2.8 cm x 1 cm and has Hounsfield density measurements of 568. No left ureteral calculi seen. Mild stranding about the left kidney. Percutaneous nephrostomy tube is seen on the right. This has a balloon tip in the central right intrarenal collecting system. Inside of this percutaneous nephrostomy tube is a smaller catheter or stent extending from the right intrarenal collecting system down the right ureter with tip in the distal right ureter a few centimeters from the UVJ on image 148. I cannot appreciate any stones in the right ureter around this catheter. There is a 5-6 mm stone in a calyx in the right mid kidney, however, on image 68. No other obvious right renal stones seen. Moderate amounts of stranding and small amounts of dense fluid seen in the right perinephric space consistent with the combination of edema and blood products related to the first cutaneous tube placement. Some of this stranding extends into the lower abdomen and upper pelvis. Old right lower rib fractures. Ossific density in the soft tissues of the

Result Summary for CT Abd/Pelvis wo IV Contrast * continued

lower back and upper pelvis. Moderate atherosclerotic change seen involving the abdominal and pelvic arteries. Foley catheter in the bladder. The bladder is not well distended and its lumen contains some increased density probably related to blood products secondary to the procedure performed on the right kidney. The prostate gland is mildly enlarged. Colonic diverticulosis. Small lipoma left hip musculature anteriorly. Abdomen and pelvis otherwise negative.

Result Impression

1) Right percutaneous nephrostomy tube seen with tip in right intrarenal collecting system with catheter inside of this tube extending from the intrarenal collecting system to the distal ureter. 5-6 mm stone in the right mid kidney. No other right-sided urinary stones.

2) Three calculi are seen in the left intrarenal collecting system and left renal pelvis. The largest of which measures 2.8 cm in diameter. See above discussion. Moderate soft tissue stranding consistent with edema in the right perinephric space with small amounts of hemorrhagic products in the perinephric space related to the percutaneous tube placement.

3) Bladder not well distended and contains Foley catheter and some blood products.

4) Prostate mildly enlarged.

5) Small right pleural effusion and mild calcified pleural thickening left lower chest.

6) Numerous additional findings as described above.

, MD
Radiologist

Lab and Collection CT ABD/PELVIS WO IV CONTRAST (Order #138807322) on 5/31/08 - Lab and Collection Information

Result History CT ABD/PELVIS WO IV CONTRAST (Order#138807322) on 6/2/08 - Order Result History Report