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JACK H. MITCHELL III
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AREA CODE 803
TELEPH NE 271-4943

May 22, 1986

Dr. Chet A. Noble
317 St. Francis Drive
Suite 210
Greenville, South Carolina 29601

Re: Michael Wayne Cox

Dear Chet:

Enclosed please find an authorization to release medical records to me signed by Michael Wayne Cox. In order for me to evaluate his potential claim for workman's compensation benefits I would request that you forward to me any and all medical records you have regarding his condition and your treatment thereof.

Yours very truly,

Bob

Robert M. Ariail

RMA:ldf
Enclosure

UCC 080379

ATTACHMENT 5

3-18-86, Ch.7

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

DATE: 3-18-86

REFERRING PHYSICIAN: Dr. Griffin

REASON FOR EVALUATION: Consideration for liver biopsy

SUBJECTIVE: This 29 year old male was admitted one day prior to this consultation to Dr. Noble after discovering that he had hemothorax. Patient was admitted to his local hospital (Oconee Memorial) on 3-15-86 when he had a syncopal episode. The patient apparently was feeling relatively well on the day of admission to his local hospital. He coughed up some blood, and became mildly short of breath. At that point in time, he developed a syncopal spell. He was taken to his local ER where he was noted to have a hemoglobin of 7.4 and ng. aspirate was negative for any active bleeding, although his stool was hemoccult positive (trace). He was apparently diaphoretic and complaining of chest discomfort at the time. Noted on his x-ray after admission was a white out of the right lung. He underwent a thoracentesis on the day of transfer which revealed 1,000 cc. of almost pure blood. The patient was transferred for further evaluation. He apparently was transfused four units in Oconee Hospital and one unit on transit to St. Francis. Two more units of blood have been transfused since admission here. CT scan of the chest was unable to define anything on the right because of all the fluid. However on the left, multiple nodules were noted. The liver, noted to be enlarged, is approximately 70 to 80% r placed with probable tumor. Thus, consultation for liver biopsy has been made. The patient denies any known history of liver disease, any previous transfusions or hepatitis or any family history of liver disease, except for the fact that his sister has cirrhosis. This is thought to be secondary to alcohol use. The patient's sister with the cirrhosis is stable and doing well with discontinuation of the alcohol.

ALLERGIES: None known.

CURRENT MEDICATIONS: 1) AquaMEPHYTON 10 mg. x 4 qid today; 2) Carafate 1 gm. po qid.

REVIEW OF SYSTEMS: Positive for weight loss with slight anorexia over the past 2 to 4 weeks. There has been no melena, hematemesis, coffee ground emesis, etc.

OBJECTIVE: The patient is a pleasant young white male in moderate respiratory distress with a chest tube just inserted by Dr. Noble. Most recent vital signs include temperature of 100.2, blood pressure 140/70, respirations 30, heart rate 80 beats per minute. HEENT examination reveals pale conjunctiva. Sclera are n t icteric. Oropharynx reveals inflamed peritonsillar areas. Funduscopic examination reveals bilateral hemorrhages. Chest reveals minimal breath sounds of the right anterior chest. The breath sounds on the left are heard, but dry rackles are noted. Cardiovascular examination reveals a regular rate and rhythm with a positive S4 but no S3. No murmurs or rubs are noted. Abdominal examination reveals good bowel sounds. There are no masses. There is no bvious tenderness to palpation. The liver is percussed approximately 13 cm. in the mid clavicular line, and palpated approximately 3 to 4 cm. below the right

TYPE OF REPORT: CONSULTATION

SIGNED: DR. MICHAEL RICKOFF/dh M.D.

UCC 080380

NAME COX, MICHAEL | ROOM NO. | HOSPITAL NO.

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

costal margin. The upper margin of the liver is difficult to determine because of the dullness above the liver related to the pleural effusion. However, the edge of the liver feels smooth and firm. I cannot detect a spleen tip at the present time. Rectal examination revealed no rectal masses and hemoccult trace positive brown stool. Extremities revealed no edema, pulses 2+ throughout. Neurol gic - the patient is grossly intact. Lymph examination reveals no obvious cervical, axillary, or supraclavicular nodes.

LAB DATA: Admission hematocrit to St. Francis 28, white count 15,600 with platelet count 150,000. Admission blood gas had a pO2 of 31, pCO2 of 38 with pH of 7.49, on 4 liters a minute pO2 of 42 and pCO2 of 42 with pH 7.46 has been noted. Pro.time on admission 14.8 with PTT of 24.2. Liver profile at Oconee Memorial revealed an SGOT of 26 and alk.phos. of 103 and bilirubin of 0.6. Serum albumin 3.3 was noted. Chest x-ray on admission to St. Francis revealed almost complete obliteration of the right lung field from hemothorax. EKG is not available. Upper GI series done at Oconee Memorial, according to verbal rep rt just received, reveal antral ulcer with some edema of the prepyloric area. The ulcer was located along the lesser curvature. There was no mention of a mass effect of the ulcer. The duodenum also had some slight defects, although there were no significant other abnormalities in the duodenum. Chest tube was recently placed by Dr. Noble and 2,000 cc. of almost pure blood were obtained. The blood was not clotted. A blood gas following the chest tube insertion is pending.

IMPRESSION: 1. Hepatomegaly with abnormal CAT scan of the liver - probable diagnoses include lymphoma vs. metastatic liver disease. I suppose with the sinus problems the patient states that he had as well as the lung lesions, a vasculitis with bleeding into the liver, possibly associated with Wegener's granulomatosis is a consideration, although again this would be very rare and unlikely.

2. Hemothorax with respiratory compromise.
   A. Status post chest tube placement today.
3. Coagulopathy.
   A. Elevated pro.time.
   B. Hemorrhages on funduscopic examination.
4. Anemia - status post transfusion of 7 units of blood in three days.
5. Antral ulcer on recent upper GI series.

UCC 080381

RECOMMENDATIONS: Diagnostic -

1. I agree that liver biopsy would probably give the diagnosis given the CT scan appearance to liver. I would prefer to do this laparoscopically, but because of the patient's respiratory compromise at the present time, insufflation of CO2 in the anterior abdominal cavity would be very, very high risk. Percutaneous biopsy thus, is probably necessary, realizing the bleeding diathesis of the patient.
2. An EGD might give us a diagnosis but the description of the ulcer by phone is not impressive and the respiratory status of the patient may be compromised. I will proceed in this manner, however, if desired.

TYPE OF REPORT CONSULTATION | SIGNED DR. MICHAEL RICKOFF/dh MD

3. We will proceed with the liver biopsy tomorrow if the pro.time is less than or equal to 3 seconds of control. Risks and benefits of the procedure, primarily bleeding, have been explained to the family and the patient and they are agreeable.

4. Fresh frozen plasma will be given prior to and during the biopsy.

3-19-86

TYPE OF REPORT: CONSULTATION

SIGNED: DR. MICHAEL RICKOFF/dh M.D.

cc: Dr. [illegible]

NAME: COX, MICHAEL WAYNE | ROOM NO. | HOSPITAL NO. 43700

4-6-86, CH. 3

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

ADMISSION: 3-17-86

DISCHARGE: 4-6-86

ADMISSION DIAGNOSIS: Bloody pleural effusion.

DISCHARGE DIAGNOSIS: 1. Angiosarcoma of liver with metastasis to lung and pleura.
2. Atrial flutter.
3. Prepyloric channel ulcer.

PROCEDURES: 1. Right tube thoracostomy.
2. Percutaneous liver biopsy.
3. Open liver biopsy.
4. Insertion of Infus-a-port catheter.

SUMMARY: This 29 year old white male was taken in transfer from Dr. Stan Rampey in Seneca where he had been admitted after a syncopal episode and found to have hemoglobin of 7.4 and opacification of the right hemithorax. Subsequent thoracentesis revealed this to be frankly bloody. Upper GI series had revealed prepyloric channel ulcer. He was given three units of blood and transferred for more definitive diagnostic and therapeutic procedures. Blood gases on admission revealed PO2 of 39 on room air. He was given 2 more packed cells, 2 fresh frozen plasma, and vitamin K on admission and hemoglobin stabilized in the 10-11 gm. range. CAT scan of the chest and abdomen revealed multiple pulmonary nodules, massive right pleural effusion and large liver masses.

Laboratory values revealed prolongation of the prothrombin time to 15.8 seconds and elevated LDH in the 350-400 range. Lab values were otherwise unremarkable.

On 3/18, right tube thoracostomy was performed and about 2500 cc. of dark, non-clotting blood was evacuated with improvement in ventilatory function. Patient was seen in consultation by Dr. William Griffin and also by Dr. Michael Rickoff. Percutaneous liver biopsy was performed on 3/19; however, no tumor or other pathological tissue was identified. On 3/22, he was taken to surgery where, under general anesthesia, small laparotomy incision was made and a generous wedge biopsy of a subcapsular mass in the right lobe of the liver was performed. Subsequent histology revealed presence of angiosarcoma. He was then seen in consultation by Dr. Reg Brooker and a course of chemotherapy was outlined. On 3/24, he had sudden development of supraventricular tachycardia with a heart rate of 160-180, although no clinical distress. He was transferred to ICU and digitalized and also given IV Verapamil. This was felt to represent atrial flutter. Heart rate came down to normal range and he was maintained on Digoxin

TYPE OF REPORT: DISCHARGE SUMMARY | SIGNED: DR. CHET NOBLE/pm

UCC 080383

NAME: COX, Michael Wayne | ROOM NO. | HOSPITAL NO.

Ch. 8 4/5/86

PREOP DX: Angi sarcoma of liver
POSTOP DX: Same
PROCEDURE: Insertion Infusiport catheter
ANESTHESIA: Local
SURGEON Dr. Noble
PROCEDURE IN DETAIL: The patient was placed on the operting table in the supine position and the left chest and neck were prepped with Betadine and draped into a sterile field. After infiltration of 1% Xylocaine with Epinephrine a transverse incision was made about 3 cm. in length about 10 cm. below the clavicle. This was deepened through the subcutaneous tissue with the electrocautery and a pocket was created bluntly just above tne pectoralis fascia to accommodate the portacath device. A separate incision was then made after infiltration with local anesthesia ov r the external jugular vein. It was ligated distally with 2-0 silk tie. A tunnel was then created between the two wounds and the venous tubing was passed between the two sites and tailored at an appropriate l ngth to be threaded into the external jugular vein. The tubing and s ptum were then filled with heparinized saline using 1,000 units/cc strength and the tubing threaded with relative ease into the external jugular vein toward the subclavian. Chest x-ray for placement was not don due to the fact that this was not going to be used for hyperalimentation but only for chemotherapy. The tubing was secured in place with 3-0 silk tie. The portacath device was then secured to the pectoralis fascia with 3-0 Dexon and both wounds were closed in layers using interrupted 3-0 Dexon on the subcutaneous tissue and continuous 5-0 Nylon mattress sutures on the skin. Sterile occlusive Tegaderm dressings were applied to both sites and the patient returned ot his room in satisfactory condition.

4/5/86

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

TYPE OF REPORT: OPERATIVE NOTE

SIGNED: Chet Noble, M. D. /hh M.D.

UCC 080384

the remainder of his hospitalization.

Further history revealed a possible occurrence of similar episode about 8 months ago during a previous admission at Oconee County Hospital. The patient and his family were informed regarding the possibility of relationship existing between the cell type of his tumor and his exposure to polyvinylchloride at his job site. The right hemithorax was difficulty to evacuate and eventually chest tube was removed. There remains a lot of pleural scar on the right side, but gases remained satisfactory and breathing was much improved over previous status. On 4/1 a course of chemotherapy was begun, consisting of Adriamycin, Cytoxin, and DTIC. This was tolerated fairly well. Hemoglobin drifted down to 8 gm. range and required transfusion of 2 more units of packed cells prior to discharge. On 4/5, the patient was taken back to surgery where portacath permanent central venous catheter was placed via the left external jugular.

DISPOSITION: Patient is discharged to be seen in the office next week for removal of skin sutures and also for follow-up with Dr. Brooker. Anticipated time of next chemotherapy treatment is approximately 3 weeks. The patient is disabled to return to work for an indefinite period of time due to the anticipated length of chemotherapy treatment and he has been advised not to return to any kind of work related to exposure to polyvinylchloride. He has no dietary limitations. Physical restrictions were discussed. He was given prescriptions for Tagamet to take 300 mg. q.i.d. for another three weeks, Tylox to take prn for pain, and Digoxin to take 0.25 mg. daily for control of cardiac arrhythmia. Overall prognosis is poor.

4-7-86

TYPE OF REPORT: DISCHARGE SUMMARY

SIGNED: DR. CHET NOBLE/pm M.D.

cc: Dr. William Griffin; Dr. Rickoff; Dr. Reg Brooker; Dr. Stan Ramp[illegible]

GREENVILLE, S.C. 29601 MEDICAL RECORD

NAME	ROOM N	HOSPITAL NO.
COX, MICHAEL	704	

3-23-86, Ch.7

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

REFERRING PHYSICIAN: Dr. Chet Noble

DIAGNOSIS: 1. Angiosarcoma of liver and lungs.
2. Hemothorax secondary to #1.

SUBJECTIVE: Mr. Cox is a 29 year old man admitted to Oconee Memorial Hospital March 15 following a syncopal episode. He was found to be severely anemic with hemoglobin of 7.4 and to have opacification of the right hemithorax with a bloody pleural effusion. He was transfused blood and transferred here March 17. He had had a two month history of cough, chest pain, and occasional hemoptysis, and this had not responded to therapy with antibiotics.

On admission here he was again noted to have a right hemothorax. Chest x-ray also showed possible small nodules in the left lung compatible with metastatic disease. CAT scan of the thorax confirmed the above findings. A chest tube was inserted into the right pleural space to drain the pleural effusion, and a CAT scan of the abdomen revealed multiple filling defects in the liver compatible with malignant disease. A percutaneous liver biopsy was performed March 19 and revealed only benign liver tissue. On March 22 he underwent an open liver biopsy, and frozen section has been interpreted as an angiosarcoma with the permanent sections still pending. For the past 4½ years he has worked with exposure to toxic chemicals including polyvinyl chlorides. These have been used in the laminating process.

PAST MEDICAL HISTORY: In July 1985 he was hospitalized about 3 days because of left sided chest pain. He then had a negative chest x-ray, and it was finally determined that this was muscular chest pain. At age 5 he sustained a fracture of the right wrist. No drug allergies.

OBJECTIVE: He is a chronically ill appearing man lying in bed in moderate respiratory distress receiving IV fluids and nasal oxygen. Skin - mild pallor without jaundice, rash. Lymph nodes - none palpable. Chest - decreased breath sounds over the right anterior chest. Left chest is clear. Heart - regular tachycardia at 110/minute. Abdomen - healing right upper quadrant surgical scars with stitches in place. Abdomen not further examined. Extremities - no edema, clubbing or cyanosis. Neurologic - grossly intact.

ASSESSMENT: He has malignancy widespread in the liver and also radiographic evidence of pulmonary metastases on chest x-ray and CT scan of the left thorax. The frozen section revealed the malignancy to be an angiosarcoma, and the permanent sections are still pending and will be reviewed tomorrow. He also had a right hemothorax and probably had a spontaneous rupture of a sarcomatous lesion to cause this. He is now less short of breath after had evacuation of the right pleural space and receiving nasal oxygen. Polyvinyl chloride has been implicated in causing angiosarcinomas of the liver, and this may be due to exposure to toxic chemicals. We will follow this very tragic case with you. Anticipate starting chemotherapy in a few days after he has had time to convalesce from surgery and after the final path. has been reviewed.

3-24-86

UCC 080386

TYPE OF REPORT: CONSULTATION

SIGNED: DR. REGINALD BROOKER/dh M.D.

cc: Dr. Chet Noble, Dr. Stan Rumpey - Seneca, Dr. Bill Griffin, Dr. Rickoff (both offices of Dr. Brooker)

NAME	ROOM NO.	HOSPITAL NO.
~~COX, Michael~~		

Ch. 9 3/22/86

PREOP DX: Metastatic malignancy
POSTOP DX: Probable angiosarcoma (frozen section)
PROCEDURE: Wedge biopsy, right lobe of liver
ANESTHESIA: General endotracheal
SURGEON: Dr. Noble
HISTORY: This 29 year old white male presented with a syncopal episode and was found to have right hemothorax. Subsequent chest tube drainage was accomplished and CT scan revealed hepatomegaly with multifocal large filling defects. Percutaneous liver biopsy was nondiagnostic and patient was prepared for open biopsy. CT scan also revealed multiple pulmonary nodules in both lung fields.

PROCEDURE IN DETAIL: The patient was placed on the operating table in the supine position, adequate general endotracheal anesthesia was obtained. The abdomen was prepped with Betadine and draped as a sterile field. A right subcostal skin incision was made and carried down sharply to the abdominal wall with the electrocautery and the peritoneal cavity was entered and explored. The abdominal exploration was unremarkable except for the liver which was enlarged and which contained multiple large masses which were subcapsular in location. The surface of the liver appeared grossly normal. At each point where a mass was in a subcapsular location there was a dark bluish-to black tinge on the surface and a firm mass underneath. Biopsy of one of these areas in the most lateral aspect of the right lobe revealed an unusual consistency of tissue which was somewhat soft and very dark red-black stained and very vascular. Frozen section examination by Dr. Gene Cox revealed evidence of probably angiosarcoma. Sufficient tissue was taken for permanent section as well as frozen section examination and hemostasis was obtained with Gelfoam gauze. The abdomen was closed in layers using continuous 0 PDS suture material on all fascial layers and the stapling device was used to approximate the skin. A sterile occlusive Tegaderm dressing was applied and the patient was transferred to the recovery room in satisfactory condition.

3/24/86

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

UCC 080387

TYPE OF REPORT	SIGNED
~~OPERATIVE NOTE~~	~~Chet Noble, M. D. /hh~~ M.D.

cc: Dr. W. R. Griffin
cc: Dr. Mike Rickoff cc: Dr. Stan Rampey,

GREE E. S. C.

DEPARTMENT OF PATHOLOGY:

PATIENT: COX, MICHAEL WAYNE

ACCOUNT NO: F-1295-86

DATE: 3-19-86

AGE: 29 SEX M

HOSPITAL NO: 232886

ROOM: 704

PHYSICIAN: Noble

CLINICAL DATA:

Liver biopsy
Bloody pleural effusion

MACROSCOPIC EXAMINATION:

This specimen labeled liver biopsy are portions of tan tissue that are three in number, measure up to 1.4 cm. in length, 0.1 cm. in cross diameters. These are submitted in a styrofoam sandwich.
WMW:sc

MICROSCOPIC EXAMINATION:

Microscopic examination reveals liver with minimal lymphocytic infiltrate of portal triads. Special stains reveal no unusual histologic abnormalities. Necrotic liver is not identified. Malignant tumor is not identified. Granuloma are not identified.

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DIAGNOSIS:

LIVER, NEEDLE BIOPSY: LIVER PARENCHYMA NEGATIVE FOR MALIGNANT TUMOR AND GRANULOMA 6 54-m0003

UCC 080388

J. Thomas Latham, Jr., M.D./sc M. D.

PATHOLOGIST

GREEN[illegible]E, S. C.

DEPARTMENT OF PATHOLOGY:

PATIENT: COX, MICHAEL WAYNE

ACCOUNT NO: F-1341-86

DATE: 3-22-86

AGE: 29 SEX Male

HOSPITAL NO: 232806

ROOM: 704

PHYSICIAN: Noble

CLINICAL DATA:

Biopsy, liver

MACROSCOPIC EXAMINATION:

Received fresh is a wedge shaped portion of dark red, rubbery tissue with a slightly nodular sections to external surface. The specimen is 1.2 x 0.7cm. On frozen section, changes highly suggestive of probable angiosarcoma of the liver are seen. A touch preparation and some tissue is saved in the frozen state. Additional formalin fixed biopsy material will be submitted by the surgeon. The other half of the specimen is submitted for routine processi at this time.

ECC/jr

B: Received in formalin labeled biopsy liver are fragments of tan tissue in the aggregate approximately 2.5 x 2.0 x 0.7 cm. The largest fragment is bisected and the specimen is submitted in its entirety.

JTL:sc

MICROSCOPIC EXAMINATION:

A: Microscopic examination reveals liver with proliferation of vascular spaces having nuclear hyperchromatism and pleomorphism.

B: Microscopic examination reveals changes similar to A, with complex branching patterns.

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

DIAGNOSIS:

A & B: LIVER BIOPSY: ANGIOSARCOMA. 54-m0002

J. Thomas Latham, Jr., M.D./sc M.D.

PATHOLOGIST

UCC 080389

3-17-86, Ch.6

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

ADMISSION: 3-17-86

HISTORY: Mr. Cox is a very pleasant 29 year old married white male, admitted to the St. Francis Hospital this evening by Dr. Chet Noble on transfer from Oconee Memorial Hospital. This gentleman's illness dates back as near as I can tell to approximately 8 weeks ago. He is rather stoic about describing his symptoms, but I think I have pretty well pinned him down to a two month duration of his illness. He began noticing what he described as cough and feeling as if he had post nasal drainage. He had a small amount of hemoptysis. He was seen by Dr. Carpenter in Oconee County and treated with some type of antibiotic to no avail. He continued to have periods of epistaxis and what sounds like hemoptysis. He saw Dr. Rampey who placed him on Amoxicillin once again to no avail. This past Saturday the patient got out of bed and had syncope. He also noted chest pain with coughing at that time and he was hospitalized at Oconee Memorial Hospital. He was noted to be rather dramatically anemic at that time. He was transfused four units of packed cells and he was given another unit in the ambulance on the way to the St. Francis Hospital. He also had multiple other abnormalities noted on laboratory testing. He was noted to have an LDH of 411 which is about twice n rmal. All of his other laboratory studies with regards to liver functions were unremarkable. He was hypocalcemic with a serum calcium of 8.1. His albumin was normal at 3.3. His admission urinalysis was unremarkable except for 3+ glucose. A repeat urinalysis showed 20 to 30 white cells and 15 to 20 red cells, this was after a Foley was inserted, but there was no glucose noted. As I mentioned, his admission hemoglobin there was 6.5, white count was 5,200 today. Differential showed 75 segs and 6 bands with 18 lymphocytes. His admission white count at Oconee was 9,800 with 65 segs and 3 bands. He had four eosinophils noted. Prothrombin time was noted to be elevated at 15. PTT was normal. Reticulocyte count was 2.6. Serum amylase was normal at 44. A chest x-ray done at Oconee showed a total white-out of the right chest. He had a thoracentesis performed today revealing a hemothorax. He had 1,000 cc. of grossly bloody fluid removed by Dr. Rampey and at that time he was transferred to Dr. Noble. He also had an upper GI done while at Oconee showing what is reported as an antral ulcer. This gentleman has always previously been in good health, although it is interesting he was hospitalized in Oconee this past fall in July with chest pain for which he was told there was a musculoskeletal origin. There was no evidence of coronary disease noted and apparently chest x-rays were done at that time which were negative. He has had anorexia and nonquantitated weight loss over the past two months. He noted melena on one occasion. I should note at this time that the patient has a very difficult time ascertaining whether he is coughing blood or whether this is post nasal drainage. He has been short of breath for about the past two weeks and has had postural light-headedness for about the past two weeks. He is not aware of any fever or chills.

PAST MEDICAL HISTORY: Other than what I have mentioned above, is totally benign other than for some lumbosacral strain several years ago. He is currently on no medications. He has no allergies.

FAMILY HISTORY: This reveals a history of coronary disease in his grandparents and father. There is no history of diabetes. The patient works at Stoffer

UCC 080390

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

Chemical Company. He has worked at J.P. Stevens as well. He is exposed to toxic chemicals at his employment.

SYSTEMS REVIEW: He denies any headaches. He does complain of some "spots" in front of his left eye intermittently. He denies, as I mentioned, any fever or chills. He admits to a scratchy sore throat and chest pain with coughing. He denies any abdominal pain. He has had some nausea. He denies any heartburn or indigestion. Bowels have been moving regularly. As I mentioned, he had one episode of what he describes as black stools. He had some urinary retention requiring a Foley catheter at Oconee and he does complain of some rather diffuse myalgias. Otherwise, systems review is negative.

PHYSICAL EXAM on the floor this evening, reveals a pleasant, acutely ill appearing gentleman. He is 29 years old. His temperature is 99.6° at this time, it was 100.2 on admission. Pulse is 112, respirations 28, blood pressure 140/74. Head, eyes, ears, nose and throat - pupils are equal, round and reactive to light. There is a small left subconjunctival hemorrhage at approximately 6 o'clock. On examination of his retina, the right fundus is normal. The left fundus reveals two small hemorrhages, one at approximately 1 o'clock, one disk margin lateral to the disk and another at about 3 o'clock. There are no exudates noted. His throat reveals some blood against the posterior pharyngeal wall. There is a rather granular appearance to his pharynx. His neck is supple. There is no adenopathy noted. Lungs reveal markedly decreased breath sounds on the right with tubular sounding breath sounds. His entire right lung is dull to percussion. Left lung reveals rales at the base. Cardiac exam reveals a regular tachycardia with a Grade I/VI ejection murmur audible at the base with radiation toward the axilla. Abdomen reveals the liver edge to be palpable 2 to 3 fingerbreadths below the right costal margin. I do think I can feel the spleen tip with only minimal inspiration. There is no tenderness noted. Extremities showed no edema. He has good distal pulses. Genitalia reveal no testicular masses. Rectal reveals a normal feeling prostate. Stool is hemoccult positive.

LABORTORY DATA here at the St. Francis Hospital reveals a hemoglobin of 8.4 with white count of 15,600 and 88 segs. Arterial blood gases on admission showed a pO2 of 31 and pCO2 of 38. Dr. Noble placed the patient on oxygen and subsequently his pO2 is 42 with pCO2 of 42. Platelet count is 150,000. Prothrombin time 14.8 seconds. PTT is 24.2 seconds. Chest x-ray done here shows a total white-out of the right hemithorax. Attempts at a decubitus film did not glean any further information.

IMPRESSION:
1. Right hemothorax.
2. Possible antral ulcer noted on upper GI at Oconee Memorial.
3. Marked anemia of questionable etiology, possibly related to #2.
4. Hepatosplenomegaly.
5. Two small retinal hemorrhages in the left eye.
6. Epistaxis vs. hemoptysis.
7. Abnormal liver function studies.

TYPE OF REPORT
CONSULTATION

SIGNED
DR. WILLIAM GRIFFIN/dh
M.D.

UCC 080391

All f the above are of questionable etiology. I think in terms of trying to define one specific illness to have caused all of this, I strongly suspect this gentleman has a malignancy with one of the lymphomas or leukemia as being the most likely. I would recommend that we proceed with correcting his prothrombin time and getting a chest tube in to improve his hypoxia. I think this will also improve the quality of the CT scan which Dr. Noble has already ordered. We'll try to do a bone marrow on him in the morning if all goes well, and I also agree with the abdominal CT scan noted. I would like to get leukocyte alkaline phosphatase and Philadelphia chromosome study. We may need to get an ENT evaluation to evaluate his oropharynx as well. I think we are going to be depressed over the ultimate findings in his work-up. We will need to proceed as rapidly as possible.

Thank you for asking us to see him with you.

3-18-86