HOSPITAL NUMBER	DATE AND TIME OF ADMISSION	PRIOR ADMISSION	CODE	FIN. CLS.	DISCHARGE DATE & TIME	DESTINATION CODE
1383686	04/23/92 12:30	03/31/92	P	I	4-W-92	

ATTENDING PHYSICIAN	PHYS. CODE	GEN SVC	HOSP. SERV.	PT. TYPE	PRIOR	SOURCE	REFERRAL SOURCE	ACCIDENT DESCRIPTION
DE MAYO ET AL 25213-39	623058	N	MED	S	R	RA		NON ACCIDENT

ROOM-BED	PATIENT NAME (LAST, FIRST, MI) AND ADDRESS	S	R	MS	AGE	BIRTHDATE	BIRTHPLACE
	REDACTED M	M	1	M	63	07/17/1928	NEW JERSEY

RELIGION: CAT CHURCH: CATHOLIC ET AL & NO REG — Anointed 4/24/92 ABJ

PHONE: NJ 07110 — RES. CODE: 0716 — SS NO: — OCC: RETIRED

NOTIFY IN CASE OF EMERGENCY	RELATION	HOME PHONE NUMBER	WORK PHONE NO.
	WIFE	[redacted]1	

NEXT OF KIN	RELATION	HOME PHONE NUMBER	WORK PHONE NO.
	WIFE		

ADMITTING DIAGNOSIS	DX CODE
ANEMIA/G.I. BLEEDING	578.9

GUARANTOR (LAST, FIRST, MI) AND ADDRESS	RELATION	GUARANTOR'S EMPLOYER
	SELF	SHERWIN WILLIAMS CO.
	OCCUPATION: RETIRED	LISTER AVE
		NEWARK NJ 07105
PHONE:	SS NO:	PHONE: 201-344-7000

	PLAN NAME	POLICY NO.	GROUP NO.	SUBSCRIBER
1	PROVIDENT LIFE 99	158203761		
	25 MERCHANT ST. S/100 CINCINNATI		OH	O
2	AARP-PRUDENTIAL	28611907-1		M
	P.O. BOX 13999	PHILADELPHIA	F	-5880

CRISP

HR

REMARKS: AD: NO. INFO REQUESTED 26 dx VW/

TO BE COMPLETED BY PHYSICIAN

	CODES
PRINCIPLE DIAGNOSIS: Anemia GI Bleeding.	(1) 285.9
SECONDARY DIAGNOSES/COMPLICATIONS:	
PRINCIPLE PROCEDURE — DATE PERFORMED: 25213	4/23@9204
"	4/24@99.04 x
SECONDARY PROCEDURES — DATE PERFORMED:	
CONSULTATIONS: 4/23 1821-D	
CAUSE OF DEATH:	
CONDITION ON DISCHARGE:	

****ADMISSIONS FORM****

ATIENT NAME: | PATIENT NO: 1422070
URS STA: CCC1 | MED REC NO: 068834
OOM/BED: 31190A | HOSP SVC: MED
IP IND: N | PT TYPE: S FC: I
OB: 07/17/1928 AGE: 63 | SEX: M RACE: I YS: M

DDRESS: TE | OCCUPATION: RETIRED
TIY: | RELIGION: CAT NOTIFY PARISH N
TATE: | CHURCH: ST. MARY [illegible]
HONE: | BIRTHPLACE: NEW JERSEY
S# | MAIDEN NAME:

REDACTED

----------------------------GUARANTOR INFO----------------------------

AME: | OCCUPATION: RETIRED
DDRESS: | EMPL NAME:
ITY: | EMPL ADDR:
TATE: | EMPL CITY:
HONE: | EMPL STATE: ZIP
SN: | EMPL PHONE:
ELATION: SELF

-----NEXT OF KIN INFO----------------------EMERGENCY CONTACT INFO----------------

AME: | NAME:
ELATION: | RELATION: WIFE
PHONE: | H PHONE:
PHONE: 000-000-0000 | W PHONE: 000-000-0000

----------------------------INSURANCE INFORMATION----------------------------

LAN NAME : 1 PROVIDENT LIFE | 2 AARP-PRUDENTIAL
OL/GRP NO: | 28612907-1 28612P
UBSCRIBER:
NS CO ADD: 4100 | P.O. BOX 13000

CINCINNATI OH 42546 | PHILADELPHIA PA [illegible]
NS CO PH: 800-621-4309 | [illegible]
LAN NAME :
OL/GRP NO:
UBSCRIBER:
CO ADD:

NS CO PH:
RECERT NO: | CLAIM NO:
UNCOMPENSATED CARE CHECKLIST
T NOTIFIED: DEP PAID: | PRE-AUTHORIZATION: N
T INTERVIEW: REF/UNAB: | MEDICARE QUESTION:
T ID SHOWN: 3RD PARTY: | MEDICARE MESSAGE:
EP REQUESTED: | PIP:

----------------------------CASE DATA----------------------------

RGAN DONOR: N | READMIT CODE: P
AST ADM DT: 04/23/92 | LAST DSCH DT: 04/26/92
A.T. CODE: N | ACCIDENT DSC: NON ACCIDENT

DM DATE: 07/09/92 10:10 | ADM PRIORITY: U
DM DR: 795930 ORSINI ET AL | ADM SOURCE: RP
TN DR: 795930 ORSINI ET AL | REF SOURCE:
DM DX: SEVERE ANEMIA | CD:285.9
EMARKS: UCCC

PAT CLERK:
ORR COPY | ADM CLERK: PB02
10:11 07/09/92 FROM TD18,ADNOADF1

035054

0007-SWP-005803089
CONFIDENTIAL

N41657 01

CLARA MAASS MEDICAL CENTER
INICAL RECORD ABSTRACT

REDACTED

MED REC #: 068834 BILLING #: 1083686 NAME:

ADM DATE:	04/23/92	DSCH DATE:	04/26/92	ATN PHYS:	DL MAYO ET AL
ADM HOUR:	07:51	DSCH STS:	A	HOSP SVC:	MED
ADM CLASS:	R	DSCH DISP:	HR	PT TYPE:	S
REF SOURCE:	RA	TRN DEST:		PC:	I INS1: I INS2: I
REF HOSP ID:		ICU DAYS:	000	TISSUE:	O BLOOD:

BIRTHDATE 07/17/1928 B.W. 0 SEX M RACE 1 ZIP 07110 HSG [illegible] 0716

**********DIAGNOSES, PROCEDURES, AND CONSULTS**********

TYPE	CODE	DESCRIPTION	DATE	PHYS
C10			042392	795930
DA	285.9	ANEMIA NOS	042392	623058
DF	285.9	ANEMIA NOS	042692	623058
PC	99.04	PACKED CELL TRANSFUSION	042492	623058
PC	92.04	GI SCAN & ISOTOPE FUNCT	042392	623058

HCPC:

DRG NO: 395 DRG RATE 3360.20 LOS 3 DAYS CERT 0 OUTLIER IND:

**********UR REVIEWS**********

TYPE	DATE	DAYS	TYPE	DATE	DAYS	TYPE	DATE	DAYS	TYPE	DATE	DAYS

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: 6/8/92

N41657.02

15:54 04/28/92 FROM TC30 MBATTS

CLARA MAASS MEDICAL CENTER
Franklin Avenue
Belleville, New Jersey

REDACTED

FINAL SUMMARY

NAME: MR#: 068834
PHYSICIAN: J. DE MAYO, M.D.

DATE OF ADMISSION: 4/23/92 DATE OF DISCHARGE: 4/26/92

This 63-year-old white male was admitted to the hospital on 4/23/92 because of severe anemia. The patient has a long history of having had anemia. He has been worked up on numerous occasions and he does have a long history of GI bleeding. He had received several units of blood and his hemoglobin continues to drop down. He had a Billroth II, two times. He has had numerous bouts of GI bleeding and has chronic gastric ulcers.

On examination, the patient was markedly pale, weak and complained about abdominal pain. His hemoglobin was low at the office and the patient was advised that he needed admission for blood transfusion.

The patient received two units of packed cells, when his hemoglobin was noted to be 5.9. Dr. Orsini and Dr. Scoppetuolo were called in consultation. He had a bone marrow done and this showed a normocellular biopsy.

His other tests included a GI bleeding scan with RBC tag. There was a negative GI bleeding scan reported and failed to show any active bleeding area at this time.

The patient had other tests done including total iron. The folate acid level was 18.3. His iron binding capacity was 233, which was low. His saturated iron was 94, which was somewhat high. The patient had been taking iron at home. His ferritin was 2,073, which is elevated. His B-12 was 902, which was in the normal range.

The patient also had other tests done, including hemoglobin and hematocrit which showed a hemoglobin of 5.8. He had a giant platelet count. His hematocrit was 18.6.

The patient received several units of packed RBC's and his hemoglobin came up to 8.9, with a hematocrit of 27. The platelets were normal.

The patient continued to have some weakness. His abdominal pain seemed to be better. His stool for occult blood was negative.

The patient, after being seen by Dr. Scoppetuolo and his group, was discharged home. He will be referred to the Hematology Clinic at the Medical School where he will be worked up for other

CONTINUED...

FINAL SUMMARY

REDACTED

FINAL SUMMARY

NAME:

MR#: 068834
PHYSICIAN: J. DE MAYO, M.D.

possible causes of his anemia which should also include the possibility of a red cell dysplasia which is the most likely diagnosis.

The patient is well aware of his diagnosis, also of his further evaluations. He has already had a complete upper GI and lower GI evaluation with no help. The patient requested that he be discharged home so that he could set up an appointment with the Hematology Clinic and get further testing done.

FINAL DIAGNOSIS:
1.) Anemia secondary to some form of GI bleeding, secondary to red cell dysplasia.

J. DE MAYO, M.D.

JD/aks
SecrePhone
DD: 6/19/92
DT: 6/23/92
Cassette #6380

Clara Maass Medical Center
BELLEVILLE, N.J.

REDACTED

DATE OF ADMISSION:

ALLERGY:

LMP:

CHIEF COMPLAINT: anemia, pallor weakness

PRESENT ILLNESS: started several months ago c pallor weakness, abd. pains, G-I bleeding. Received several units PRBCs. Work up in hosp.

PAST HISTORY:
Billroth II x 2
G-I bleeding
Chronic gastritis ulcers

SOCIAL HISTORY:
Negl

FAMILY HISTORY:
Negl

SYSTEM INVENTORY:
Pale
weak
abd. pains

ATTENDING PHYSICIAN: _____, M.D. DATE: 4/23/9-

OF 4575 **HISTORY**

0007-SWP-005803093
CONFIDENTIAL

N41657.04

REDACTED

Clara Maass Medical Center
BELLEVILLE, N.J.

[illegible] MR 068634 1
07/17/1928 63 M
[illegible] MAYO ET AL
[illegible] MAYO ET AL

PHYSICAL FINDINGS:

Head: normocephalic

Eyes: PERLA

Ears: neg

Mouth, Throat: clear

Neck: supple

Chest: clear

Breasts: neg

Cardio-Vascular: RSR no m/r

Abdomen: soft, tender midepigastric region.

Genito-Urinary: neg

Skin: pale

Extremities: neg.

Reflexes: wnl

Rectal: (if indicated) - deferred

Pelvic: (if indicated)

IMPRESSION: Anemia
GI bleeding

EXAMINED BY: [signature], M.D. DATE: 4/23/82

CLARA MAASS MEDICAL CENTER
Franklin Avenue
Belleville, New Jersey

REDACTED

Report of Consultation

NAME :
DATE : 4/23/92
DATE REQUESTED :

MR# 06-88-34
ATTENDING PHYSICIAN : DR. J. DE MAYO
CONSULTING PHYSICIAN : DR. M. SCOPPETUOLO

ROOM# 262A

REPORT REQUESTED REGARDING: anemia

SIGNATURE OF ATTENDING PHYSICIAN _____ M.D.

The patient is a 63-year-old white male whom we are asked to see in consultation regarding severe anemia.

The patient's history dates back to approximately 10-15 years ago when he underwent a Billroth II surgery for peptic ulcer disease. The patient has been stable up until recently when he was found to have severe anemia approximately four to six weeks ago. He was admitted to Clara Maass Medical Center and underwent a bone marrow that was essentially normal with good iron stores. The patient also was transfused at that time and had a workup that included B12 and folate levels that showed adequate levels. An upper endoscopy apparently was performed that was negative. He was well and was discharged home in a stable state. He was readmitted back into the hospital at this point when his hemoglobin had dropped down to 7. He was seen as an outpatient, and it was felt that the concern was that the patient may be having some GI bleeding. He thusly was admitted to the hospital for a bleeding scan. We are asked to see the patient in regard to concurrent care. He denied any vibratory or sensory deficits in the lower extremities and denied any positional or cerebellar complaints at this point.

PAST MEDICAL HISTORY was significant for his Billroth II for peptic ulcer disease. He carries a history of chronic gastric ulcers.

MEDICATIONS: Zantac alone.

REVIEW OF SYSTEMS: As contained in his HPI.

ALLERGIES: He denied any allergies to medications.

PHYSICAL EXAMINATION: HEENT: Pale conjunctivae. No palpable lymphadenopathy. Lungs: Clear. Heart: Normal S1 and S2. Abdomen: Soft. No masses or organomegaly. Neurologic: Intact.

All laboratory studies are pending at this time.

ASSESSMENT: Severe anemia, possibly secondary to gastrointestinal bleeding. Also must rule out the possibility of B12 deficiency or early myelodysplastic syndrome or red cell aplasia.

PLAN: GI bleeding scan, B12 level, iron levels. The possibility of the need for a colonoscope must be considered or an upper endoscopy if this was not previously done. We will await reports of his blood work before deciding on any need for any transfusion, etc.

Thank you very much.

MICHAEL SCOPPETUOLO, MD

d4/23/92 t4/23/92 ll

NO | YES: YEAR 92-966 | IA | 2N 02620A

TRANSPORT: | O2 N | VENT N

NJ 07110

EXAMINATION REQUESTED: GI BLEED ROUTINE | 07/17/1928 | 63

DIAGNOSIS: ANEMIA/G.I. BLEEDING | 1383686 DE MAYO ET AL | MR 068824

HISTORY AND CLINICAL INFORMATION (PLEASE GIVE BRIEF CLINICAL HISTORY AND IMPORTANT PHYSICAL FINDINGS:) NO REQUEST ACCEPTED WITHOUT CLINICAL INFORMATION BY M.D.

SEX	WEIGHT	HEIGHT	IS PT. PREGNANT?	IS PT. NURSING?
M	182	5.10	N	N

G.I. BLEEDING

RBC TAGGED ORDER NO: 2

REQUESTED BY: DE MAYO ET AL .M.D.

REPORT G. I. BLEEDING DATE April 23, 1992--vc.

A G. I. Bleeding study was performed today on your above named patient, following the intravenous administration of 21.5 mCi of Tc labeled pertechnetate after the patient had received 6 mgm. of sodium pyrophosphate, containing 1.7 mgm. of stannous chloride with in vivo labelling of the red cells.

Serial images were performed every 5 mins. up to 1 hr. as well as a dynamic flow study, which showed an increased hyperemia throughout the spleen, which appeared to be significantly large. Aside from that there was no evidence of extravasation or any unusual vascular markings.

The static images failed to show any collection in the abdomen which appeared to be extraluminal, and therefore excluding the possibility of a active bleeding.

In the delayed image performed 4 hrs. later, again failed to show any evidence of active bleeding.

IMPRESSION: NEGATIVE G. I. BLEEDING SCAN, ~~FAILING TO SHOW ANY ACTIVE~~ BLEEDING AREA.

Candido P. Quinones, M. D./vc M.D.

DEPARTMENT OF NUCLEAR MEDICINE
CLARA MAASS MEDICAL CENTER
BELLEVILLE, NEW JERSEY 07109

CHART COPY

0007-SWP-005803097
CONFIDENTIAL

#1.5445 HBF REV. 2/92

N41657.06

CLARA MAASS MEDICAL CENTER, BELLEVILLE, N.J. | MU06

MEDICAL RECORD NO.	CORRECTED COPY	ORGAN	PAT CODE	IND.
068834		N	N	N

HOSPITAL NUMBER	DATE A-D TIME OF ADMISSION	PRIOR ADMISSION	CODE	FIN. CLS.	DISCHARGE DATE & TIME	DESTINATION CODE
1373075	03/31/92 12:43		N	I	4/6/92	

ATTENDING PHYSICIAN	PHYS. CODE	GEN SIC	HOSP. SERV.	PT. TYPE	PRIOR	SOURCE	REFERRAL SOURCE	ACCIDENT DESCRIPTION
DE MAYO ET AL 2521339	623058	N	MED	S	R	RA		NON ACCIDENT

ROOM-BED: 2587

PATIENT NAME (LAST, FIRST, MI) AND ADDRESS: [redacted]AM

S	R	MS	AGE	BIRTHDATE	BIRTHPLACE
M	1	M	63	07/17/1925	NEW JERSEY

RELIGION: CAT CHURCH: ST. MARY'S NUTLEY

ADOPTED in Jail 3/31/92

PHONE: [redacted] RES. CODE: 071[redacted] SS NO: [redacted] OCC: RETIRED

NJ 07110

NOTIFY IN CASE OF EMERGENCY	RELATION	HOME PHONE NUMBER	WORK PHONE NO.
	WIFE	[redacted]	

NEXT OF KIN	RELATION	HOME PHONE NUMBER	WORK PHONE NO.
[redacted]	WIFE		

ADMITTING DIAGNOSIS: G.I. BLEEDING

DX CODE: 578.9

REDACTED

GUARANTOR (LAST, FIRST, MI) AND ADDRESS: [redacted]AM

RELATION: SELF

OCCUPATION: RETIRED

GUARANTOR'S EMPLOYER: SHERWIN WILLIAMS CO. LISTER AVE NEWARK NJ 07105

PHONE: [redacted] SS NO: [redacted] PHONE: 201-344-7[redacted]

S.M.D.

	PLAN NAME	POLICY NO.	GROUP NO.	SUBSCRIBER
1	PROVIDENT LIFE 199 25 MERCHANT ST.S/100 CINCINNATI	SE203761		[redacted]
2	AARP-PRUDENTIAL P.O. BOX 13999 PHILADELPHIA	2861907-1		[redacted]

C.R.I.S.

HR

REMARKS: ADD NO. INFO RE [redacted] 44

TO BE COMPLETED BY PHYSICIAN

	CODES
PRINCIPLE DIAGNOSIS: Anemia	280.0 (3)
Chronic gastritis	535.10 (1)
R/O any further hemotological problems.	414.0 (4)
SECONDARY DIAGNOSES/COMPLICATIONS: Status post G.I bleed.	535.40 (2)
Anesth. 24108	
PRINCIPLE PROCEDURE — DATE PERFORMED: 18349 4/3	45.13 (1)
18148 4/1	41.31 (2)
SECONDARY PROCEDURES — DATE PERFORMED: 25213 4/1	99.0477 (3)
CONSULTATIONS: 4/1 18M8-10	
3/31 18349-01	
CAUSE OF DEATH:	

CONDITION ON DISCHARGE: ☑ Alive ☐ Transferred Dest: _____ ☐ A.M.A.
☐ Died: ☐ Within 24 Hrs. ☐ Within 48 Hrs. ☐ Autopsy: C YES C NO ☐ Not Tested

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPLE AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNED: [redacted] DATE: 4/6/92

CLINICAL RECORD ABSTRACT

MED REC #: 068834 BILLING #: 1373075 NAME: **REDACTED**

ADM DATE:	03/31/92	DSCH DATE:	04/06/92	ATN PHYS	DR MAYO ET AL
ADM HOUR:	12:43	DSCH STS:	A	HOSP SVC:	MED
ADM CLASS:	R	DSCH DISP:	HR	PT TYPE:	S
REF SOURCE:	RA	TRN DEST:		PC:	I INS1: I INS2: I
REF HOSP ID:		ICU DAYS:	000	TISSUE:	O BLOOD:

BIRTHDATE 07/17/1928 B.W. 0 SEX M RACE 1 ZIP 07110 RES CODE 0716

**********DIAGNOSES, PROCEDURES, AND CONSULTS**********

TYPE	CODE	DESCRIPTION	DATE	PHYS
CO1			033192	841916
C10			040192	795930
DA	535.10	ATROPHIC GASTRITIS	033192	623058
DF	535.10	ATROPHIC GASTRITIS	040692	623058
DF	535.40	GASTRITIS NEC	040692	623058
DF	280.0	CHR BLOOD LOSS ANEMIA	040692	623058
DF	414.0	CORONARY ATHEROSCLEROSIS	040692	623058
PC	45.13	SM BOWEL ENDOSCOPY NEC	040392	841916
PC	41.31	BONE MARROW BIOPSY	040192	795930
PC	99.04	PACKED CELL TRANSFUSION	040192	623058

HCPC:

DRG NO: 182 DRG RATE 3454.21 LOS 6 DAYS CERT 0 OUTLIER IND:

**********UR REVIEWS**********

TYPE	DATE	DAYS	TYPE	DATE	DAYS	TYPE	DATE	DAYS	TYPE	DATE	DAYS

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: 6/8/92

0007-SWP-005803099
CONFIDENTIAL

11:11 04/10/92 FROM TC30,MRATT

TC285219

N41657.08

CLARA MAASS MEDICAL CENTER
Franklin Avenue
Belleville, New Jersey

REDACTED

FINAL SUMMARY

NAME: MR#: 068834
PHYSICIAN: J. DE MAYO, M.D.

DATE OF ADMISSION: 3-31-92 DATE OF DISCHARGE: 4-6-92

This 63-year-old white male was admitted as an emergency because of suspected G.I. bleeding. The patient had been at home and having some problem with his blood count. He came to the office appearing quite pale and feeling weak. He had been on iron for over a year and had not been seen in our office for over a year also.

The patient has a history, prior to this, of having some G.I. bleeding and anemia. He was treated with iron and had a workup which was not conclusive other than the fact that he had a past history of having had two surgical procedures for bleeding ulcers. Upper G.I. showed that he had a Billroth II which seemed to be functioning and he had no signs of bleeding at that time.

It was felt, at this point, that the patient may have some chemical problem which may be causing some bone marrow suppression. The patient had been working Sherman Williams, a paint company and was in contact with Benzine and other chemicals. Because of this, the patient will have a bone marrow before any further testing is done. The patient is also to be seen by Dr. Rizvi, gastroenterologist who worked out the possibility of having some kind of G.I. hemorrhage. The patient, other than his G.I. problems has had no other problem other than his anemia and having received several blood transfusions, having two surgical procedures for his G.I. bleed. The patient's workup in the hospital, when he was admitted, included blood work and urinalysis.

The urine was totally negative. There was no sign of any blood or bleeding in it. He had a stool for occult blood which also came back negative. His hemoglobin, at the time of admission, was 6.1 with a white count of 12.3, platelets 587. His differential showed 68 polys, 2 bands, 23 lymphs, 1 mono and 4 eosinophils. He had anisocytosis of 3+, poikilocytosis of 2+, polychromia 2+. Toxic granulation of the platelets appeared increased. Basophilic stippling was also present.

The patient's subsequent hemoglobins were 6.8 and went down to 5.8. At that point, it was felt that the patient could not wait any longer and he had a blood transfusion. Prior to the transfusion, he had a bone marrow done and his hemoglobin then went up to 9.2 and eventually came down to 8.7 and prior to his discharge, it was at 7.8. The patient's reticulocyte count was

CONTINUED...

REDACTED

FINAL SUMMARY

NAME:

MR#: 068834
PHYSICIAN: J. DE MAYO, M.D.

1.2, 1.3. His platelets remained somewhat elevated.

Testing revealed that his potassium was slightly elevated and the patient was not on any potassium. Repeat showed that it came down to 5.0. His glucose was 115. His LDH and SGOT were slightly elevated at 257 and 68 respectively. Repeat showed a sodium was normal. Potassium was also normal.

His hemoglobin continued to remain at the 8.0 level. His ferritin level was 2,910 which is markedly elevated. His iron binding capacity was 235 which is somewhat low. His iron saturation was 96, which was also high. His vitamin B-12 level was 884. His serum iron was 226, which is also on the high side. The patient had been taking iron. He was also given some Vitamin B-12 injections. The patient had a PSA done which was .2. His endoscopy was not revealing for any bleeding at all. The patient's bone marrow will be reviewed by Dr. Orsini and Dr. Scoppetuolo.

His repeat blood work is not back as yet, but the patient was very anxious and would like to go home. Since no further testing is being done at this time, it was decided that the patient could be discharged home, today, 4/6/92, and he will be followed up in the office as an outpatient, on Wednesday, two days from now and he will be given his blood work at that time to re-evaluate, as well as to re-evaluate what is going on with his blood work at this point. The patient is well aware that the diagnosis is not conclusive as of yet and that his blood work is not conclusive and we will be doing further testing as an outpatient. He would prefer that rather than staying in the hospital and doing further studying.

FINAL DIAGNOSIS:

1.) Anemia, unknown etiology.
2.) Chronic gastritis.
3.) Rule out any further hematological problems.
4.) Status post G.I. bleed.

J. DE MAYO, M.D.

JD/aks SecrePhone
DD: 4/6/92 DT: 4/7/92 Cassette #6564

Clara Maass Medical Center
BELLEVILLE, N.J.

REDACTED 662834

DATE OF ADMISSION:

ALLERGY:

LMP:

CHIEF COMPLAINT: pale, weak, nausea.

PRESENT ILLNESS: began several months ago c pallor, weakness, abd. discomfort. Pt. was taking iron pill, but cont to have weakness & pallor. No tarry stools

PAST HISTORY: bleeding ulcer
Billroth II x 2
anemia
Blood transfusion.

Contact c chemicals at work eg benzene

SOCIAL HISTORY: retired

FAMILY HISTORY: neg.

SYSTEM INVENTORY: pale
weak
naus
abd. discomfort

ATTENDING PHYSICIAN: _____, M.D. DATE: 3/3/82

OF 4575
Rev. 3/72 Rev.2/82 Rev.9/85

HISTORY

0007-SWP-005803102
CONFIDENTIAL

N41657.1

Clara Maass Medical Center
BELLEVILLE, N.J.

REDACTED

PHYSICAL FINDINGS:

Head: normocephalic

Eyes: PERLA, Sclera pale

Ears: neg

Mouth, Throat: dry

Neck: supple, no masses

Chest: clear

Breasts: neg

Cardio-Vascular: RSR

Abdomen: tender mid epigastric region, scars from previous surgery. No masses

Genito-Urinary: neg

Skin: pale

Extremities: no edema

Reflexes: WNL

Rectal: (if indicated) — neg

Pelvic: (if indicated)

IMPRESSION:
1. Anemia 2° to bleed
2. G-I hemorrhage
3. Bone marrow supp. due to chem.
4. ASHD
5. S/P Billroth II

0007-SWP-005803103
CONFIDENTIAL

EXAMINED BY: _____, M.D. DATE: 3/31/92

PHYSICAL EXAMINATION

NO [illegible]
LSK [illegible]
[illegible]

Clara Maass Medical Center

033192

REDACTED

Dr DeMayo
FROM: ATTENDING PHYSICIAN
Dr Rizvi
TO: CONSULTING PHYSICIAN DATE:

1373675 MR 068834 1
07/17/19[illegible] 63 M
DE MAYO ET AL
DE MAYO ET AL

REPORT REQUESTED REGARDING: Anemia. Poss GI Bleeding

☐ CONSULTATION ONLY ☐ CONSULTATION AND CONCURRENT CARE ☐ TRANSFER TO CONSULTANT'S CARE

SIGNATURE OF ATTENDING PHYSICIAN: [signature] M.D.

REPORT

FINDINGS:
3/31/92. Chart Reviewed & pt. Examined.
63 yr Male c Hx of 2 Surgeries for Peptic ulcer disease 30 yrs & 10 yrs ago.
Hx. of anemia for past 10 yr, on Oral Iron, Tagamet & Zantac. 2 upper & Lower endoscopies Neg. Last one 1991 at another Hospital.
Vague epigastric discomfort & Hx of lesion ? in sigmoid colon.
Denies any Hematemesis or altered Bowel habits - 6-8 lbs wt Loss in past 6 mths.

DIAGNOSIS: PMH PUD & 2 Surgeries.
Personal Retired Oct 91.
Worked c Benzene & Asbestos

RECOMMENDATIONS:
P/E: Pale looking male
In no distress.
NO Postural drop in BP or Tachycardia
[illegible]

0007-SWP-005803104
CONFIDENTIAL

N41657.11

2582

CLARA MAASS MEDICAL CENTER
Franklin Avenue
Belleville, New Jersey

REDACTED

Report of Consultation

NAME: MR# 06-88-34 ROOM:
DATE: 4/1/92 ATTENDING PHYSICIAN:
DATE REQUESTED: CONSULTING PHYSICIAN: Dr. J. Orsini

REPORT REQUESTED REGARDING: anemia chronic, contact c benzene, peptic ulcer disease

SIGNATURE OF ATTENDING PHYSICIAN _____ M.D.

This is a 63-year-old retired gentleman who I am asked to evaluate because of a severe anemia with a hemoglobin level of approximately 6 grams as reported by Dr. De Mayo.

The patient's history dates back several years ago when he had been evaluated for an anemia with a complete gastrointestinal evaluation by Dr. Rizvi that included an upper GI endoscopy and lower endooscopy, according to the patient. He had been placed on ferrous sulfate since that period of time and has been comfortable up until recently when severe weakness prompted an investigation and an evaluation had shown the hemoglobin level to be significantly low. I have now been asked to evaluate him for considerations for further evaluation and/or possible therapy.

The patient's history also includes a history of anemia with peptic ulcer disease dating back ten years ago, status post surgery, on Tagamet and Zantac since that period of time. It appears that an endoscopic evaluation may have been done some time in 1991 and I do believe it was done by Dr. Rizvi but this will have to be clarified. He has been having increasing epigastric discomfort with no nausea, vomiting, diarrhea or constipation being reported. His stools are always black because of the iron.

SOCIAL HISTORY: He has worked with a number of chemicals including benzene and asbestos as a laborer in a paint factory for some 40+ years.

FAMILY HISTORY: Noncontributory.

MEDICATIONS: As stated above.

PHYSICAL EXAMINATION: Finds a chronically ilkl-looking male who appears to be in some distress with vague abdominal discomfort. The temperature is low grade at 99°, the blood pressure is normal 110/70. The skin is sallow in color. There is no evidence of petechiae or ecchymotic lesions. The eyes, mouth and mucous membranes were

relatively negative. The lungs were clear. The heart was normal sinus rhythm. The breasts were negative. The abdomen was soft. There was no tenderness or organomegaly. His testicular examination was negative. The rectal vault was empty. The prostate was enlarged approximately 1-2+. No nodularities. The reflexes and neurological examination were grossly intact.

Checking laboratory tests and x-rays, none of which are available at this time, preliminary labs had indicated the anemia. Further lab tests are pending including follate, B12, serum ferritin, PSA levels, sed rate and reticulocyte count.

I will schedule him for a bone marrow biopsy and aspiration in an attempt to help find the problem. It appears that we are dealing with some chronic intermittent problem which may be related to the GI tract. An AV malformation may be a vague consideration and the working history also may be a consideration. The differential and CBC will help to ascertain this. I will complete the workup within the next 24-48 hours.

Thank you.

FINAL DIAGNOSIS:
SEVERE AMEMIA, ETIOLOGY TO BE DETERMINED.

JAMES M. ORSINI, M.D.

d4/1/92 t4/1/92 df

DATE 4-3-92 PAGE OR

DIAGNOSIS

PROCEDURE

06 88 34

REDACTED

SURGEONS Dr. Rizvi	PREMEDICATION/DOSAGE	ROUTE	TIME	EFFECT
				☐ SATISFACTORY
ANESTHESIOLOGIST				☐ UNSATISFACTORY

FINDINGS GROSS:

Premedication: as per anesthesiologist.

INDICATIONS FOR PROCEDURE: Severe anemia. History of occult gastrointestinal bleeding

PROCEDURE: The patient was placed in the left lateral position. The Olympus gastroscope was advanced under direct vision to both the loops of the Billroth II anastomosis. The anastomosis was patent. No evidence of ulceration was noted but there was bile-induced gastritis in keeping with the diagnosis and also free reflux of bile was noted in the esophagus. The esophagogastric junction was normal. No evidence of esophagitis was seen.

IMPRESSION: Patent Billroth II anastomosis. Bile-induced gastritis. Bile reflux. No evidence of ulcer or bleeding noted.

The patient tolerated the procedure well and left the endoscopy room in good condition.

WHAT WAS DONE AND SUTURE MATERIAL USED:

IMMEDIATE POSTOPERATIVE CONDITION: HEMORRHAGE, SHOCK, ETC.:

DATE DICTATED: 4-3-92

DATE TRANSCRIBED: 4-3-92bfm

SIGNATURE OF OPERATOR

Masood Rizvi, M.D.

CLARA MAASS MEDICAL CENTER

OPERATIVE RECORD

SPECIMEN: X BONE MARROW ☐ CYTOLOG CELL BLOCK

REDACTED

AGE 63 SEX M OPERATING SURGEON Dr. Orsini

PRE-OP DIAGNOSIS: GI Bleeding

POST-OP DIAGNOSIS: Severe anemia

PAST HISTORY: anemia R/o mets.

CLINICAL DATA: anemia

NATURE OF SPECIMEN: Bone marrow & Bone Sol

SPECIAL REQUESTS: none

Slides - Routine Stain 0 1

068834 1

63 M

258

1902

DATE RECEIVED	PATH. NO.
04/01/92	92-1902

PLEASE WRITE FIRMLY WITH BALL-POINT PEN

The receptacle labeled bone marrow biopsy consists of a core of tissue that measures approximately 3½ cm which is received in Bouin's fluid and the specimen is submitted in cassettes labeled A and B.

MICROSCOPIC SLIDES REVEIWED:

Multiple sections of the bone marrow biopsy demonstrate areas of dense cellularity with the red blood cells and white cell lines appear normally represented. Throughout there is an adequate number of platlet precursors Throughout the sections there is no evidence of atypical giant cells, granulomata or atypical cells.

IMPRESSION:

Bone marrow - normocellular
Vide sopra.

N41657.14

FPG/ld 03 April, 1992
DATE REPORTED

Frank P. Gradone, M.D.
PATHOLOGIST

CLARA MAASS MEDICAL CENTER ORIGINAL SURGICAL PATHOLOG

CHECK:	CHAIR	STRETCHER	WALK	BED	PORTABLE	O.R.	O_2	IV		X-RAY NO. 313641

EXAMINATION REQUESTED: Chest X-ray

☒ INPATIENT ☐ E.R.
☐ OUTPATIENT ☐ PAT.

[illegible] 068834 NO
[illegible] 63 M DR
[illegible] MAYO ET AL
[illegible] MAYO ET AL
NAME
ADDRESS (O P OR E P

HISTORY AND CLINICAL INFORMATION — NO REQUEST ACCEPTED WITHOUT (PERTINENT CLINICAL INFORMATION)

G.E. Bleed

OLD X-RAY NO

FILMS USED						
8x10	10x12	11x14	14x17	14x36		TOTAL
			2			2

POSSIBLE COMP CASE ☐ YES ☐ NO

REMARKS

L.M.P. | PATIENT'S WEIGHT

ARE YOU PREGNANT? ☐ YES ☐ NO | PREPARED BY | REQUESTED BY [illegible] M.D. | DATE TAKEN 3/31/92 | TECH [illegible]

DO NOT WRITE BELOW THIS LINE

PATIENT DATE

92-313641 4-1-92

CHEST X-RAY, PA AND LATERAL

REDACTED

The lung fields are clear of infiltrate or congestive change. Heart and mediastinal structures are unremarkable. Surgical sutures are noted in the anterior aspect of the abdomen on the lateral projection.

IMPRESSION: No acute cardiopulmonary pathology is noted.

JH/lb
4-1-92

1992 MAR 31 P 5:29

JAMES HEIMANN, M.D. MD
RADIOLOGIST

X—RAY REPORT

DEPARTMENT OF RADIOLOGY — CLARA MAASS MEDICAL CENTER, BELLEVILLE, N.J. 07109

ORIGINAL

0007-SWP-005803109
CONFIDENTIAL

N41657.15

CLARA MAASS MEMORIAL HOSPITAL

BELLEVILLE, N. J.

323760 9 — Emergency

1	RC 315B S J	PATIENT		DOCTOR 623058 J.De Mayo,Crsini			NOTIFY IN EME Mrs. Same		
2	DATE ADMITTED 072478 0215 P M.		SEX M	RACE W	AGE 50	MARITAL 1	SERVICE MS	PHONE Same	RELATIONSHIP Wife
3	DATE DISCHARGED 8-5-78 1000 A.M. P.M.		RELIGION CAT St.Mary		DATE LAST ADMITTED 1975?			RESP. PARTY (OR INSURED) Patient	RELA
4	OCCUPATION LiftTruck Operator		BIRTH PLACE Newark,N.J.		BIRTH DATE 071728			ADDRESS Same	
5	DIAGNOSIS GI Bleeding							EMPLOYER AND ADDRESS Sherwin Williams Brown St. & Lester Ave. Newark,N.J.	
6	FATHER'S NAME	MOTHER'S MAIDEN NAME							
7	INSURANCE PLAN N.J.B.C.	CTF. NO. 1223-07-1728	M & S NO. Gr 01-70246	Codes 580	586 Eff 9/1/70			OCCUPATION	
8	INSURANCE BENEFITS Wife Mandee Shop, Allwood Rd.Clifton,N.J.		REMARKS no val					ADMITTED BY JH	
9									

(12)

REDACTED

TO BE COMPLETED BY PHYSICIAN

CODE NO.

FINAL DIAGNOSIS: GI bleeding
2° anemia

SECONDARY DIAGNOSIS OR COMPLICATIONS:

OPERATIONS: 7-31 Gastroscopy

CONSULTATION WITH: Gidanella

RESULTS: ☐ RECOVERED ☐ IMPROVED ☐ UNIMPROVED ☐ NOT TREATED ☐ DIAGNOSIS ONLY ☐ DIED

CAUSE OF DEATH: AUTOPSY ☐ YES ☐ NO

I HAVE EXAMINED AND APPROVED THIS COMPLETE MEDICAL RECORD.

DATE 8/5/78 SIGNED [signature] M.D. (ATTENDING PHYSICIAN)

AUTHORIZATION

I hereby authorize Clara Maass Memorial Hospital and the physician or physicians in charge of the care of this patient, to carry out such diagnostic procedures, to administer such treatments and administer such anesthetics, transfusions, intravenous medications, and to perfo such operations as may be deemed necessary or advisable in the diagnosis or treatment of this patient, and to examine and to make prop disposition of all tissue or anatomical parts.

Date 7/24/78 Signed X

Witness Joan Malley Signed _____ (NEXT OF KIN) (RELATIONSHIP)

SUMMARY

3-315

REDACTED

CLARA MAASS MEMORIAL HOSPITAL
BELLEVILLE, N. J.

32-37-60-1
U.S. DEPT. OF H.E.W. [illegible]

CHECK ✓ if findings are normal after examination.	MARK X in appropriate space in column at left if findings are abnormal on examination, and describe in space below

PRESENT COMPLAINT
Concise statement of complaints with date of onset and duration of each.
Record in order of importance.

Weakness, abd. pain, tarry stool.

PAST HISTORY

_ Measles	_ Influenza
_ Whooping Cough	_ Pleurisy
_ Mumps	_ Tuberculosis
_ Chicken pox	_ Asthma
_ Tonsilitis	_ Arthritis
_ Scarlet Fever	_ Amebiasis
_ Diphtheria	_ Lues
_ Rheumatic Fever	_ Gonorrhea
_ Typhoid Fever	_ Injuries
_ Malaria	_ Operations
_ Pneumonia	_ Other

(1) Duodenal ulcer
(2) Had surg. c gastrectomy 1964.

FAMILY HISTORY
If living, health of, and if deceased, cause of death of father, mother, siblings, children.
Any familial:

_ Cancer	_ Heart Disease
_ Tuberculosis	_ Allergy
_ Diabetes	_ Arthritis
_ Hemophilia	_ Other
_ Kidney Disease	_____

(1) Grandmother diabetes
(1) Brother had bleeding ulcers.

INVENTORY BY SYSTEMS

GENERAL

_ Nutrition	_ Tremor
_ Fever	_ Weight Gain
_ Night Sweats	_ Weight Loss
_ Falling Hair	_ Other

SKIN

_ Eruptions	_ Jaundice
_ Cyanosis	_ Other

HEAD

_ Headache	_ Syncope
_ Trauma	_ Other

EYES

_ Eye Strain	_ Lacrymation
_ Diplopia	_ Glasses
_ Photophobia	_ Other

(over)

ATTENDING PHYSICIAN: [signature] M.D. Date: 2/24/78

N41657.17

CLARA MAASS MEMORIAL HOSPITAL
BELLEVILLE, N. J.

REDACTED

PHYSICAL FINDINGS:

Scalp: neg

Eyes: OD-R L-A

Ears: neg

Mouth, Throat: neg

Neck: supple no masses

Chest: clear A & A

Breasts: neg

Cardio-Vascular: RSR no m

Abdomen: soft, tenderness mid epigastrium region

Genito-Urinary: neg

Skin: pale

Extremities: NS

Reflexes: neg

Rectal: (If Indicated)

Pelvic: (If Indicated)

Impression:

g + bleeding
2° anemia

0007-SWP-005803112
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EXAMINED BY: _____, M.D. Date: 2/9/71

PHYSICAL EXAMINATION

Rev. Oct. 1977

CLARA MAASS MEMORIAL HOSPITAL
Belleville, New Jersey

INITIAL PHYSICIAN ADMISSION NOTES

124 3

3-315-

52-37-60-9
BAS. DE MAYO; CRSTM

REDACTED

REASON FOR ADMISSION: Weakness, tarry stool abd. pains.

RESPONSE TO PREVIOUS THERAPY (IF ANY): no help

DIAGNOSTIC PLAN OF ACTION (TESTS, X-RAYS, ETC.) G.I.

ANTICIPATED CONSULTATIONS; SPECIAL THERAPY: G.I.

POST DISCHARGE PLAN:
- [x] HOME
- [ ] HOME WITH ASSISTANCE
- [ ] NURSING HOME

[signature] M.D.
ATTENDING PHYSICIAN

2/4/72
DATE

2/2/72 H&H stable. Has abd. discomfort & heart murm. Has G.I. this A.M.

[signature]

0007-SWP-005803113
CONFIDENTIAL

CLARA MAASS MEMORIAL HOSPITAL

BELLEVILLE, N. J.

REDACTED

HOSP. NO. 21-70-95-0	EMERGENCY								
ROOM 300B	PATIENT Mr.		DOCTOR 623058 J. De Mayo				NOTIFY IN EMERGENCY Same		
DATE ADMITTED 050275	0330 P M.	SEX M	RACE W	AGE 46	MARITAL 1	SERVICE M/S	PHONE Same	RELATIONSHIP Wife	
DATE DISCHARGED 5/11/75	9:25 A.M. P.M.	RELIGION CAT			DATE LAST ADMITTED		RESP. PARTY (OR INSURED) Patient (Self)		
OCCUPATION		BIRTH PLACE Newark, N.J.			BIRTH DATE 071728		ADDRESS		
DIAGNOSIS G. I. Bleeding							EMPLOYER AND ADDRESS Sherwin Williams Paint Co. Lister Avenue Newark, N.J.		
FATHER'S NAME Admission Certified Days 569		MOTHER'S MAIDEN NAME 5					U.R.C.		
INSURANCE PLAN Admission not Certified		CITY NO.			MBS NO.		ID Date		
UBC 1223-07-1728 Ca:530/586 Eff: 9/1/70 Gr:01-702							OCCUPATION 6 Lift Truck Operator Direct Admission		
INSURANCE BENEFITS Wife works at Mendes Shops-65 Passaic Ave., Kearny, N.J.		REMARKS No Valuables.					ADMITTED BY JV		

TO BE COMPLETED BY PHYSICIAN

COD NO.

FINAL DIAGNOSIS: Erosive Gastritis — 535.1

2° Anemia — 285.1

2-PC Ot — 216.2

SECONDARY DIAGNOSIS OR COMPLICATIONS:

OPERATIONS: 5-7 Gastroscopy — 44.1

CONSULTATION WITH: Graziano

RESULTS: ☐ RECOVERED ☐ IMPROVED ☐ UNIMPROVED ☐ NOT TREATED ☐ DIAGNOSIS ONLY ☐ DIED

CAUSE OF DEATH: AUTOPSY ☐ YES ☐ NO

I HAVE EXAMINED AND APPROVED THIS COMPLETE MEDICAL RECORD.

DATE 5/11/75 SIGNED J. De Mayo M.D. (ATTENDING PHYSICIAN)

AUTHORIZATION

I hereby authorize Clara Maass Memorial Hospital and the physician or physicians in charge of the care of this patient to carry out such diagnostic procedures, to administer such treatments and administer such anesthetics, transfusions, intravenous medications, and to perform such operations as may be deemed necessary or advisable in the diagnosis or treatment of this patient and to examine and to make proper disposition of all tissue or anatomical parts.

Date 5/2/75 Signed

Witness Jane Williams Signed (NEXT OF KIN) (RELATIONSHIP) (X)

0007-SWP-005803114
CONFIDENTIAL

SUMMARY 1.00

N41657.18

REDACTED

2 3

CLARA MAASS MEMORIAL HOSPITAL
BELLEVILLE, N. J.

25-70-95-0

DR. J. DE MAYO

CHECK √ if findings are normal after examination.	MARK X in appropriate space in column at left if findings are abnormal on examination, and describe in space below

PRESENT COMPLAINT
Concise statement of complaints with date of onset and duration of each.
Record in order of importance.

46 years old W/M

Ch. C. PT was operated e 12 years ago of gastric ulcer - since last 2 days passing black stool and feeling dizzy: admitted for check up + Tx.

PAST HISTORY

_ Measles _ Influenza
_ Whooping Cough _ Pleurisy
_ Mumps _ Tuberculosis
_ Chickenpox _ Asthma
_ Tonsilitis _ Arthritis
_ Scarlet Fever _ Amebiasis
_ Diphtheria _ Lues
_ Rheumatic Fever _ Gonorrhea
_ Typhoid Fever _ Injuries
_ Malaria _ Operations
_ Pneumonia _ Other

P.H/operat: Hemorrhoidectomy op. done.

Allergies: none.

R. past diseases: nothing [illegible]

FAMILY HISTORY
If living, health of, and if deceased, cause of death of father, mother, siblings, children.
Any familial:

_ Cancer _ Heart Disease
_ Tuberculosis _ Allergy
_ Diabetes _ Arthritis
_ Hemophilia _ Other
_ Kidney Disease

INVENTORY BY SYSTEMS

GENERAL
_ Nutrition _ Tremor
_ Fever _ Weight Gain
_ Night Sweats _ Weight Loss
_ Falling Hair _ Other

SKIN
_ Eruptions _ Jaundice
_ Cyanosis _ Other

HEAD
_ Headache _ Syncope
_ Trauma _ Other

EYES
_ Eye Strain _ Lacrymation
_ Diplopia _ Glasses
_ Photophobia _ Other

(over)

appetite: ok.
Bowels: passing black stool
drinking: daily/beer.
Married c 3 children
F.H. grandmother [illegible] diabetes

TAKEN BY: [signature] (Signature of Physician taking History) Date: 5/2/75

ATTENDING PHYSICIAN: [signature] M.D. Date: 5/3/75

OF 4575 REV. MARCH 1972

HISTORY

0007-SWP-005803115
CONFIDENTIAL

15 2 75 **REDACTED**

25-70-75-0

DR. J. [illegible]

CLARA MAASS MEMORIAL HOSPITAL
BELLEVILLE, N. J.

GENERAL CONDITIONS: Temp. Height Wt. n. pr. Pulse: rate char.

B.P.: s. d. Resp.: rate char.

Nutrition, etc.: W/M w/d w/n

PHYSICAL FINDINGS: [illegible]

HEAD: EENT: NS

NECK: [illegible]

CHEST: Symmetrical - lungs: [illegible]

CARDIO-VASCULAR: [illegible]

ABDOMEN: [illegible] epigastrium [illegible]

GENITO-URINARY: [illegible]

SKIN: [illegible]

BONES & JOINTS:

GLANDULAR: } NS

NEURO-MUSCULAR:

[illegible]: NS

WORKING DIAGNOSIS: (After Physical Examination)

EXAMINED BY: [signature] Date: 5/2/75

ATTENDING PHYSICIAN: [signature], M.D. Date: 5/2/75

OF 4160 **PHYSICAL EXAMINATION** 0007-SWP-005803116 Rev. July 1972

CONFIDENTIAL

CLARA MAASS MEMORIAL HOSPITAL
BELLEVILLE, N. J.

5( ) 75

25-70-95-0 REDACTED

DR. J. DE MAYO

Date	Each Note Should Be Signed by Physician
5/2/75	46 yr. w/m admitted because of tarry stools for past 24 hrs. weakness dizziness & fainting feeling. Pt. had gastrectomy 14 years ago for ulcer. Has not been on diet or meds since operation.
	BP 110/70
	HEENT - sclera pale
	Heart reg.
	Lungs: clear
	Abd: soft no masses
	Ext. neg.
	Dx Impres.
	① G.I. bleeding
	② 2° anemia
	[signature]
5/3/75	Dizziness on arising. Heart reg. Lungs clear. Hgb. 7.8 gms.
	[signature]
5/4/75	Weakness. Hgb. stable at 7.3 gms.
	[signature]

OF 4580 0007-SWP-005803117 CONFIDENTIAL **PROGRESS NOTES**