Name WARREN, JOHN K. Guarnieri, M.D. Disc: 6/13/87 # 056428288

HISTORY OF PRESENT ILLNESS: Chief complaint was unsteadiness and dizziness.

This 63 year old, white male with a 20 years history of Meniere's Disease presents complaining of a two day history of dizziness and significant headache. The patient states that he had been in his usual state of good health until 5/30/87 when shortly after awakening he developed some nausea. Shortly after his nausea began he developed a headache which began initially in his right eye and subsequently migrated across his forehead, down the crown of his head, and down to the occiput. He stated that the headache was right sided only. The headache and nausea were accompanied by dizziness, trouble focusing, and some dry heaves, although the patient's wife states he had vomited up some brownish material. He did not go to work that day because of his nausea and light headedness. He had anorexia for the rest of that day, but stated his headache began to resolve. On Sunday, he stated his headache was gone, but his nausea, dry heaves, and dizziness persisted. He also noted that his right arm was somewhat unsteady and it felt as if he had light headedness in that arm. Throughout the rest of that day, 5/31/87, he reportedly began to feel somewhat better. This a.m. 5/31/87, the patient states that his nausea and vomiting had resolved and he was able to keep solid foods down. He stated that he was still dizzy, unsteady, and his right arm still is somewhat unsteady. He reports that he typically has an attack of his Meniere's Disease every four to five years, but it was felt that this particular episode was similar to his previous attacks, except that he was a little more unsteady than usual. Also atypical is that he does not have arm
Typically he does not have a headache associated with his Meniere's attacks.

PAST MEDICAL HISTORY: 1) Status post head trauma with 13 sutures on the occiput on 11/19/85. 2) History of arrhythmias 11/85 to 12/85 on Procan, subsequently discontinued by Cardiologist. Follow-up Holters and tread mill stress tests within normal limits. 3) History of fibula/tibia fracture right leg in 1984. 4) Status post right eye surgery secondary to strabismus. 5) History of Meniere's Disease. 6) History of asthma. 7) History of bronchitis, 5/19/87.

FAMILY HISTORY: Father died of an M.I. in 1985. Mother died at age 80 secondary to carcinoma of the uterus and ovaries. He's got a brother at the age of 67 who had a CVA, a 66 year old brother also had a CVA. An 84 year old sister alive and well, status post hip replacement.

SOCIAL HISTORY: Patient is married, lives with his wife in Springfield, has children. Denies any history of cigarette smoking or alcohol use. Works as a tank farm operator at Monsanto. Reports exposure to and

MEDICATIONS: Dramamine prn. dizziness. Allergies; none.

SYSTEM REVIEW: Poor dentition by history. History of some dizziness times many years. Fatty tumor the right upper extremity.

PHYSICAL EXAM: Generally well developed, well nourished, white male in no acute distress. Alert and oriented times four. Temp. 98.9, pulse 72, BP 124/64 lying, pulse 76, BP 130/70 sitting position, respirations 16. HEENT; NCAT, scar on the occiput. PERL. EOMI. Strabizmus noted of the right eye. Patient with horizontal nystagmus of eyes on right gaze, greater than left gaze. Fundi poorly visualized. TMs clear without erythema. Nose and throat clear. Mouth with poor dentition. Neck; supple, full range of motion without JVD, without lymphadenopathy, without thyromegaly, without bruits. Heart; RR normal, normal S1, S2, with a 1/6 systolic murmur at the left sternal border without S3 or S4. Lungs; clear to auscultation. Coarse bilateral breath sounds. Abdomen; soft, nontender, positive bowel sounds, without masses or organomegaly. Extremities; without clubbing, cyanosis, or edema. Cranial nerves 2 through 12 grossly intact. Cerebellar was intact. Motion was 5/5 in the upper and lower extremities bilaterally. Sensory exam was grossly intact to light touch and pin prick. Rectal; heme negative without masses.

LABORATORY: Upon admission revealed a hemoglobin 11.9, hematocrit 34.8, a WBC count 8.7. Patient had a differential of 3 bands, 25 polys, 1 lymph, 1 mono, sodium 139, potassium 4.3, chloride 108, bicarb. 24, glucose 70, BUN 19, creatinine 1.1, calcium 9.0.

HOSPITAL COURSE: Patient was admitted with the diagnosis of Meniere's Disease versus a cerebral vascular accident. Patient underwent a CAT scan of the head to rule out cerebral vascular accident. CT scan of the head revealed multiple lesions suggestive of metastases. As a result radiation therapy was consulted to begin radiation therapy to the patient's head. Patient underwent a bronchoscopy to attempt to assess possible pulmonary source for his metastases. Bronchoscopy showed inflammatory disease of unknown etiology, however, without any evidence of a metastatic or gross primary lesion. Patient underwent a CT scan of the chest on 6/4/87 which revealed multiple nodular densities on lungs with scarring and fibrosis at both lower lobes. CT scan of the abdomen showed a large liver mass, however, no clear primary was again elicited. A CT directed needle biopsy of the liver mass was scheduled to attempt to determine if that was the etiology of the patient's liver biopsy. CT scan with liver biopsy revealed necrotic tissue without clear evidence of either primary cancer or metastasis to the liver. Patient was placed on

IV Decadron to try to reduce some of his cerebral edema and radiation to his brain was continued. However, again no clear cut primary source was evident. Further work-up of the patient's brain lesions included IVP and CT scan of the pelvis which were again nondiagnostic of primary lesion. He continued to have daily radiation therapy as well as Decadron. However, as no primary lesion was discovered from the patient's cancer and he was feeling somewhat better after receiving radiation therapy and Decadron, patient was discharged to home in stable condition on 6/13/87 with regular diet and activity ad. lib. Medications on discharge were Decadron 4 mg. p.o. q.i.d. for three days and 2 mg. p.o. q.i.d. for two days. Patient was to see Dr. Arthur McGuire at his office one week after discharge for continuing of the tapering schedule. Patient was placed on Reglan 10 mg. p.o. one rac and q. hs., Carafate 1 gm. p.o. one rac and q. hs.

FINAL DIAGNOSIS: 1. METASTATIC BRAIN CANCER WITH UNDETERMINED PRIMARY. 2. QUESTION OF A LUNG CARCINOMA. 3. RADIATION THERAPY TO THE BRAIN. 4. STATUS POST BRONCHOSCOPY. 5. STATUS POST COMPUTED TOMOGRAPHY DIRECTED BIOPSY OF THE LIVER WHICH REVEALED MENINGIOMA. 6. MENIERE'S DISEASE.

The patient will be followed by Dr. Arthur McGuire for further work-up as well as for further therapy of his carcinoma.

K. Guarnieri, M.D.

KG:bss#28
D:10/5/87
T:10/10/87
cc: Dr. K. Guarnieri

Baystate Medical Center
Springfield, Massachusetts

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

Adm: 1/1/88

expired 231633
Name WARREN, JOHN H. Dr. Flatow Disc: 1/29/88 # 056629646

This 64-year-old white male with hemangiosarcoma of the liver widely metastatic was admitted through the Emergency Room with persistent vomiting of coffeeground material, progressive weakness. The patient was discharged home 36 hours prior to this admission following reinstitution of whole brain radiation for central nervous system metastases. He had a long history of Meniere's disease with tinnitus and vertigo but was admitted in June of 1987 with exacerbation of symptoms. Study at that time showed multiple brain metastases and following biopsy of pleural and pulmonary metastases the diagnosis of hemangiosarcoma was made. The patient gave a long history of exposure to vinyl chloride at his place of employment. In June he was treated with whole brain radiation plus Decadron with improvement and then received chemotherapy with DTIC, Adriamycin followed by Methotrexate plus Citrovorum rescue without any improvement. There was progression of multiple pulmonary nodules, intermittent hemoptysis, intermittent hematuria, progressive anemia with positive stool guaiacs requiring multiple transfusions. On his recent admission for severe weakness and ataxia repeat CT scan of the brain showed recurrence of the CNS metastases particularly in the posterior fossa. On 12/31/87 radiation to the whole brain for a second course was begun by Dr. Stark and he was discharged home over the long holiday weekend. On 1/1/88 he began to vomit, was unable to maintain his medications, complained of headache on the right side radiating to the occipital area. He was treated with Torecan and oral Decadron, neither of these modalities helped and he was brought to the Emergency Room with his persistent vomiting. Other medications at home included Dilantin 400 mgs daily, Digoxin .25 mgs daily for arrhythmias, folic acid and iron for his anemia and Decadron.

PHYSICAL EXAM: Revealed a chronically ill, pale white male. Blood pressure 150/80, pulse 120, temperature 99.1. HEENT: total alopecia, no scleral icterus, pupils were equal, extraocular movements normal, nose and pharynx unremarkable. Neck: no venous distension. Lungs: clear to percussion, inspiratory rales present lower left lung field. Heart: sinus tachycardia, grade 2/6 systolic murmur left sternal borde Abdomen: soft, no palpable liver, no focal tenderness. Genitalia: normal male. Rectal exam: copious soft, dark stool guaiac positive. Vomitus brought in by the family also tested at this time and guaiac positive, no frank blood seen. No rectal masses. Extremities: no focal weakness, no dependent edema, deep tendon reflexes 3+ and symmetrical.

LABORATORY DATA: Hemoglobin 8.1, hematocrit 24.5, white count 15,300, platelet count 577,000. Reticulocyte count 3.5%. Sodium 133, potassium 4.5, chloride 102, C02 23, glucose 157, BUN 17, creatinine 0.3.

continued.....

Unit ☐ Springfield-Wesson Women's ☐ Wesson Memorial

☐ History and Physical ☐ Operative Note ☒ Discharge Summary ☐ Other

Calcium 7.8, total protein 3.7 with albumin 1.9, alkaline phosphatase 316, LDH 804, SGOT 59. Dilantin level 4.6, Digoxin level 0.6. No additional x-ray studies were done.

HOSPITAL COURSE: The patient was continued on full fluid diet, given IV fluids and continued on his Lanoxin and Dilantin. Decadron was switched to 4 mgs intravenously every 6 hours. Compazine was given IM for nausea. Carafate and Zantac were added for possible upper GI bleeding. The patient was continued by Dr. Stark on his whole brain radiation with treatments through 1/12/88 to a total of 4600 rads with 1400 in this most recent course. Because of his poor clinical condition it was elected to discontinue the whole brain radiation. Unfortunately the family remained very optimistic throughout this course of treatment and failed to accept the progressive deterioration in Mr. Warren's condition. They continued to describe excellent oral intake due to their feeding efforts in the hospital but total oral intake/day was measured in teaspoons of food. Mr. Warren became progressively weak, had continued blood loss anemia and at the family's insistence required numerous transfusions of packed cells to maintain satisfactory hemoglobin. Multiple nodules developed progressively on the skin consistent with cutaneous metastatic lesions. Great difficulty was had in maintaining peripheral IV sites. Toward the end of his course additional discussions were held with the family who still spoke of surgical consultations to remove all metastatic lesions from the brain, the lungs, skin, the liver, the gastrointestinal and genitourinary tracts. They were discouraged from this approach and finally after extensive review of the problem concluded that additional supportive care was of no long term benefit. When no more peripheral IV sites were obtainable it was elected not to prepare a central line and not to continue with blood transfusions. At this point the patient's status was very poor and he slipped further over subsequent days to expire at 2:35 PM 1/29/88 with the family and undersigned present. Permission for postmortem examination was not obtained.

FINAL DIAGNOSIS: 1. HEMANGIOSARCOMA OF THE LIVER. 2. RECURRENT METASTATIC DISEASE TO THE BRAIN. 3. MULTIPLE PULMONARY METASTASES. 4. PERSISTENT GASTROINTESTINAL BLEEDING WITH SUSPECTED GASTROINTESTINAL METASTASES. 5. INTERMITTENT HEMATURIA WITH SUSPECTED URINARY TRACT METASTASES. 6. MULTIPLE CUTANEOUS METASTASES. 7. PAST HISTORY OF CARDIAC ARRHYTHMIAS.

F. Flatow, M.D.

FF/bss23
D: 2/16/88
T: 2/18/88
cc: Dr. Flatow

05662264 03-0 677 B
WARREN, JOHN H
PLATON, FRED PLATON, FRED
0231633 09/14/23 034

(ADDRESSOGRAPH IMPRINT)

BAYSTATE MEDICAL CENTER
Springfield, MA 01199

Division of Nursing

PATIENT PROGRESS NOTE

Date / Time	Problem #	
1/2/88	12A	Pt. lethargic but responds verbally [illegible]. IV [illegible]
		[illegible] arm. No [illegible]. No vomiting. [illegible] RN
	5A	Pt turning [illegible]. Incont. [illegible] [illegible]
		[illegible]
1-2-88	9A	[illegible] - difficult [illegible]
	11A	[illegible] - [illegible]
		[illegible] repeated [illegible]
		[illegible]
	1300-215	Family members visiting - [illegible]
		[illegible] RN
1/2/88	7P-pm	Incidental - VSS, infused 2 u of PRBC over 2-3 h each
		IV D5 ½ NS held during infusions pt continues to be
		lethargic and responsive only to nail bed pressure —
		[illegible]
1/3/88	2A	S-0
		O - Pt in bed, eyes closed, [illegible]. Repositioned for comfort.
		Incont. of urine. Voiding!
		A - alteration in skin integrity R/T ↓ mobility + incont.
		P - turn frequently + check for incontinence.
		E - No breakdown noted. [illegible] RN
1/4/88	5A	S - 0
		O - [illegible]. Lying in bed, eyes open, [illegible]
		[illegible]. VSS. [illegible] urine
		A - Alt in skin integ. R/T ↓ mobility
		P - [illegible] [illegible]
1-4-88	8A	C/o headache [illegible] taken
	10:30	To Radiation via stretcher. [illegible] during
		shift. While in [illegible] medicated [illegible]
		[illegible] Tylenol for headache pain [illegible] effective
		results. [illegible]
1/5	#1	Pot. for alt. in skin integrity
3:50 A		S. " My leg "
		O. Pt incont. of urine during noc.
		[illegible] products turned
		and repositioned q 2 h. No redness

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

Date / Time	Problem #	
		for skin breakdown noted, c/o
		of pain when repositioning
		A: Potential alteration skin integrity
		P: Check q 2° for incontinent, and skin
		care c each incontinent, turn +
		repos q 2°, monitor for skin
		brkdn, massage pressure pts.
		E: free from skin brkdn at this
		time. — Christina [illegible] RN
1-6-88	#1	S: [illegible]
	1P.M.	O: [illegible] in bed [illegible] pt [illegible]
		incont [illegible] when turned
		P: [illegible] linens changed, skin care given [illegible]
		q 2° — [illegible] LPN
1-6-88 12N		[illegible]
		[illegible]
—	—	[illegible] Tylenol [illegible] mg [illegible]
	—	[illegible] — [illegible]
1/6.	6p	Med c Tylenol for c/o H/A — M[illegible]
11-7	11-7	S: "I feel so good now."
		O: pt. c leaking texas inc of stool in evening.
		family request air mattress as pt
		had on last admit. pt alert talkative [illegible]
		[illegible] in most [illegible].
		A: Alt in skin integ. —
		P: NCP #1
		E: inc of stool (+) — Texas cath reapplied
		+ remained attached throughout shift. skin care given
		EGG crate mattress on. pt A position
—		thru noc — [illegible] RN
1-7-88	8A	Appetite good [illegible] continuously. Stool x1
		c positive guaiac results. Ensure given c
		[illegible] [illegible] this am!
	11AM	To radiation via stretcher.
	12	[illegible] returned from radiation. A. [illegible]
1-8-88	10A	Readied for radiation via stretcher.
		Appetite poor — ensure given [illegible] ice cream
		and [illegible] taken.
	11	Returned [illegible] radiation c texas cath [illegible]
		[illegible] of [illegible] A. [illegible] RN

05662964 ... 677 B
WARDEN, JOHN H
FLATOW, FRED FLATOW, FRED
0231533 09/14/23 064

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BAYSTATE MEDICAL CENTER
Springfield, MA 01199

Division of Nursing

PATIENT PROGRESS NOTE

Date / Time	Problem #	
1-8-88	11 30	[illegible] applied. [illegible] custard & ice cream Taken [illegible] for lunch! [illegible]
1-8-88	9 30 pm	Incidental - VSS IV infusing D5 1/2 NS @ 75cc/hr via controller s̄ redness or swelling taking po fluids well c̄ sons encouragement medicated @ 8pm c̄ Tylenol for c/o headache c̄ subsequent relief more alert than two days ago. [illegible]
1-9-88	3 AM	S - ø
		O In bed, alert, Texas cath on, no stool at this time.
		P Care continues as per NCP. — [illegible]
		A Pot Alt in skin integrity d/t incontinence
		E Pt skin remaining intact [illegible]
1-10-88	3 AM	S ø
		O In bed Texas cath off incont of urine alert c̄ periods of confusion.
		P Care continues as per NCP. [illegible]
		A - pot alt in skin integrity
		E - [illegible] x2 → night no skin break-down noted — [illegible]
1/11/88	5am	S: ø
		O: pt in bed, 4 rails ↑, Texas cath ∆'d, drng well, pt turned + repositioned thru noc. IV patent, no c/o from pt
		A: Pot alt in skin integrity
		P: as per NCP
		E: No ∆ in skin integrity noted @ this time - [illegible]
1/11/88		Pt. tol. bfast well. eating full liq diet well when fed. texas cath intact - draining clear yellow urine. Turn + repo on eggcrate matt. IV patent infusing s̄ difficulty ø c/o offered. To Radiation Ther 9:15a lethargic sleepy @ lunch time PO flds given to pt. draining out of mouth/some swallowing. buttocks s̄ breakdown. [illegible]
1/12/88	5am	S: ø
		O: Pt in bed, 4 rails ↑, VSS, texas cath patent/drng, turned + repos, ↑med, ↑ confusion

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UCC 081381

Date	Time	Problem #	
			noted, no c/o from pt, no s/s distress
			A: pot alt in skin integrity
			P: as per NCP
			E: no Δ in skin integrity noted – M[illegible] RN
1/13	4am		S: Ø
			O: pt in bed 4 rails ↑ IV infusing well, site v/d
			pt turned and repositioned, sm reddened area
			on ~~[illegible]~~ coccyx area, skin care given, transparent applied
			A: pot alt in skin integ
			P: as per NCP #1
			E: reddened area faded ̄c [illegible] – continue
			freq turning + skin care — M[illegible] RN
1/13/88	11A		inc: 4 u PRBC infused [illegible] ̄ complic [illegible] 10 [illegible]
			[illegible] @ 8A for 90 [illegible] — [illegible]
1/14/88	4am		S – Ø
			O – Resting quietly, denies discomfort. Texas cath intact. No skin breakdown noted.
			P – as per NCP #1. [illegible] RN
1/14/88	11P		Incidental H&H 8.1/24.1 – WBC 18.3 – [illegible] 1.6 reported to Dr Hatow — [illegible]
1/14/88	9-9		[illegible] diet taken. Texas cath remains intact, repositioned. [illegible]
1-14-88	10P		app [illegible] for supper [illegible] pt did take [illegible] Texas catheter applied [illegible] IV infusing as ordered VSS. Family members present [illegible] — [illegible] RN
1/15/88	2A		S: Ø
			O: Pt. in bed incontinent of urine, pt. keeps pulling Texas cath off. IV infusing. Bed changed, pt. repositioned.
			A: Pot alt in skin integrity
			P: as per NCP #1
			E: Reddened area on coccyx noted, pt. positioned on side. [illegible] RN
1/16/88	3a		S: O
			O: pt in bed, Texas patent, VSS, IV infusing, turned and repo'd
			A: pot alt in skin integrity
			P: as per NCP #1
			E: area on coccyx reddened – skin care given, pt turned — M[illegible] RN

PRIVILEGED AND "CONFIDENTIAL MATERIAL SUBJECT TO PROTECTIVE ORDER"

[illegible] John
[illegible] JOHN H
FLATON, FRED
FRED FLATON 061
09/11/23
6773

(ADDRESSOGRAPH IMPRINT)

BAYSTATE MEDICAL CENTER
Springfield, MA 01199

Division of Nursing

PATIENT PROGRESS NOTE

Date / Time	Problem #	
1-16-88	9 30	Appetite poor, repositioned no change in
		alert or swallowing status. B. Devine RN
1-17-88	2A	S: "My bed is wet"
		O: Alert, incontinent of urine. Sleeping in naps. IV in-
		fusing @ 75/hr. Repositioned.
		A: alt in comfort & skin integrity
		P: see NCP #1
		E: Repositioned, egg crate mattress on bed changed, skin care
		[illegible] redness [illegible] area on coccyx. [illegible]
1-17-88	8 am	Incontinent of a lg amt. of urine - am care
		given - no changes noted. [illegible] intake [illegible] -
		1/2 of cereal - all of soft egg + 1/2 milk - 1/2 OJ.
	10 30 A	Incontinent of a lg amt. of urine - cleaned
		+ repositioned. B. Devine, RN
	12 N	Appetite fair - sml amt. of creamed veg, pot.
		+ meat, milk & ice cream taken. Repositioned.
		B. Devine, RN
1/18/88	3A	S:
	#	O: IV infusing no pain, redness, swelling @
		insertion site, [illegible] 1/17.
		A: Potential for complication of IV therapy
		P: as per NCP [signature]
1-19-88	4 am	Refusing ensure - still sipping earlier [illegible].
		Barbara Devine RN
1/20/88	5A	O: Incontinent large amnt of semi liquid
		black tarry stool + urine.
		A: alt in ellimination
		P: as per NCP [signature]
1/21/88	4A	S: O
		O: Incontinent large amnt of urine, turned
		[illegible], [illegible]
		[illegible]
		A: Alt in elimination
		P: as per CP [signature]

Date / Time	Problem #	
		S Ø
1-22	2AM	[illegible] in bed [illegible] a warm [illegible]
	# 1	[illegible]
		P [illegible] as per NCP #1 — [illegible] LPN
1/23	#3	Pot for Infection
3am		S. none offered
		O: IVF is D5½NS infusing @ 50cc/hr as ordered. No sign infection – no redness or swelling noted
		A: Pot for Infection
		P. as per current plan of care
		E. No s/s infection @ this time
		Christine M Skowera RN
1/23	9am	WBC 20.8 H+H 5.9/18 - plts 29000 - reported to Dr. [illegible] - IV infusing [illegible] - M [illegible]
1/24	#1	Pot for alt in Skin Integrity
3am		S. none
		O. Texas catheter intact draining s̄ difficulty. Incont. small amt feces. Skin care given; turned + repositioned. No broken areas noted
		A Pot for alt in Skin Integrity
		P. Cont to V for incont, turn + reposition, good skin care
		E. Presently no sign skin breakdown
		Christine M Skowera RN
		Incidental: 2 u. PRBC's transfused on eve's & ABC for am – Christine M Skowera RN
1/24	9³⁰	WBC 20.5 H+H 8.6/25.6 plts 203000 - [illegible] to be restarted [illegible] feel - reported to Dr Kochan — [illegible]
1/24/88	10am	S: Ø
		O: VSS Texas catheter intact draining clear yellow urine. Incontinent mod amt black feces - heme (+) skin care given. Turned & repositioned. No broken areas noted. IV Infusing s̄ difficulty in (R) [illegible]
		A: Pot [illegible] alt in skin integrity
		P: As per NCP #1 — [illegible] RN
1-25-88	12A	S Ø
		O In bed incontinent of urine. Texas catheter [illegible]

PRIVILEGED AND
"CONFIDENTIAL MATERIAL
SUBJECT TO PROTECTIVE
ORDER"

055529 [illegible] 877
WARREN, JOHN H
FLATOW, FRED FLATOW, FRED
023033 09/[illegible] 024

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BAYSTATE MEDICAL CENTER
Springfield, MA 01199

Division of Nursing

PATIENT PROGRESS NOTE

Date / Time	Problem #	
		P. Skin care given. Turn & reposition. Care
		continue per NCP #1 ——— Paula [illegible]
1/26/88	4A	S-0
		O - Pt. in bed sleeping in naps. T/C now intact. No skin
		Turned [illegible]
		A - Pt. alt. in skin integrity.
		P - see NCP #1
		E - No broken areas noted. Diane Picard RN
1/26/88	11A inc	WBC 19.9, Hgb 7.4, Hct 22.1 / Plt 187 phoned to
		Dr Flatow's office ——— [illegible]
1/26/88 11pm		S: Ø
		O: VSS Texas catheter intact draining clear
		yellow urine. Skin on coccyx & back [illegible]
		Skin care given. Turned & repositioned. No
		broken areas noted. [illegible] difficulty
		in (R) arm @ [illegible]
		A Pot alt in skin integrity
		P Care per NCP #1 —— [illegible] RN
1-26-88	2:20P	inc - c/o back pain - Tylenol 650mg given @ 2:20P [illegible]
1-27-88	5A	S-0
		O - Pt. in bed, sleeping in naps. Repositioned. T/C intact +
		draining. Turned + [illegible]
		A - Potential alt in skin integrity
		P - see NCP #1
		E - No broken areas noted. Diane Picard RN
1-28-88	2A	S Ø
		O In bed taking naps, afebrile, T/C on
		and draining well
		P. care continue as per NCP #1 - Paula [illegible] RN
	7-3	Incidental: VSS [illegible]
		Texas cath changed. [illegible]
1/28/88	11:50pm	Incidental. VSS IV infiltrated IV nurse [illegible] called
		unable to restart despite 3 attempts and hot packing
		Dr Flatow notified IV D/C'd Texas cath drained 250
		concentrated urine ——— [illegible] RN

UCC 081385

Date / Time	Problem #	S O
1-29	4P	O In bed [illegible]. [illegible] [illegible] [illegible] take
		taking [illegible] of juice [illegible] [illegible] [illegible].
		[illegible] reposition [illegible] [illegible] for pain [illegible] RN
1/30/98	11am	WBC-10.0 Hb-7.12.5 Plt-180 Na-137 K-5.2 Cl-109
		CO_2-19 phoned to Dr. [illegible] office. [illegible] RN
1/30/98	8pm	Family members present [illegible].
	8pm	[illegible] [illegible] well. Went to [illegible] [illegible] to [illegible]
	8pm	[illegible] [illegible] [illegible] Dr. [illegible] notified
		[illegible] RN

PRIVILEGED AND
"CONFIDENTIAL MATERIAL
SUBJECT TO PROTECTIVE
ORDER"

UCC 081386