

Adm: 6/1/87

23-16-

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 11/19/83. 2) History of arrhythmias 11/83 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.

Unit ☐ Springfield-Wesson Women's

☐ Wesson Memorial

☐ History and Physical

☐ Operative Note

☒ Discharge Summary

☐ Other

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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. ECOMI. Strabismus 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; none 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

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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.

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


K. Guarnieri, M.D.



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UCC 086033

Adm: 1/1/88

Name WARREN, JOHN H.

Dr. Flatow

expired 231633
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 resection 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 Torcan 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 border. 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, CO2 23, glucose 157, BUN 17, creatinine 0.3.

continued.....

Unit ☐ Springfield-Wesson Women's
☐ Wesson Memorial

UCC 086034

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

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WARREN, JOHN H.
continued....

Dr. Flatow

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



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PATIENT PROGRESS NOTE

Date	Time	Problem #	
			or skin breakdown noted, c/o too pain when repositioning A/P for action skin integrity T. Check o 20 & 40, good skin care o back, incant, turn + reps o 40, monitor for skin brkdn, massage pressure pts E: free from skin brkdn at this time. <u>Christine McKenna</u>
1-6-88	#1	5 L ERECT	
	1 PM		O Lying in bed son sitting & pt quiet incant - moaning when turned P. Re-liners changed, skin care given & for incant 20 - <u>Christine McKenna</u>
1-6-88	12N		PO status on to x-ray. <u>Christine McKenna</u> about 1/2 inch. pt in distress. med. tend. 09 mg to 10 mg 1/2 L.P. 20 mg. <u>Christine McKenna</u>
1/6	6P		Med & Tylenol for c/o 1/2 A <u>McKenna</u>
1/7	11-7		R: "I feel so good now." TO: pt looking Texas inc. of stool. In Evening, family re request air mattress as pt had on last admit. Alert. Halkive time thin in past mcs. A: Alt in skin integ. — <u>UCC 086037</u> P: NCP #1 E: inc. of stool @ Texas cath reattached + ^{remained} attached throughout shift. Skin care given. EGG crate mattress on. pt. A position thru noc. <u>Christine McKenna</u>
1-7-88	8 th		Appetite good & condition continuously. Stool x1 & positive guaiac. Results. Pouch given to amb. unit. Taken to home this am! <u>Christine McKenna</u>
	11 th		To position via stretch. <u>Christine McKenna</u>
	12 th		With crutch, return to position. A. Devine, M.D.
1-8-88	10 th		Reattached for position via stretch. Appetite good - ensure given to ice cream amb. unit only taken. <u>Christine McKenna</u>
	11 th		Returned with reattachment to table with amb. unit of a. inc. of skin. A. Devine, M.D.

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WARDEN, JOHN H
FLATON, FRED FLATON, FRED
0231033 09/14/23 064

BAYSTATE MEDICAL CENTER
Springfield, MA 01199

Division of Nursing

PATIENT PROGRESS
NOTE

(ADDRESSOGRAPH IMPRINT)

Date	Time	Problem #	
8-5-88	11:30		Pin tubes care applied. Most of constant ice cream taken only for lunch. R. & Q. 11:30
8-8-88	9:30pm		Incidental - VSS IV tubing 0.5% 0.75% via controller
			S. redness or swelling. taking po fluids well & sons encouragement. medicated @ 8pm Tylenol for c/o headache & subsequent relief more alert than two days ago. 11/11/88
1-9-88	3AM	S. 1	O. In bed, alert. Texas cath on, no stool at this time
			P. Care continues as per NCP. Penka Quin 2/1
			A. P. All in skin integrity d/t incontinence
			S. p. skin hemorrhoid intact Shigleth Hill
1-10-88	3AM	S. 1	O. In bed Texas cath off, incontinent of urine alert & periods of confusion
			P. Care continues as per NCP. Penka Quin 2/1
			A - p. All in skin integrity
			E - p. All in skin integrity
			note: 1 - 1/2 x 2 - right no skin break-down noted Shigleth Hill
1/11/88	5am	S. 1	O. Flanked d. m. l. r. Texas cath d. d. drawell pt turned & repositioned. IV patent, no cl. m. m. p. A: p. All in skin integrity
			P: as per NCP
			E: No A in skin integrity noted @ this time - M. G. (L. G. R.)
1/11/88			pt. tol. b. fast well. eating full 11:00 alet well when fed. Texas cath intact & draining clear yellow urine.
			Turn & repo on eggcrate matt. IV patent infusing & difficulty. 0.5% offered, TO Radiation Ther 9:15a
			lethargic sleepy @ lunch time PO fluids given to pt. drawing out of mouth/some swallowing.
			butcher's breakdown. - Mattie A. B. Rep
1/12/88	5am	S. 1	O: pt in bed, 4 rails, VSS, Texas cath, patent, b. fast well, turned & repositioned. 11:00 alet well when fed.

UCC 086038

Date Time	Problem #	
		noted. no clt from pt, no S/S distress A: Pot alt in skin integrity P: as per NCP E: No A in skin integrity noted - Maxley R
1/13 4am	5:0	O: pt in bed, 4 rails ↑ IV infusing, well, site Vd, pt turned and repositioned, sm reddened area on coccyx area, skin care given, Texas applied A: Pot alt in skin integ P: as per NCP #1 E: reddened area faded & macula - continue freq turning + skin care — Maxley R
1/13/53 11A		inc: 4x PRBC infused due to 5 compic blood 8^{30} ~ 10^{30} Tye @ 8A for 90 headache — Gloppe R
1/14/53 4am	8-0	O: Resting quietly, denies discomfort. Texas 1 cath intact. No skin breakdown noted. P: as per NCP #1. — Gloppe R
1/14/53 11A	11A	Incidental Hct 48.1/24.1 - WBC 18.3 - Platelets 1.6 Reported to Mr. Hatten — Maxley R
1-14-53	9-9:30	Adm and 4 pm diet taken. Texas cath remains intact, repositioned. Sublingual Quinine, con
1-14-53	10P	app pm for supper, but pt did take small amt. New Texas cath. applied the of excellent thick dend at 10 infusing as ordered VSS. Family members present most of evening — Maxley R
1/15/53	2A	5:0 O: Pt. in bed, incontinent urine, pt keeps pulling Texas cath off. Infusing. Red changed, pt repositioned. A: Pot alt in skin integrity P: as per NCP #1 E: Reddened area on coccyx noted, pt. positioned on side. Quine Rind R
1/15/53	3a	5:0 O: pt in bed, Texas patent, VSS, IV infusing. turned and reposed A: pot alt in skin integrity P: as per NCP #1 E: Area on coccyx reddened - skin care given, pt turned — Maxley R

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PATIENT PROGRESS
NOTE

(ADDRESSOGRAPH IMPRINT)

Date	Time	Problem #	
1-14-88	9 ³⁰	9 ³⁰	Appetite poor, repositioned no change in short or swallowing status. B. Davies, MD
1-14-88	2A	2A	5" milk in wet" (1) O: Pt. incontinent of urine. Sleeping in naps. Skin lesions @ 75/100. Repositioned. A: alt. in comfort & skin integrity P: see NCP #1 E: Repositioned. ear tubes removed on bed changed. skin care monitored. redness area on coccyx. Discharge noted
1-17-88	8 ³⁰	8 ³⁰	Incontinent of a large amt. of urine - on care given & napkins applied. Some intake. good - 1/3 of cereal - all of soft eggs & 1/2 milk - 1/3 of 10 ³⁰ Incontinent of a large amt. of urine - changed & removed. B. Davies, MD
1-17-88	12 ³⁰	12 ³⁰	Appetite fair - small amt. of cereal med. amt. meat, milk & ice cream taken. Repositioned. B. Davies, MD
1/19/88	3A	3A	SD O: 11/12 indicating no pain, redness swelling or infection. Site, looking 1/17 Potential complication. RT 11/17 therapy # aspect NCP 1/19/88 5 ³⁰ Requiring secure - still requiring ear tubes. secure. B. Davies, MD
1/20/88	5A	5A	O: Incontinent large amount of semi liquid black loose stool & urine. A: In elimination P: as per NCP 1/21/88 4 ³⁰ SD O: Incontinent large amount of urine, turned on. Incontinent. Abundant amount of lubrication applied. A: In elimination P: as per NCP

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Date	Time	Problem #	S O
1-22	2 AM	#1	lying in bed, color of skin good & warm to touch, inc of urine P. urine as per WCP #1 — Paula Hunter L.N
1/23	3am	#3	Pot for Injection S. urine assessed O: IVF's D5 1/2 NS infusing @ 50cc/hr, as ordered. No sign infection — no redness or swelling noted A. Pot for Injection P. appear present plan of care E. No S/S infection at this time Christine M. Kowala RN
1/23	9am		WBC 20.8, Hct 41.4 S. 9/18. p/t 29000 — reported to Mr. Rygel — IV tubing line — M. Beaulieu
1/24	3am	#1	Pot for act in skin integrity S. urine O: Texas catheter intact, draining. S difficulty. Incont. small amt feces. Skin care given; turned & repositioned. No broken areas noted. A. Pot for act in skin integrity P. Cont to V for incont, turn & reposition, good skin care E. Presently, no sign skin breakdown Christine M. Kowala RN Incidental: 2 vx. PRBC's transfused on eve & ABE for am — Christine M. Kowala RN
1/24	9:30		WBC 20.5, Hct 41.4 S. 6/25.6 p/t 20300 — IV line to be restarted in a new site — reported to Mr. Keenan — M. Beaulieu
1/24/88	10am		S: O O: VSS & Texas catheter intact draining clear yellow urine. Incontinent mod amt. Black feces — heme (+). Skin care given & turned & repositioned. No incontinence noted. OK. Infusing & difficulty in @ lt A. Pot for act in skin integrity P. appear WCP #1 — Christine M. Kowala RN
1-25-88	12:15		S: O O: In bed in environment of incision. Texas catheter @ lt

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WARREN, JOHN H
FLATOW, FRED FLATOW, FRED
0231033 09/14/23 034

Division of Nursing

PATIENT PROGRESS
NOTE

(ADDRESSOGRAPH IMPRINT)

Date Time	Problem #	P. signs and symptoms, signs & symptoms. Care combined per VCP #1
1/26/88	4A	S-O C - Pt. in bed, sleeping in naps, TLC intact. No oral Trends intermittent. A - pt. alt. in skin integrity. P - see NCP #1 E - No broken areas noted. Done Pseud R
1/26/88 11 th	inc	WBC 19.9, Hgb 7.4, Hct 20.1 / Plt 187 phoned to Dr Flatow's office
1/26/88 11 ³⁰ pm	S: O	00
		O. VSS & flexion catheter intact draining clear Yellow urine (one am amt. back stool - home @) Urine care given. Catheter repositioned. No HOB in area noted. (Inclusion of difficulty in D arm @ 50cc/hr. draining properly.) A - Pt. alt. in skin integrity. P - No on NCP #1 - (Chronic Handwritten) 1-26-88 2 ³⁰ P inc - 90 back pain - Tylenol 65mg given @ 2 ³⁰ P 1-27-88 5A S-O C - Pt. in bed, sleeping in naps. Repositioned. TLC intact - draining. Trends intermittent. A - pt. alt. in skin integrity. P - see NCP #1 E - No broken areas noted. Done Pseud R
1-27-88	2A	S O
		P. in bed, taking naps,afebrile, TLC on and draining well. P. care continue as per VCP #1 - Done Pseud R
7-3		Incidental: U.S.S. Intake from H&C - core are under. Trends with changed. Temp. 100.2, 100.4, 100.6, 100.8, 101.0, 101.2, 101.4, 101.6, 101.8, 102.0, 102.2, 102.4, 102.6, 102.8, 103.0, 103.2, 103.4, 103.6, 103.8, 104.0, 104.2, 104.4, 104.6, 104.8, 105.0, 105.2, 105.4, 105.6, 105.8, 106.0, 106.2, 106.4, 106.6, 106.8, 107.0, 107.2, 107.4, 107.6, 107.8, 108.0, 108.2, 108.4, 108.6, 108.8, 109.0, 109.2, 109.4, 109.6, 109.8, 110.0, 110.2, 110.4, 110.6, 110.8, 111.0, 111.2, 111.4, 111.6, 111.8, 112.0, 112.2, 112.4, 112.6, 112.8, 113.0, 113.2, 113.4, 113.6, 113.8, 114.0, 114.2, 114.4, 114.6, 114.8, 115.0, 115.2, 115.4, 115.6, 115.8, 116.0, 116.2, 116.4, 116.6, 116.8, 117.0, 117.2, 117.4, 117.6, 117.8, 118.0, 118.2, 118.4, 118.6, 118.8, 119.0, 119.2, 119.4, 119.6, 119.8, 120.0, 120.2, 120.4, 120.6, 120.8, 121.0, 121.2, 121.4, 121.6, 121.8, 122.0, 122.2, 122.4, 122.6, 122.8, 123.0, 123.2, 123.4, 123.6, 123.8, 124.0, 124.2, 124.4, 124.6, 124.8, 125.0, 125.2, 125.4, 125.6, 125.8, 126.0, 126.2, 126.4, 126.6, 126.8, 127.0, 127.2, 127.4, 127.6, 127.8, 128.0, 128.2, 128.4, 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