MBSAQIP Case Study

Directions: This case study will be used to reinforce the variables and definitions presented in the training modules. Answer the test questions in the training modules using this case study.

Patient: Anita Case  
IDN: 123-45-6789  
Age at date of admission: 60y  
Date of Hospital Admission: 2/28  
Diagnosis: 278.01-Morbid Obesity

2/10: Preoperative History & Physical Exam Note

Procedure: 60 year-old white, non-Hispanic female scheduled for Laparoscopic RNY Gastric Bypass on 2/28.

CC: The patient has dealt with weight issues since her early teens. She has tried numerous diets, would lose 20 to 30 lbs. and would regain the weight. The most successful diet was an Adkins diet supported at the local clinic with a weight loss of 50 lbs. All the weight was regained plus an extra 25 lbs. She has also tried a prescribed weight loss medication 20 years ago. Her highest weight taken was on 3/1 last year which was 324 lbs. Current weight is 273 lbs. and lowest weight with dieting was 162 lbs. back in the late 1990s.

PMH: Hypertension, tachycardia, asthma, sleep apnea, GERD, diabetes, hypothyroidism, obesity, essential thrombocytthemia, and myocardial infarction.

PSH: Open Cholecystectomy 1985, cardiac ablation therapy 1990s, attempted PTCA of the left anterior descending and left circumflex for MI 2010. PTCA unsuccessful and double bypass performed.

Family History: No family history of adverse reactions to general anesthesia. Mother is a diabetic, has HTN, and had a stroke. Father died of an MI at age 72. Father also had hypertension and CHF.


Allergies: Sulta. No food, shellfish or latex allergies.

Social History:
Smoking: Never  
ETOH: 4-5 glasses of wine/month. Last drink 1/1  
Substance abuse: None  
Exercise: walking 3-4x/week for 20 minutes, approximately 1 mile  
Occupation: ICU Nurse  
Marital Status: Married with 2 children

ROS:
General: Feels well. Independent with ADLs. Denies any pain, fever or constitutional symptoms. 
Skin: Denies pruritus, rashes, abnormal pigmentation, sores, lumps, or open wounds.
HEENT: (+) hearing loss – to be evaluated for hearing aids. Denies glaucoma or cataracts. Wears glasses for near and far sightedness. Denies eye redness/discharge, nosebleeds, sore throat, hoarseness, post nasal drip, sinus infections, ear infections, tinnitus

Respiratory: (+) asthma – hospitalized in the 1990’s. No use of oral steroids in many years. Sleep apnea – diagnosed one year ago with sleep study. Prescribed and uses CPAP. Experiences occasional dyspnea upon exertion. Denies cough, sputum, SOB, hemoptysis, bronchitis, wheezing, COPD, emphysema, pneumonia, TB.

Cardiovascular: (+) Hypertension – on Lisinopril and HCTZ. Had ablation therapy in 1998 for tachycardia. No further episodes of tachycardia. Denies chest pain, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, palpitations, syncope, heart murmurs, rheumatic fever, angina, hypercholesterolemia, CHF, or pedal edema. Had an MI in 2010 with double bypass after PTCA was unsuccessful for opening blockages in left anterior descending and left circumflex coronary arteries.

GI: (+) GERD – well controlled with the regular use of Prilosec. Denies n/v, diarrhea, constipation, hemorrhoids, bleeding, trouble swallowing, appetite changes, food intolerance, unintentional weight loss/gain, or abdominal pain.

Hepatobiliary: No history of jaundice, hepatitis, or biliary colic.

GU/GYN: (+) nocturia. Denies frequency, polyuria, hematuria, UTI, hesitancy, incontinence, stones, colic, reduced caliber of stream, obstruction or CRF.

Musculoskeletal: (+) muscle cramping. (+) ankle pain, left > right. Treats with ice and Tylenol as needed. Does not limit activities. Denies other joint pain, muscle pain, stiffness, arthritis, gout, or limitation with ROM.

Neurologic: Denies headaches, migraines, dizziness, fainting, weakness, vertigo, seizures, paralysis, tingling, tremors, involuntary movements, TIA or stroke.

Peripheral Vascular: Denies varicosities, DVT, claudication, cramps, or ulcers.

Endocrine: (+) diabetes mellitus - diet-controlled. (+) Hypothyroidism - no recent change in medications.

Psychiatric: Denies history of anxiety, depression, panic attacks, or psychosis.

Hematology/Oncology: (+) essential thrombocythemia – followed by Hem/Onc physician – Dr. Kim. Denies easy bruising, bleeding anemia, malignancy, chemotherapy, or radiation.

Physical Exam:
Temp: 99.4 F
BP: 154/65
P: 102
SaO₂: 95%
Resp: 20
Ht: 64 inches
Wt: 283 lbs.

General: Patient is well-appearing, obese female in no apparent distress.
Skin: Warm and dry to touch. No sores, lesions, rashes, bruising or petechiae noted.


Respiratory: Lungs clear to auscultation bilaterally. No retractions or accessory muscle use noted.

Cardiovascular: Regular rhythm, normal rate. S1/S2. No murmurs, rubs, or gallops noted. No jugular venous distention.

GI: Abdomen soft, large amount of central adiposity, nontender, +bowel sounds in all 4 quadrants. No masses, distension, or hepatosplenomegaly.

GU/GYN: No Costovertebral angle tenderness or hernias.

Musculoskeletal: Normal range of motion. No vertebral body tenderness.


Motor: Gait: Steady. Coordination: able to get on exam table without difficulty. Strength/tone – intact, 5/5 throughout

Peripheral Vascular: No varicosities, pedal edema, or prominent veins. No clubbing or cyanosis. Carotids, radials, anterior tibia and dorsal pedis all 2+.

J Smith MD, FACS, FASMBS

Ancillary studies:

Labs: 2/10: Na 139; K 4.3; Cl 101; CO₂ 29.7; BUN 30; Cr 1.1; Glu 136; Albumin 4.9; Direct Bili 0.3; Total Bili 0.8; Alk Phos 46; SGPT 47; Amylase 28; SGOT 26; WBC 9.9; Hematocrit 36.1; Hemoglobin 12.7; RBC 4.04; Plt 592; PTT 26; PT 11.6; INR 0.9.

2/10 CXR: Lungs show evidence of abnormal opacities. Cardiac size and contour are normal without evidence of congestive heart failure/edema. No abnormalities of hilar, mediastinal, pleural or bony structures. No prior exams available for comparison.

2/10 EKG: Ventricular rate 89, NSR. PR interval 130 ms, QRS duration 80 ms, QT 338 ms, QTc 411 ms; P axis: -2 degrees; R axis: 34 degrees; T axis: 11 degrees. Junctional ST depression, probably normal. No previous tracing available for comparison. Old anterior myocardial infarction.
2/27: Preoperative Anesthesia Assessment

60 year-old female with HTN, MI, asthma, GERD, and essential thrombocythemia here for preop visit for Laparoscopic RNY. Discussed tentative plan for use of general anesthesia. Anesthesia consent to be obtained day of surgery.

ASA: 2
Plan: proposed anesthesia: General
Monitors: standard
Pain Mgmt: IV Patient Controlled Analgesia (PCA)
Autologous blood: none
Premed: none
Usual and current meds: Prilosec, HCTZ, Lisinopril, Advair
Meds to be held on day of surgery: remaining meds including Lisinopril
Diabetes meds: None
NSAIDS: Avoid for 3 days prior to surgery
ASA: Avoid for one week prior to surgery
NPO: After midnight

B Wayne MD

2/28: Nursing Admission Note
Patient arrived to floor without any complaints. Traveled 30 minutes from home.

Allergies: Sulfa
Meds taken today: HCTZ, Prilosec, Advair
ID band on. Consents signed
Ht: 64 inches (actual)
Wt: 273 lbs. (actual)
Vitals: Temp-98.5, HR-88, RR-14, BP 143/88, Sp02 97% on Room Air

D Reynolds RN

2/28: Intraoperative Anesthesia Information

Ht: 64 inches
Wt: 273 lbs.
ASA: 3
ETT: 7 mm ETT,
Blade: Mac 3,
Intubation: Atraumatic. Bilateral breath sounds after intubation.
In room: 0935
Intubated: 1007
Surgery start: 1024
Surgery end: 1400
Extubated: 1400
Out of room: 1450

R Grayson CRNA
Description of procedure: Patient was brought to the OR, placed supine on the operating table, and general endotracheal anesthesia was induced. The abdomen was prepped and draped in the usual sterile fashion and 5 mm incision was made below the left costal margin, and the Veress needle was inserted. A pneumoperitoneum was established and subsequently a 5 mm Ethicon XL trocar was placed under direct videooscopic vision into the abdomen without difficulty. The anatomy was visualized. There were significant adhesions in the entire right upper quadrant, extending across the midline. Pt had a large open cholecystectomy incision scar on that side. Subsequently, another trocar was placed on handbreath toward the left lower quadrant from the tip of the falciform. This allowed scissors to be placed and lysis of adhesions was performed. The adhesions were taken down, allowing a 12 mm port to be placed as the tip of the falciform ligament. A 5 mm trocar was placed in the epigastrium. The last trocar was placed after more lysis of adhesions in the right upper quadrant. A small amount of subcutaneous fat and omental fat were taken.

Next, the gastrohepatic ligament was opened up. There was good visualization of the space posterior to the stomach; however, the antrum of the stomach was somewhat tethered to the cholecystectomy scar. Therefore, sharp dissection was used to take this down. This provided a better view in the posterior gastric space. Next, common landmarks were identified, which included the second gastric vein, which was just below the level of the left gastric bundle, and was approximately 1.5 cm below the Belsey’s fat pad. At this point, the mesentery was taken with firing the 45 x 2.0 mm stapler, and subsequent firings of the 45 x 3.5 mm stapler were used to create a small egg-shaped pouch, which was approximately 30 mm in size. The posterior aspect of the pouch was dissected with the Harmonic scalpel. The gastric remnant staple line was inspected, and on the medial ¼, there were multiple staples that were somewhat misshaped. These were oversewn with a running 2-0 Polydek suture. The result was quite satisfactory. The remained of the staple line appeared to be intact. The posterior aspect space was dissected, and a few adhesions in this area were taken down. Next, the common ligament of Treitz was identified, and the small bowel was run for approximately 80 cm using a cloth tape. At that point it was transected with a 60 x 2.5 mm stapler, and the Roux-en-Y limb was marked with a Penrose, and was stitched to this end. The intervening mesentery was taken with 1-1/2 firings of the 45 x 2.0 mm vascular load with the stapler. The Roux-en Limb was then run for approximately 100 cm using a cloth tape. At that point, a jejunojejunostomy was created. Limbs of bowel were tacked together with an Endostitch. Enterotomies were made medially in either lumina, and 60 x 2.5 mm stapler was inserted and fired for its full length. The common enterotomy was reapproximated with a single Endostitch. The serosal edges were lifted up and this common enterotomy was closed with a 60 x 2.5 mm stapler. The result was quite satisfactory. The crotch of the staple line was intact with an Endostitch. A Brolin’s antiobstruction stitch was created between the Roux limb and the biliopancreatic limb, and subsequently the intervening mesenteric trap was closed with a running nonabsorbable Endostitch. The anastomosis was inspected. All 3 limbs were patent, open and viable. There is no evidence of a leak. Next, the ligament of Treitz was identified. There was some difficulty initially getting into the retrocolic retrogastric space due to her omentum, which was large and firm. Subsequently, and adequate passage was identified, and the Roux limb was passed into the upper abdomen in the retrocolic retrogastric space. The mesentery was inspected. There was no evidence of kinking or twisting. Next a gastrojejunostomy
was created at the posterior aspect of the pouch, sewn to the antimesenteric border of the Roux limb. A nonabsorbable Endostitch was placed for the posterior row. Enterotomies were made medially in either lumina, and a 45 x 3.5 mm stapler was inserted for a 2.5 cm and fired. The result was quite satisfactory.

The common enterotomy was reapproximated using an absorbable Endostitch, starting from one side and then from the other side in a running fashion. Before this was closed, an esophagogastroscopy was performed with the scope passed under direct laparoscopic vision across the anastomosis and into the Roux limb. This was left in place for the remainder of the case. Subsequently, the common enterotomy was completed in its closure using the absorbable Endostitch. A nonabsorbable Endostitch was placed for a second anterior row, oversewing the staple line as well. A 2-0 Polydek was used for this.

The gastroscope was partially withdrawn, and the Roux limb bowel was clamped with the noncrushing bowel clamp. A provocative leak test was then performed, with the scope used to visualize the anastomosis, where there is no evidence of a leak. The air was insufflated, and the anastomosis was placed under saline. There was no evidence of leak with this provocative leak test. The gastroscope was removed. The redundant Roux limb was brought into the lower abdomen, and subsequently the Peterson’s defect was closed with a nonabsorbable Endostitch. The Roux limb was tacked to the mesenteric opening in 4 different areas to close this trap as well. Next the jejunojejunostomy was again inspected and all limbs appeared to be patent and viable with no evidence of leak.

A 15 round Jackson-Pratt drain was brought anterior to the anastomosis and posterior to the gastric remnant. Subsequently, the trocars were removed and the pneumoperitoneum was released after the 12 mm trocar was closed at the fascial level with an interrupted figure-of-8 zero Vicryl suture using a suture passer device.

The patient tolerated the procedure well and there were no apparent complications. The skin was reapproximated with a 4-0 Vicryl and 0.5% Marcaine with epinephrine was injected prior to placing of Tegaderms over Steri-Strips.

Sponge counts were correct x 2 and instrument counts were correct x 1. As the attending surgeon, I was present and scrubbed for the entire procedure.

J Smith MD

2/28: Brief Operative Note
Preop Diagnosis: Morbid obesity
Postop Diagnosis: Same
Procedure: Laparoscopic Roux-en-Y gastric bypass with extensive lysis of adhesions
Surgeon: John Smith, MD
Assistant: Jane Jones, MD, PGY 4
Anesthesia: General Endotracheal Anesthesia
Complications: none
Estimated Blood Loss: minimal.
IV fluids: 4700 ml Urine Output: 400 ml
Condition/Disposition: stable – to PACU.

Date of Operation: 2/28
Surgery start: 10:24
**Surgery end:** 14:00

**Procedure:** Laparoscopic Roux-en-Y with extensive enterolysis

*J Smith MD*

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### Postop Progress Notes

**2/28 20:15 - PACU Resident note**

* S Smith MD PGY 3

**2/28 22:15 - Surgical Resident Note**

* J Jones MD PGY 4

**3/1 06:30 - Surgical Resident Note**

* J Jones MD PGY 4

**3/1 08:00 - Surgical Attending Note**
- Ambulate
- Swallow study - if no leak, no obstruction then start stage I diet.
- Check labs

* J Smith MD

**3/1 19:30 - Nursing Note**
Vital signs stable. Ambulated x 2, gait steady. No c/o lightheadedness.
Skin: Dressing changed by surgeon. JP dressing stained with serosanguinous drainage.
Gastric Bypass diet stage 1 started after barium swallow study showed no leak and no obstruction.

* J Reyes RN

**3/1 23:30 - Surgery Cross-coverage Note**
Called to assess 60 y/o female, POD 1 status post Lap RNY for fever to 103.8. Pt c/o epigastric pain, worse with movement. She has not been using the incentive spirometry. She has had asthma and requires CPAP at home. T 103.8, HR 94, BP 108/52, RR 15, O2 sat 95% on 2Liters nasal cannula.
Gen: fatigued, morbidly obese female
Chest: coarse rales R > L on anterior exam CV: RRR, normal S1/S2
Abd: soft, diffuse tenderness all 4 quadrants, no rebound/guarding
Wounds: Removed dressing, (+) serosanguinous drainage, but no erythema, no pus, no tenderness
Ext: no calf tenderness/palpable cord, Homan’s (-)
A/P: 60 y/o female status post lap RNY with postop fever. Most likely cause is atelectasis, PMH of asthma and CPAP and lack of Incentive Spirometer use, however must also consider pneumonia. Wounds show no evidence of infection. No DVT suggested on exam. Send stat CBC w/ diff, lytes, blood & urine cultures and U/A. CXR ASAP, Tylenol for fever, incentive spirometer, Chest PT, cough & deep breath. 

M Caldwell MD 3/2 06:00 - Nursing Note
On PCA Dilaudid w/ good relief of pain. Tmax 103.8. House Officer notified. CXR done, blood work and cultures sent. Encourage incentive spirometer, cough and deep breathing, Tylenol x 1. Temp now 99.8. JP with scant serosanguinous drainage. Other VSS.

P Costas RN

3/2 06:00 - Surgical Resident Note
A/P: soft, nondistended, wounds with no s/s of infection. Ext: no edema

J Jones MD PGY 4

3/2 08:00 - Surgical Attending Note
Tmax 103.8. No n/v. Tolerating sips. Swallow study no leak, no obstruction
A/P: benign
WBC 18.7; Hct 27

J Smith MD

3/3 06:00 - Surgical Resident Note T 101.6 this a.m.
No symptoms localized. No n/v. Tolerating stage 1 diet. UA/Urine Culture pending, CXR (-), blood culture pending.
Hct 22.6 Transfusions x 2. Recheck Hct.
Fever: will check abd/pelvic CT. Must use gastrographin po for study. NPO until after CT. Await urine results.

J Smith MD

3/3 06:00 - Surgical Attending Note
T 101.6 now 99.8- 110/53- 95% room air. Abd: soft, non-tender, non-distended. One trocar site with sanguineous stained dressing.
A/P: s/p lap RNY, check coags, lytes, CBC, f/u cx.

J Jones MD PGY 4

3/3 Blood Bank
Blood transfusions. 2 units PRBCs transfused. First unit started at 1600 and second unit started at 2140.

3/4 06:00 - Surgical Resident Note
S: reports feeling well this a.m. Transfusions made her feel better.
O: Temp 100.7 yesterday afternoon. Now 99.1. 94 119/59 20 96% Abd: soft nontender, non-distended.
JP-Drain serosanguinous.
Urine Culture (-).
A/P: POD 4 s/p Lap RNY. Will check lytes and CBC.
J Jones MD PGY 4

3/4  08:00 - Surgical Attending Note
Tmax 100.7 88% room air.
Feels well. Looks well. No n/v.
Hct dropped to 22 yesterday. Transfused x 2 u PRBC.
Abd/Pelvic CT: small amount blood, no evidence of leak or obstruction
Plan: full liquid diet, ambulate > 4x/day. Check Hct.
J Smith MD

3/5 06:00 - Surgical Resident Note
Pain controlled. No n/v.
Tmax 99.4 -116/55 -83 -96% on room air. Hct - 31
Abd: soft, non-tender, non-distended, incisions c/d/i. JP site c/d/i.
A/P: check labs in a.m., continue stage 2 diet, if labs okay, d/c home with JP in place.
J Jones MD PGY 4

3/6 - Discharge Summary

**Principal Diagnosis:** s/p laparoscopic RNY for morbid obesity  
**Associated diagnoses:** Diabetes, HTN, Asthma, obstructive sleep apnea, GERD  
**Operations and procedures:** laparoscopic RNY  
**Allergies:** IV contrast

**History and reason for hospitalization and significant findings**
HPI: Preoperative for laparoscopic Roux-en-Y gastric bypass. She has been doing well. No fevers or chills. No nausea or vomiting. No recent illnesses. She has seen Dr. Kim with regards to her essential thrombocythemia. His recommendations include perioperative Lovenox and resumption of her aspirin soon after the operation. Comorbid conditions otherwise unchanged.

**PE:**
Chest: clear to auscultation.
Heart: regular rate and rhythm.
Abdomen: soft, nontender with a well healed right upper quadrant incision, which extends her entire right upper quadrant, Kocher type, and an infraumbilical trocar site from a tubal ligation. No hernia is palpated.
Extremities: with no edema. Pulses 2+.
Her preadmission testing labs were reviewed. Her platelet count was 592,000.

**Admission labs and other studies**
2/28 – Iron 102, TIBC 338, Ferritin 128  
2/10 – Hct 36.1, WBC 9.9, Plt 592 (h), Sodium 139, Potassium 4.3, Chloride 101, CO2 29.7, BUN 30 (h), Creatinine 1.1, Glucose 136 (h), Albumin 4.9

**Hospital course and treatment**
Patient taken to the OR and underwent laparoscopic Roux-en-Y gastric bypass on 2/28. Please see the separately dictated operative report for details of the procedure. Postop the patient did well. Vital signs remained stable. Mobilized OOB and ambulated first postop night. Pain well controlled with PCA Dilaudid, transitions over to PO pain medication when tolerating diet. POD 1 swallow study indicated contrast passing easily through the esophagus, into the gastric pouch and into the Roux limb. Sips of Stage 1GBP diet started and tolerated. The patient then had a drop in Hct on POD 3. She was CT scanned emergently and transfused 2 units PRBC. CT scan showed a hematoma so lovenox and ASA were stopped. She also had a temp elevation to 103.8. WBC 11.7. She was able to void with no problems. By POD 4 she was doing better and was advanced to a stage 2 diet. Her pain was well controlled with PO pain med and she was deemed ready for discharge to home.

**Most recent labs and other studies**

3/3 – Abd CT – s/p gastric bypass. 1. No evidence of anastomotic leak identified. No evidence of contrast within the excluded portion of the stomach. 2. Moderate intra-abdominal hematoma seen adjacent to the gastrojejunostomy site and extending into the lesser sac. A small amount of blood is also noted within the pelvis. 3. Small bibasilar atelectasis.

3/1 – Barium Swallow – no evidence of extravasation or obstruction.

**Condition of discharge:** stable

**Discharge medications:** levothyroxine, lisinopril, advair, dilaudid, prilosec. Also atenolol for 1 month per bariatric protocol.

_J Smith MD_

3/13 - Bariatric Surgery – 2 week postop visit

*Height:* 64 Inches  
*Preop Weight:* 273 lbs.  
*BMI:* about 45

*Today’s Weight:* 243lbs.  
*Wt loss to date:* 30 lbs.

*Date of surgery:* 2/28  
*Surgeon:* Smith

*Type of Surgery:* Lap Roux-en-y gastric bypass  
*Complications:* Needed 2 units of blood post op  
- Just started the aspirin. Ecotrin.
- Was sent home without ASA or lovenox because of low HCT and hematoma on CT, question bleeding.
- Feels fatigued, not wanting to eat much, eats by the clock, wants to be curled up into a ball.
- Legs feel heavy, walks shuffling, head is heavy and lightheaded (not orthostatic not vertiginous).
- Eating protein ok: cottage cheese, eggs, and fish.
- Food adversions to meat.

*Tolerance of foods, N/V/dumping sx:* dumping x2.

*Protein sources/intake:* eggs, cottage cheese, fish

*Hunger/satiety:* no hunger fills quickly

*Constipation/diarrhea:* no

*Hydration: Fluid intake:* 48 to 54 oz

*Lightheaded?* Yes

*Urine dark?* No

*Abdominal pain or sx suggestion ulcer, stenosis, hernia, or gallstones:* No

*Legs/VTE sx:* No LE swelling, pain, erythema, numbness/tingles; no SOB, CP, pleuritic symptoms

**Exercise:** walking short distances every day
Excess skin complications (1 yr and after); no

Mrs. Case is 2 weeks s/p Lap RNY for morbid obesity, HTN, GERD, sleep apnea. She is feeling fatigued and not wanting to eat much. Reporting some incisional pain when moving ‘a certain way’. VSS. She is tolerating a Stage III diet with minimal dumping and no n/v. Trocar incisions-left quadrant site with small amount of pus and minimal opening at right corner. Upon inspection appears to be superficial. Will start on po Keflex for superficial infection. Sites cleansed. Instructed on wound care. Other trocar sites healing well and no signs of infection. No incisional hernias noted. No signs/symptoms of VT or PE noted. JP drain with very small amt drainage – d/c’d. Site w/out s/s of infection. Pt to come to Bariatric Center for f/u on 4/17.

C Senter NP
Bariatric Nurse Practitioner

4/17 - Bariatric Center Post-Surgery Visit
Height: 64 Inches
Preop Weight: 273 lbs. BMI: about 45
Today's Weight: 234 lbs. Wt loss to date: 39 lbs.
Date of surgery: 2/28
Surgeon: Smith
Type of Surgery: Lap Roux-en-y gastric bypass
Complications: Needed 2 units of blood post op
- Feels fatigued, not wanting to eat much, eats by the clock, wants to be curled up into a ball.
- Legs still feeling heavy, head is heavy and lightheaded (not orthostatic not vertiginous).
- Eating protein ok: cottage cheese, eggs, and fish.
- Food adurrences to meat.
Tolerance of foods, N/V/dumping sx: dumping x1.
Protein sources/intake: eggs, cottage cheese, fish
Hunger/satiety: no hunger fills quickly
Constipation/diarrhea: no
Hydration: Fluid Intake: 48 oz
Lightheaded? Yes
Urine dark? No
Abdominal pain or sx suggestion ulcer, stenosis, hernia, or gallstones: No
Legs/VTE sxs: No LE swelling, pain, erythema, numbness/tingles; no SOB, CP, pleuritic symptoms
Exercise: walking every day
Excess skin complications (1 yr and after); no

PMH r/t obesity complications:
Obesity: Gastric bypass 2/28.
Hepatic: None
Respiratory: Asthma: Advair 250 bid. Sleep apnea. Had sleep study 1/3/2012; Index 11 (more during REM), desat nadir 66. Did not tolerate CPAP at sleep study. Now is able to tolerate CPAP and continues to use CPAP.
GI: GERD/HH. Prilosec 40 started in 6/11, symptoms now resolved on medication. Occasional dysphagia when not chewing well.
**MS:** Ankle swelling, related to Achilles tendonitis from injury 2008.

**Nutrition:** Vitamin D deficiency. Now taking MVI and 1000 mg of calcium daily. She has had bone density.

**Other PMH/PSH:**

**ENT:** Environmental allergies

**Endocrine:** Hypothyroidism 2004 Levothyroxine 75.

**Hematology:** Essential Thrombocytemia, Anagrelide in the past. ASA 81 qd. Enlarged spleen.

**GI:** Esophageal spasm. Occasional pain/dysphagia. UGI was normal. No symptoms since surgery.

**Medications:** Lisinopril 10, Atenolol 50, levothyroxine 75, ASA 81, Prilosec 40, MVI, Viactiv 3 a day, Advair 250 bid

**Med Allergies** Contrast dye (asthma attack, throat close, eyes swelled)

**Family History**

**CAD:** Father had MI and died from it at age 72

**DM:** Mother, uncle aunt grandmother

**HTN:** Mother

**Stroke:** Mother at 45 “caused by blood pressure”

**Cancer:** Brother

**DVT/PE/clotting:** Parent had DVT, Sister had clot when had a cast on leg, (Mother had stroke but may have bleed, was told it was caused by high BP)

**Social History** Never tobacco. 2 wine per weekend ETOH. No recreational drugs. Married with 2 adult children. 4 grandchildren. Work: ICU Nurse

**ROS:**

**Diabetes:** No polyuria, no polydipsia, no blurry vision

**Cardiovascular Disease:** No CP w/ exertion, no DOE, no claudication

**Liver Disease:** No history or risk factors other than obesity

**Skin:** No rashes. No cellulitis.

**Neuro:** No headaches, no h/o head trauma correlated with obesity onset, no numbness/tingling, no seizures.

**Psychiatric:** No depression, no anxiety

**Genitourinary:** No stress incontinence

**Clotting Risks:** No h/o DVT/ PE, no varicose veins

**Cancer Screening:** PAP (yes) Mammography (yes) Colon (yes)

**PHYSICAL EXAM:**

**BP:** 122/56 (138/56) **HR:** 72 (90)

**Gen:** Appears well in NAD. Mood good. No venous thrombosis noted.

**HEENT:** Moist mucous membranes. Neck: No neck bruits.

**Lungs:** CTA, no signs or symptoms of PE

**CV:** RRR no murmur.

**Abd:** Soft, obese, NTND. Trocar incisions-left quadrant site with small amount of pus and minimal opening at right corner. Upon inspection appears to be superficial. No hernia. **Extrem:** No edema

**Skin:** No rashes.

**Vitals:** **BP:** 144/60 **HR:** 78 Neck circumference 14.75”

**Pleasant:** Full range of affect. Generalized obesity with prominent abdomen. Anicteric. Voice not hoarse. No neck bruits. No buffalo hump or supraclavicular fat pads. No thyromegaly or nodules RRR no murmur/rub/gallop.

ASSESSMENT AND RECOMMENDATIONS:
- 60 yo female with preop BMI 45, s/p gastric bypass 2/28, and complications of obesity complications as reviewed above. Lost 39 lb so far. Doing well.
- Multiple small meals, protein in each.
- Ok to increase calcium to 1500/day
- Diabetes diet controlled
- Sleep apnea. Continue CPAP.
- GERD: Recommend continuing PPI to treat GERD.
- ASA use: Has restarted.
- HTN: Continue lisinopril to treat HTN
- Discontinue atenolol per completion of hospital protocol.
- ID use: Recommend against NSAID use post-op INDEFINITELY to prevent anastomotic ulcers. If necessary, should be taken for short courses only and pre-medicate with a proton pump inhibitor.
- No hyperlipidemia
- Nutritional supplements: As discussed in pre-op nutrition groups, patient is expected to remain on lifelong daily multivitamin and at least 1000mg of calcium, in 2 divided closes. These does may be adjusted subsequently.

C Senter NP
Bariatric Nurse Practitioner