Patient 1

S: 73-year-old female with PMHx of HTN, HLD, nonobstructive CAD (s/p cath 2014 after positive stress ECHO), hypothyroid, asthma, osteopenia, diverticulitis with colovesical fistula s/p excision of large intestine and takedown of colovesical fistula, post-op day 9, presents to general surgery clinic today for follow-up. Patient had a foley that was kept in post-op and presents today to have it removed. She states that she doesn't have much of an appetite and when she eats, she has nausea. During the day she munches on fruits and vegetables and drinks water. Patient admits to having normal bowel movements and passing gas more than usual. Denies fever, chills, chest pain, SOB, vomiting, diarrhea, abdominal pain, constipation, dysuria or hematuria. Denies any erythema, swelling or discharge from surgical site.

O:

Vitals	BP:132/82 Seated, LA
R: 16, unlabored	P: 90 bpm, regular
T: 36.8 °C Orally	SpO2: 100 % on RA

Physical Exam:
General: Seated, well-groomed and good hygiene, in no apparent distress.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Chest/Lungs: Respirations unlabored, clear to auscultation bilaterally.
Abdomen: BS present in all four quadrants, soft, non-tender, non-distended with 10 staples along 8cm midline incision. Some erythema noted around incision but healing well. Clear discharge mixed with blood noted upon insertion of cotton swab stick.
GU: Foley with clear yellow urine in bag.

Surgical Pathology Report – Auth (Verified)
Diagnosis
A. Colon, rectosigmoid, resection:
- Segment of colon showing diverticular disease with acute and chronic diverticulitis and marked pericolonic acute and chronic inflammation with focal abscess formation.
- Focal granulation tissue seen, which may represent fistula formation.

A: 73-year-old female with history of diverticulitis with colovesical fistula s/p excision of large intestine and takedown of colovesical fistula post-op day 9, with seroma from center of incision.

P:
- 2cc of old seroma evacuated from midline incision between staples; 3 of 10 staples removed
- Packing placed in section of incision were seroma was evacuated. Continue daily packing and apply dry dressing on top. Patient and daughter taught how to do daily dressing changes.
- Patient's Foley was removed in clinic. Patient advised to go to the emergency room if she is unable to urinate within the next 8 hours or starts to experience pain in the suprapubic region or blood in urine.
- Patient can eat a regular diet and encouraged to maintain fruits and vegetables in her diet.
- Patient can shower daily and should remove the dressing prior to showering. Avoid bathing.
- RTC on Tuesday 11/10/2020 at 1:30pm

Patient seen and examined with Dr. Morel and PA Marina

Patient 2

S: 35-year-old female with history of right breast ultrasound guided biopsy x2 with benign pathology, right breast cysts and galactorrhea, recently diagnosed with PCOS, presents to breast clinic today complaining of increasing right breast pain that radiates to the right axilla. Pt had breast pain prior to this and was referred to Endocrinology who prescribed her Dexamethasone which she states has not helped. She reports an increase in whitish discharge from the nipples especially after a hot shower. Pt states that the pain is worse around the time of her menstrual cycle. She is currently following up with endocrinology for workup of elevated prolactin levels, hirsutism and diagnosis of PCOS. Denies new palpable breast masses or breast skin changes. Denies any fever, chills, chest pain, SOB, weight loss, or weakness.

O:

Vitals	BP:113/73 Seated, LA
R: 16, unlabored	P: 80 bpm, regular
T: 36.8 °C Orally	SpO2: 100 % on RA

Physical Exam

General: Seated, well-groomed and good hygiene, in no apparent distress.
Skin: Warm and dry, no erythema, masses, or lesions.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Lungs: Respirations unlabored, clear to auscultation bilaterally.
Breast/Chest: Right breast exhibits tenderness. Right breast exhibits no skin changes. Left breast exhibits no skin change and no tenderness. No lymphadenopathy and nipple areolar complex WNL.

A: 35-year-old female with history of PCOS and right breast cysts, right breast pain and dense breasts with increasing pain.

P:
- Bilateral Breast Ultrasound scheduled on 11/19/2020 at 10am
- Pt advised to avoid manipulation of nipples
- Breast pain protocol discussed. Patient advised to avoid caffeine, high salt diet. Advised to apply ice and take NSAIDs for pain.
- Continue follow-up with Endocrinology and Gyn.
- RTC 3 weeks after study

Patient discussed with Dr. Morel and PA Marina

Patient 3

S: 23-year-old female with history of chronic constipation, reports symptomatic hemorrhoids s/p hemorrhoidectomy on 08/15/2020 in Guyana. She is being followed in the clinic for a fissure that she developed after the surgery in Guyana. She reports pain after bowel movements and sometimes cries due to pain. Patient has tried high fiber diet, stool softeners, and sitz baths with not that much relief of pain. As per patient, her stool is soft and regular, no active constipation, or bleeding. She denies fever, nausea, vomiting, dizziness, abdominal pain, or diarrhea. Patient said her constipation has been well controlled with current regimen of daily Colace, Metamucil and Miralax and she is able to tolerate diet. The patient is requesting sphincterotomy for permanent relief of pain.

O:

Vitals	BP:119/85 Seated, LA
R: 16, unlabored	P: 79 bpm, regular
T: 36.9 °C Orally	SpO2: 100 % on RA

Physical Exam

General: Seated, well-groomed and good hygiene, in no apparent distress.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Chest/Lungs: Respirations unlabored, clear to auscultation bilaterally.
Abdominal: Soft. Bowel sounds present in 4 quadrants.
Anorectal: Left-posterior nonbleeding anal fissure, limited examination due to tenderness, no significant improvement.

Meds

Docusate sodium (COLACE) 100 MG capsule TID PRN for constipation
Psyllium (METAMUCIL) 0.52 g capsule QD
Polyethylene glycol 3350 (MiraLAX) 1 capful dissolved in 8 oz. water PRN

A: 23-year-old female with history of constipation, s/p hemorrhoidectomy in Guyana 8/2020 presents with non-healing anal fissure, pain, and discomfort with bowel movements.

P:

-Scheduled for Anal Sphincterotomy on 11/9/2020
-Risks of surgery discussed with patient. Pt verbalizes understanding and agrees with surgical plan.
-Pre-surgery instructions given to patient
-Patient advised to continue high fiber diet and drinking lots of water
-Prescription sent for Colace and Metamucil daily and Miralax as needed
-Return to clinic as instructed after surgery
-Patient will be called by Pre-Admission Testing to scheduled covid19 test and review CBC done today
-Questions from patient and her mother were answered

Patient seen and examined with Dr. O'Connor and PA Tommy

Patient 4

S: 60-year-old male with h/o right indirect inguinal hernia repair with mesh done 3 months ago presents to general surgery clinic today for follow up. Pt states he felt well after the surgery but, recently he started experiencing intermittent right groin pain. Pt admits he works as a super and occasionally is required to lift heavy items which exacerbate the pain. Additionally, pt reports darkening skin of his penis after a recent sexual encounter. Pt denies fever, chills, erectile dysfunction, penile discharge, rashes, lesions, masses, dysuria, hematuria, changes in urination or bowel movements. Denies any abdominal pain, nausea, vomiting, or diarrhea.

O:

Vitals	BP:144/81 Seated, LA
R: 16, unlabored	P: 62 bpm, regular
T: 36.4 °C Orally	SpO2: 100 % on RA

Physical Exam:
General: Seated, well-groomed and good hygiene, in no apparent distress.
Abd: soft, non-tender, non-distended, BS present in all 4 quadrants
Right groin: 2.5 cm scar noted from hernia repair, no recurrent hernia or inflammation noted
GU: glans penis with minimal ecchymosis at the base and mild tenderness on palpation. No discharge, masses or lesions noted.

A: 60-year-old male s/p right inguinal hernia repair with mesh 3 months ago presents with intermittent right inguinal pain and penile ecchymosis likely secondary to trauma.

P:
- Pt advised to wear jock strap for extra support especially during heavy lifting and avoid straining.
- Apply warm compresses to right groin and take NSAIDs PRN for pain.
- Urology referral given to evaluate penile discoloration, appointment to be scheduled by the patient
- Return to clinic as needed
- Pt advised to go to ED if difficulty with urination or bowel movements.

Pt seen and examined with Dr Morel and PA Monika