HR: 91052759 MORENO,EVELYN,LOUISE RESULTS REPORTING SYSTEM
PH: (503)434-5047 F 53 YRS AS OF: 30-DEC-2002 11:26:09

Referred By: UNKNOWN MD SERV, NG Svc: INPT Dict: MARSAL,SCOTT,W 12-26-02

DRAFT

HR: 91052759 Name: MORENO,EVELYN,L 102-84688

Interim Summary

DATE OF ADMISSION: November 29, 2002.

DATE OF INTERIM SUMMARY. December 26. 2002.

DIACNOSES
1. Metastatic adenocarcinoma with malignant ascites and mesenteric metastatic deposits with resultant subtotal bowel obstruction.
2. Acute onchronic respiratory failure with severe underlying chronic obstructive pulmonary disease with previous oxygen dependence; progressive failure with overall functional and nutritional decline secondary to progressive malignancy.
3. Anemia: Multifactorial from chronic disease, malnutrition, as well as myelosuppressive effects of chemotherapy.
4. Subtotal gastric outlet obstruction secondary to tumor burden as outlined above.
5. Diabetes mellitus.
6. History of anxiety with frequent panic attacks.

ADDITIONAL DIAGNOSES
1. Coronary artery disease.
2. Peripheral neuropathy secondary to diabetes.
3. Sleep apnea.
4. Depression.
5. Adrenal suppression secondary to chronic steroid use.
6. History of breast cancer, status post disease in the right breast in 1982. She had a modified radical mastectomy but did not have chemotherapy or radiation therapy.
7. Gastroesophageal reflux disease.
8. Osteoporosis.
9. Chronic sinusitis.
10. History of colonic polyps.

PROCEDURES PERFORMED
1. Hematology/oncology consultation.
2. Internal medicine consultation.
3. ICU management.
4. Intubation with mechanical ventilation.
5. PICC catheter placement.
6. Total parenteral nutrition.
7. Noninvasive positive pressure ventilation.
8. Chemotherapy.
9. Palliative care consultation.
10. Paracentesis.

11. Abdominal ultrasound.
12. Fluoroscopy for PICC placement.

91052759 MORENO,EVELYN,LOUISE RESULTS REPORTING SYSTEM
H: (503)424-3047 F 63 YRS AS OF: 30-DEC-2002 11:26:09

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DRAFT

HR: 91052759 Name: MORENO,EVELYN,L T02-84688

13 Abdominal computed tomography (CT) scan.

REASON FOR ADMISSION: Ms. Moreno is a 63-year-old woman with a long-standing history of severe COPD and coronary disease, as well as depression and severe anxiety. She presented on the day of admission with complaint of increasing abdominal distention. The patient was noted to have recurrent ascites with adenocarcinoma to the omentum, increasing abdominal girth found in the emergency department. She states that her abdomen had increased in size by about 50% and had had persistent problems with constipation over one to two months' time.

She was admitted on the day of admission with concerns over progression of her abdominal metastatic adenocarcinoma with the thought that further management with possible paracentesis, as well as hematology/oncology consultation would be needed, as well as close management of her COPD given her chronic severe lung disease. Please see the dictated admission history & physical for further details.

By the time of this dictation the patient has had a prolonged and complex course. The patient had respiratory failure with CO2 retention and has been intubated and subsequently extubated with a very tenuous post-extubation course. She did receive chemotherapy approximately two weeks prior to this dictation. Despite this she has had increasing abdominal pain and essentially a subtotal gastric outlet obstruction/small bowel obstruction thought to be almost certainly secondary to her mesenteric adenocarcinoma, which was re-demonstrated on CT scan.

Issues will now be addressed by her major active problems as follows:

1. Metastatic adenocarcinoma: The patient is followed by oncology and again, was given one course of chemotherapy. Unfortunately this did not really palliate her symptoms and the patient has had progressive pain and worsened bowel continuity in general. The patient, after careful review with oncology, as well as numerous family conferences, has elected at this point to not contemplate any additional chemotherapy and has shifted her emphasis to management of her symptoms. Unfortunately she continues to have essentially a near complete lack of GI continuity and requires intermittent nasogastric suctioning to avoid increasing abdominal pain, distention, and vomiting.

At this point the patient expresses no further interest in pursuing chemotherapy at any further time and it is unlikely, given her extremely poor functional/performance status, that she could tolerate any additional systemic chemotherapy. Paracentesis this admission again re-demonstrated cells which were consistent with adenocarcinoma.

2. Pulmonary: The patient had a prolonged ICU course. She had recurrent problems with CO2 retention and was essentially intolerant of anything but very carefully titrated anxiolytic and narcotic analgesics. The patient had prolonged ICU monitoring and subsequently required very close pulmonary management on the 1 South telemetry unit. She requires non-invasive positive pressure BiPAP ventilation whenever sleeping and very frequently throughout the

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day. She has a clear history of CO2 retention and her medications and oxygen need to be titrated carefully.

At the current time she appears to have very slowly increasing pleural effusions based on the most recent radiographic data, which is not surprising given her declining nutritional status and overall progression of her neoplastic disease. I anticipate that she will continue to have worsening pulmonary function and increasing respiratory distress as time goes forward.

3. Gastric outlet obstruction, subtotal with a probable small bowel obstruction component as well. The patient is not a candidate for any endoscopic procedures based on currently available data and her inability to tolerate any kind of sedation. Similarly she is not a candidate for a laparotomy. She continues to require intermittent nasogastric suction with up to 400 cc of gastric contents per shift being noted currently. It is anticipated that she will go home with nasogastric suctioning for symptom control.

4. Anemia: The patient has had an anemia which is likely multifactorial secondary to chronic disease, malnutrition, and the myelosuppressive effects of her chemotherapy. She has continued to have a stable hematocrit in the 29 to 30 range at this time.

5. Fluids, electrolytes, and nutrition: The patient's electrolytes have been relatively stable with adjustments of her TPN. She continues to request that TPN be continued, although it has been reviewed with the family that it is unclear whether TPN will necessarily prolong her life in the setting of metastatic adenocarcinoma.

6. Renal: Stable renal function with a creatinine of 0.5 on December 26, 2002.

7. Anxiety: The patient has episodes of severe anxiety which were extraordinarily difficult to manage initially after extubation and remain quite problematic intermittently. She was initially managed with intravenous Versed because of its short half life; subsequently she has been transitioned to intravenous Ativan. It is anticipated that she, at this point, will go home with parenteral dosing of this agent for adequate control of her anxiety, although again, titrating this is requiring very cautious dosing because of her stated wishes to not have excessive respiratory depression and to have maximal medical support.

8. Pain control: The patient continues to have slowly worsening abdominal pain and distention. This to has been a problematic symptom intermittent as the patient again has demonstrated respiratory depression with excessive doses of her IV morphine. She is not felt a candidate for transdermal narcotics secondary to excessively long half lives and inability to titrate this carefully. It is also anticipated that the patient will go home with family dosing intravenous morphine as needed with final doses yet to be determined based on her discharge date.

9. Lines: The patient current has a left arm PICC catheter in place, as well as

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a Foley catheter and a nasogastric tube for intermittent gastric decompressions with suction. She is also requiring nocturnal and very frequent daytime BiPAP therapy.

10.Care issues: Palliative care, Dr. Robert Richardson and April >_____ have been very involved in helping the patient through this difficult end of life admission. In the last several days the patient has indicated two primary goals: 1. To return home. 2. To want "maximal' medical measures, including advanced cardiac life support and intubation in the event of a cardiopulmonary arrest. It has been reviewed that these are extraordinarily unlikely to be successful in this setting.

Nonetheless, the patient continues to want all of these measures and maximal support of her pulmonary status. I personally believe that these are inherently irreconcilable wishes and have expressed this to the patient and her son. She currently seems to be indicating that her desire to return home exceeds her desire for maximal medical management, although she continues to request full code status at this time.

I have also reviewed with the patient and her son that I do not believe that a single family member with a once daily home health nurse visit will be able to replicate the very high care need she is experiencing here.

Nonetheless, the patient is asking that arrangements be made and we are currently attempting to arrange the equipment and training for her son, Pat, to potentially allow this to occur. Training is now ongoing with anticipation of transition to her going home sometime in the next few days is quite likely.

Dr. Wendy Meyers, who has been updated as to the current status of Ms. Moreno's care, will be assuming care on December 27, 2002, and will dictate the remainder of the summary.

HR: 91052759 MORENO,EVELYN,LOUISE RESULTS REPORTING SYSTEM
PH: (503)434-5047 F 63 YRS AS OF: 30-DEC-2002 11:31:55

Referred By: UNKNOWN MD SERV. NG Svc: INPT Dict: MEYERS,WENDY,S 12-30-02

DRAFT

HR: 91052759 Name: MORENO,EVELYN,L 102-85285

Discharge Summary

ADMITTED: 11/29/02

DISCHARGED: 12/30/02

See interim summary dictated by Dr. Scott Marsal on December 26, 2002, for discussion of patient's hospital course. This dictation will contain information regarding the last several days of patient's hospitalization and an updated discharge medication list.

Briefly, this is a 63-year-old female with metastatic adenocarcinoma and malignant ascites, pleural effusions and subtotal bowel obstruction secondary to mesenteric metastatic deposits. She also has chronic obstructive pulmonary disease (COPD) and poor functional status at baseline. Patient had a prolonged hospital course. She was admitted with increasing ascites and underwent chemotherapy but did very poorly after chemotherapy and required multiple intubations and ICU management. The patient continued to want aggressive care and was kept on BiPAP during this hospitalization.

At the time of this dictation the patient is aware that she has a terminal condition and there is nothing to do to reverse her metastatic cancer. She understands that she is not a candidate for chemotherapy, surgery or any kind of endoscopic procedure. She also has the basic understanding that this is a terminal condition, and she will die with this. She had consistently stated that she wanted full resuscitative efforts in the event of her death, and many people have spoken with her and talked to her about the course of her illness. She understands she is terminal. At this point patient wishes to go home; above everything else she wants to be at home. She still wishes, however, to be full code. The patient's son is convinced that once she gets home she will change her mind and will wish to be a do not resuscitate.

Patient was set up for discharge around December 26, 2002, but was deemed too unstable to discharge. We have spent the last several days trying to stabilize the patient and talk with her regarding her prognosis. Patient and her son have asked repeatedly for discharge home. We have gone over all the care needs. Patient has IV morphine and IV Ativan, BiPAP, nasogastric tube, Foley catheter, total parenteral nutrition and nebulizer. The son has been instructed by the nurses on how to manage these medications and interventions; although he realizes it a lot, he wants to take patient home. He was offered hospice and understands that he can get much more in the way of support with hospice versus Home Health, but he wishes to take patient home with Home Health, as he says she would not accept hospice.

We discussed with the son our reluctance to send the patient home. We told him we felt it was almost certain that she would end up coding in the ambulance or possibly need to be diverted to a hospital between here and home. He understood that and continued to push for patient's discharge home. Patient repeatedly

asked to be discharged home. They understand that once the patient is home she would likely not be able to benefit from advanced life-support. He also understands that if she gets intubated again either here or in another hospital, that she will likely not get home. He is willing to accept all these risks, and his primary goal at this time is to get his mother home comfortably. I have discussed this case with Dr. Richardson of pulmonology who is also on the ethics committee and is also on the palliative care team, and he agrees with this plan. Patient's primary care physician, Sean Jones, M.D., came and saw her in the hospital yesterday, and he also agrees with working to get patient home. In order to honor the patient's wishes, we will transfer her home today if arrangements can be made by earlier enough in the afternoon and, if not today, she will be discharged home tomorrow.

DISCHARGE MEDICATIONS
1. Total parenteral nutrition, 70 ml per hour, to be managed by home infusion pharmacy.
2. Atrovent metered-dose inhaler six puffs four times a day.
3. Albuterol metered-dose inhaler two to four puffs as needed.
4. Albuterol nebulizers as needed.
5. Nystatin powder, apply to groin three times a day.
6. Lorazepam 2 mg/ml 0.5 mg IV q.12h. scheduled, q.2h. as needed.
7. Hydrocortisone 100 mg IV each morning.
8. Morphine 2 mg/ml 2-4 mg IV every hour as needed.
9. D50 1 amp as needed for blood sugar less than 70.

The patient's son has been instructed to check her blood sugars twice a day and to call for help if the blood sugars are greater than 400. He has also been instructed on how to use the BiPAP, how to mix and inject Ativan, how to inject the morphine and how to deal with the nasogastric tube and the suction and the Foley catheter. He has suction, albuterol nebulizer machine, oxygen, hospital bed, TPN and all DME needs at her home. Home Health will meet patient and son out at their house at 3:30 p.m. this afternoon to complete the teaching. Home Health will continue to follow with patient at home.

Primary physician is Dr. Sean Jones. He is aware of the discharge plans and is in agreement. Dr. Jones will be notified of the patient's discharge.