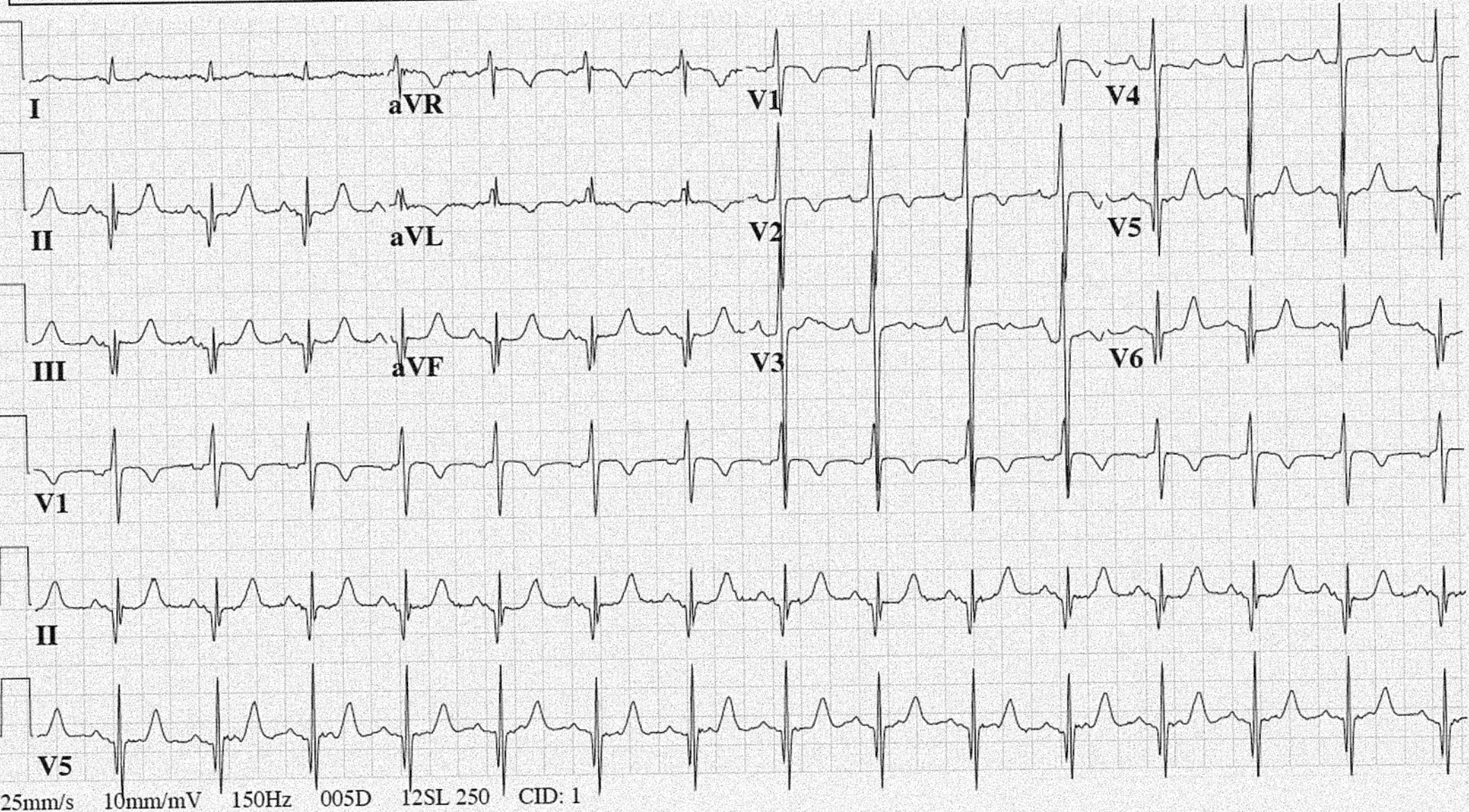


City Hospital ECG Report

Report ID : 1000002
QRS : 78 ms
QT / QTcBaz : 373 / 434 ms
PR : 158 ms
P : 98 ms
RR / PP : 734 / 731 ms
P / QRS / T : 79 / -2 / 66 degrees

Impression:
Atrial fibrillation with rapid ventricular response. Low voltages. ST-T wave abnormalities. Compared to prior from 2020-10-04, the atrial fibrillation is new, and ST-T wave abnormalities are more prominent.

Patient Name: Arabella Gabrielson
Patient ID: 11110002
DOB: 1960-05-23 15:04:07
Date/Time: 2022-02-10 20:46:26
Technician: ML
Ordering MD: Lochlainn Arrighi
Attending MD: Bryson Stark





General Heart Hospital

Cardiac Imaging Laboratory
100 Main Street
Anywhere, ST 99999
(800) 555-5555

DOB: 1960-05-23 15:04:07
Patient Location: Outpatient
Accession: 1000013

Check-in #: 1111222
Procedure date: 2022-03-01
09:05:34

Unit #: n/a
MRN: 11110002

Arabella Gabrielson
333 Anytown Street
Anystate, USA 55511

Dictating Physician: Bryson Stark
Ordering Physician: Bhaskar Dolan

REASON FOR EXAM:

Aortic valve replacement. Assessment of stenotic valve. Evaluation for thrombus on the valve.

TECHNIQUE:

The procedure was explained to the patient with risks and benefits. The patient agreed and signed the consent form. The patient received a total of 3 mg of Versed and 50 mcg of fentanyl for conscious sedation and pain control. The oropharynx anesthetized with benzocaine spray and lidocaine solution. Esophageal intubation was done with no difficulty with the second attempt. In a semi-Fowler position, the probe was passed to transthoracic views at about 40 to 42 cm. Multiple pictures obtained. Assessment of the peak velocity was done later. The probe was pulled to the mid esophageal level. Different pictures including short-axis views of the aortic valve was done. Extubation done with no problems and no blood on the probe. The patient tolerated the procedure well with no immediate postprocedure complications.

FINDINGS:

The left atrium was mildly dilated. No masses or thrombi were seen. The left atrial appendage was free of thrombus. Pulse wave interrogation showed peak velocities of 60 cm per second. The left ventricle was normal in size and contractility with mild LVH. EF is normal and preserved. The right atrium and right ventricle were both normal in size. Mitral valve showed no vegetations or prolapse. There was mild-to-moderate regurgitation on color flow interrogation. Aortic valve was well-seated mechanical valve, bileaflet with acoustic shadowing beyond the valve noticed. No perivalvular leak was noticed. There was increased velocity across the valve with peak velocity of 3.2 m/sec with calculated aortic valve area by continuity equation at 1.2 cm² indicative of moderate aortic valve stenosis based on criteria for native heart valves.

Pulmonic valve was somewhat difficult to see because of acoustic shadowing from the aortic valve. Overall showed no abnormalities. The tricuspid valve was structurally normal. Interatrial septum appeared to be intact, confirmed by color flow interrogation as well as agitated saline contrast study. The aorta and aortic arch were unremarkable. No dissection.

IMPRESSION:

1. Mildly dilated left atrium.
2. Mild-to-moderate regurgitation.
3. Well-seated mechanical aortic valve with peak velocity of 3.2 m/sec and calculated valve area of 1.2 cm² consistent with moderate aortic stenosis. Reevaluation in two to three years with transthoracic echocardiogram will be recommended.

FINAL

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X-RAY REPORT

SOUTHWESTERN IMAGING CENTER

SUITE 201, 34 DUNSTER ROAD, FLAGSTAFF, AZ 86001 TELEPHONE: 928-555-1212

Requesting Physician: Dr. Geevarghese Kilpatrick
Patient Name: Arabella Gabrielson
Patient ID: 11110002
Patient DOB: 1960-05-23 15:04:07
Patient gender: female

Accession #: 1000024
Study Date: 2022-02-05 19:25:11

XR ABDOMEN

INDICATION: Abdominal distention and pain. R/o SBO.

COMPARISON: Comparison is made to CT of the abdomen and pelvis from yesterday.

TECHNIQUE: 2 supine views of the abdomen.

FINDINGS:

Multiple gas-filled loops of bowel are noted in the center of the abdomen. There is no evidence of free intraperitoneal air. The small bowel gas pattern is normal.

No abnormal calcifications or osseous abnormality is seen.

IMPRESSION:

No obvious pneumoperitoneum or bowel obstruction, but evaluation is limited on these supine views. Centrally located loops of bowel are suggestive of ascites - for clinical correlation.

Attending Physician: Mukhtar Sherazi

City Hospital
City Health

RADIOLOGICAL REPORT

Patient:Arabella Gabrielson
MRN:11110002
DOB:1960-05-23
Ordering MD:Nino Campana
Accession:1000035

Exam Date: 2022-03-08 12:04:48

EXAM TYPE:
CT HEAD

REASON FOR EXAMINATION: Facial paresthesia. Please evaluate for intracranial abnormalities.

COMPARISON EXAMINATION: None.

TECHNIQUE: Multiple axial images were obtained of the brain. 5 mm sections were acquired. 2.5-mm sections were acquired without injection of intravenous contrast. Reformatted sagittal and coronal images were obtained.

FINDINGS: No acute intracranial abnormalities appreciated. No evidence for hydrocephalus, midline shift, space occupying lesions or abnormal fluid collections. No cortical based abnormalities appreciated. The sinuses are clear. No acute bony abnormality is identified.

IMPRESSION: No acute intracranial abnormalities appreciated. Further evaluation via MRI is recommended.

Preliminary report was telephoned to Dr. Wong by Dr. Smith.

Signed by: Mukhtar Sherazi, MD



City Hospital
100 Francis Street
El Dorado, AR 71730

Surgical Pathology Report

Patient: Arabella Gabrielson

Patient ID: 11110002

DOB: 1960-05-23 15:04:07

Gender: female

Requesting Physician: Lylou Masi

Accession Number: 1000046

Procedure: SKIN BIOPSY

Attending: Dejan Zlatkov

Date: 2022-02-22 21:48:15

TISSUE:

Left chin.

CLINICAL HISTORY:

Nevus recently changed, r/o atypia. Punch biopsy.

GROSS DESCRIPTION:

Container label: L chin. A cylindrical skin biopsy, 0.2 x 0.3 cm.

MICROSCOPIC DESCRIPTION:

There are orderly nests, cords and strands of uniform nevus cells within the dermis.

DIAGNOSIS:

L CHIN: MELANOCYTIC NEVUS, INTRADERMAL TYPE.

Patient Name: Arabella Gabrielson
MRN: 11110002
Age: 61
DOB: 1960-05-23 15:04:07

Document ID: 1000057
Dictating Physician: Junpei Matsumoto
Document Date: 2022-03-13 12:00:00

City Hospital Discharge Summary

Chief Complaint:
Acute Renal Failure

History of Present Illness:

This 61 year old female was recently seen by her primary care provider for her annual physical exam. Routine blood work was drawn on this visit. Earlier today, the patient was called by PCP and advised to come to the emergency department given that her bloodwork showed new acute renal failure with a creatinine of 4.75 with a potassium of 7.8.

On history, the patient has no known history of renal disease. She had dysuria and frequency while on vacation in florida (having returned 2 weeks ago). While in Florida, she went to a walk-in clinic for these symptoms and was prescribed ciprofloxacin for a UTI. There is no other history of new medications. No recent exposure to contrast dye. She denies any vomiting or diarrhea or abdominal pain. She has no known history of autoimmune diseases. She has had subjective fevers since her diagnosis of her urinary tract infection. She has had about a 20lb weight loss in the last two months and she attributes this to increased physical activity. She does endorse a cough with occasional blood tinged sputum but did not think it was anything that required medical attention. She has also noticed that she has required increased tylenol for her joint pains which have been slightly worse over the last few weeks but denies any excessive use of NSAIDs. In addition, when questioned, she does endorse decreased urine output over the last week but cannot quantify how much urine output she produces.

Past Medical History:

1. Asthma
2. OSA
3. Hypertension
4. Hypothyroidism

Allergies:
None

Medications on Admission:

1. Salmeterol 50mcg/Dose inhalation BID
2. Ipratropium bromide 1 inhalation OD
3. Albuterol INH 1-2 puffs q4h for asthma
4. Levothyroxine 75mcg PO OD
5. Enoxaparin 40 mg SC OD

Social History:

Patient is married with 3 children. She lives with her husband in a house. She is highly functioning and quite active at baseline. She doesn't smoke and drinks

the occasional glass of wine at social functions. She is retired but used to work as an accountant.

Physical Exam:

On examination, her blood pressure was 160/98 with a pulse of 78. Her temperature was 37.7 degrees celsius. Her oxygen saturation was 93% on room air. Oropharynx was unremarkable. Her lungs were clear to auscultation bilaterally. Abdomen was non tender and not distended. There was no palpable organomegaly. No suprapubic tenderness and no CVA tenderness. There was no peripheral edema, rashes or clubbing of her extremities.

Laboratory Data:

On lab work, she was found to have a microcytic hypochromic anemia with a hemoglobin of 10.0, white blood cell count of 15 and a platelet count of 560. Creatinine was 4.98 and urea was 182. Potassium was 7.6, bicarb 19 with no anion gap. ESR was 80. Calcium, phosphate, magnesium and albumin were normal. ANA and RF were negative. p-ANCA antibody was positive. c-ANCA and Anti GBM titers were unremarkable. HIV and hepatitis B/C serology were negative.

Urinalysis showed red blood cells and nephrotic range proteinuria.

Induced sputum for AFB was negative x 3.

Renal biopsy showed pauci-immune deposition of antibodies, mostly IgG, in a linear pattern with crescent formation.

Radiologic Studies:

ECG showed normal rhythm with tall peaked T waves, flattening of the P wave and PR prolongation.

CXR showed reticulonodular infiltrates bilaterally as well as an enlarged cardiac silhouette.

Non Contrast CT chest showed multiple cavitating lesions involving the upper and middle lobes of both lungs.

Abdominal ultrasound showed no evidence of masses, hydronephrosis or findings of medical renal disease.

Echocardiogram showed normal left atrial size. Normal LV wall thickness, cavity size, and systolic function (LVEF 55%). Normal regional LV systolic function. No VSD. Normal right ventricular chamber size and free wall motion. Normal trileaflet aortic valve. No aortic stenosis. No AR. Normal mitral valve leaflets with trace MR. Normal tricuspid valve leaflets with trace TR. No pericardial effusion.

Hospital Course:

The patient was admitted under the medicine service for further workup and management of her acute renal failure.

She was immediately hooked up to telemetry given her hyperkalemia. ECG showed normal rhythm with tall peaked T waves, flattening of the P wave and PR prolongation. She was given 1 amp of calcium gluconate, 10 units of insulin followed by dextrose as well albuterol nebulizers. She was also given 30g of kayexalate. Repeat potassium level 4 hours later showed a potassium of 5.3 and another dose of kayexalate 30g was administered. There was subsequent normalization of her potassium level and normalization of her ECG findings.

Nephrology was consulted given her acute renal failure in the context of significant proteinuria. They suggested IV fluid hydration and a foley catheter to monitor urine output. They ordered an abdominal ultrasound which was unremarkable.

CXR showing diffuse infiltrates was further investigated with a non contrast CT scan of her chest which showed multiple cavitating lesions involving the upper middle lobes bilaterally. She was subsequently isolated with airborne precautions. Induced sputum for AFB was negative and isolation precautions were then discontinued.

Given the enlarged cardiac silhouette on CXR and uremia, a echocardiogram was performed to rule out a pericardial effusion. This did not show a pericardial effusion and was essentially normal.

Given the pulmonary and renal findings, a diagnosis of vasculitis was entertained. She was seen by the respirology service and a bronchoscopy with BAL was performed. Visualization of the airways showed diffuse erythema with friable mucosa and ulceration but no masses or stenosis. Bronchoalveolar lavage fluid showed an increase in neutrophils and no growth on bacterial culture.

Transbronchial biopsy was performed but was non diagnostic.

Therefore, a renal biopsy was ordered. This showed pauci-immune deposition of antibodies, mostly IgG, in a linear pattern with crescent formation.

A diagnosis of Wegener's granulomatosis (Granulomatosis with polyangiitis) was made on the above findings. She was started on IV methylprednisolone for 3 days followed by prednisone 60mg PO and azathioprine 150mg PO.

Her renal function started to improve along with her respiratory symptoms. Once all the investigations were complete and a diagnosis was made she was eager to go home and therefore follow up arrangements were made.

Her creatinine on discharge was 1.92 with a normal potassium. Repeat CXR showed no worsening of her pulmonary infiltrates.

Follow up was arranged with both respirology and nephrology. She was to do q2weekly blood work with CBC, creatinine and microscopic urine analysis.

Condition at Discharge:
Stable

Discharge Status:
Home

Discharge Diagnosis:

1. Wegener's Granulomatosis
2. Acute Renal Failure
3. Hyperkalemia
4. Asthma
5. OSA
6. Hypertension
7. Hypothyroidism

Discharge Medications:

-
1. Prednisone 60mg PO OD
 2. Pantoprazole 40mg PO OD
 3. Azathioprine 150mg PO OD
 4. Salmeterol 50mcg /Dose inhalation BID
 5. Ipratropium bromide 1 inhalation OD
 6. Albuterol INH 1-2 puffs q4h
 7. Levothyroxine 75mcg PO OD
-

Transcribed/Edited by: ML

Copies: Dr. Arnold Chang, Dr. Jim Owens



City Hospital

1717 St. James Avenue
La Jolla, CA 92037

Operative Report

Patient Name: Arabella Gabrielson
Account #: 1018291
MRN: 11110002
DOB: 1960-05-23 15:04:07

Procedure Date: 2022-02-22 04:25:10
Adding MD: Vilhelmina Reece
Document ID: 1000068

PREOPERATIVE DIAGNOSIS:

1. Abnormal uterine bleeding.
2. Uterine fibroids.

POSTOPERATIVE DIAGNOSIS:

1. Abnormal uterine bleeding.
2. Uterine fibroids.

PROCEDURE:

Laparoscopic-assisted vaginal hysterectomy.

PROCEDURE ANESTHESIA:

General endotracheal anesthesia.

PROCEDURE IN DETAIL:

After adequate general endotracheal anesthesia, the patient was placed in dorsal lithotomy position, prepped and draped in the usual manner for a laparoscopic procedure. A speculum was placed into the vagina. A single tooth tenaculum was utilized to grasp the anterior lip of the uterine cervix. The uterus was sounded to 10.5 cm. A #10 RUMI cannula was utilized and attached for uterine manipulation. The single-tooth tenaculum and speculum were removed from the vagina. At this time, the infraumbilical area was injected with 0.25% Marcaine with epinephrine and infraumbilical vertical skin incision was made through which a Veress needle was inserted into the abdominal cavity. Aspiration was negative; therefore the abdomen was insufflated with carbon dioxide. After adequate insufflation, Veress needle was removed and an 11-mm separator trocar was introduced through the infraumbilical incision into the abdominal cavity. Through the trocar sheath, the laparoscope was inserted and adequate visualization of the pelvic structures was noted. At this time, the suprapubic area was injected with 0.25% Marcaine with epinephrine. A 5-mm skin incision was made and a 5-mm trocar was introduced into the abdominal cavity for instrumentation. Evaluation of the pelvis revealed the uterus to be slightly enlarged and irregular. The fallopian tubes have been previously interrupted surgically. The ovaries appeared normal bilaterally. The cul-de-sac was clean without evidence of endometriosis, scarring or adhesions. The ureters were noted to be deep in the pelvis. At this time, the right cornu was grasped and the right fallopian tube, uteroovarian ligament, and round ligaments were doubly coagulated with bipolar electrocautery and transected without difficulty. The remainder of the uterine vessels and anterior and posterior leaves of the broad ligament, as well as the cardinal ligament was coagulated and transected in a serial fashion down to level of the uterine artery. The uterine artery was identified. It was doubly coagulated with bipolar electrocautery and transected. A similar procedure was carried out on the left with the left uterine cornu identified. The left fallopian tube, uteroovarian ligament, and round ligaments were doubly coagulated with bipolar electrocautery and transected. The remainder of the cardinal ligament, uterine vessels, anterior, and posterior sheaths of the broad ligament were coagulated and

transected in a serial manner to the level of the uterine artery. The uterine artery was identified. It was doubly coagulated with bipolar electrocautery and transected. The anterior leaf of the broad ligament was then dissected to the midline bilaterally, establishing a bladder flap with a combination of blunt and sharp dissection. At this time, attention was made to the vaginal hysterectomy. The laparoscope was removed and attention was made to the vaginal hysterectomy. The RUMI cannula was removed and the anterior and posterior leafs of the cervix were grasped with Lahey tenaculum. A circumferential injection with 0.25% Marcaine with epinephrine was made at the cervicovaginal portio. A circumferential incision was then made at the cervicovaginal portio. The anterior and posterior colpotomies were accomplished with a combination of blunt and sharp dissection without difficulty. The right uterosacral ligament was clamped, transected, and ligated with #0 Vicryl sutures. The left uterosacral ligament was clamped, transected, and ligated with #0 Vicryl suture. The parametrial tissue was then clamped bilaterally, transected, and ligated with #0 Vicryl suture bilaterally. The uterus was then removed and passed off the operative field. Laparotomy pack was placed into the pelvis. The pedicles were evaluated. There was no bleeding noted; therefore, the laparotomy pack was removed. The uterosacral ligaments were suture fixated into the vaginal cuff angles with #0 Vicryl sutures. The vaginal cuff was then closed in a running fashion with #0 Vicryl suture. Hemostasis was noted throughout. At this time, the laparoscope was reinserted into the abdomen. The abdomen was reinsufflated. Evaluation revealed no further bleeding. Irrigation with sterile water was performed and again no bleeding was noted. The suprapubic trocar sheath was then removed under laparoscopic visualization. The laparoscope was removed. The carbon dioxide was allowed to escape from the abdomen and the infraumbilical trocar sheath was then removed. The skin incisions were closed with #4-0 Vicryl in subcuticular fashion. Neosporin and Band-Aid were applied for dressing and the patient was taken to the recovery room in satisfactory condition. Estimated blood loss was approximately 100 mL. There were no complications. The instrument, sponge, and needle counts were correct.

Pacific Endoscopy Associates Ltd

301-32 West 96th Street, Portland, OR 97220

Patient: Arabella Gabrielson
Date of Birth: 1960-05-23 15:04:07
Medical Record Number: 11110002
Gender: female
Age: 61

Procedure Date: 2022-02-10 20:46:26
Attending MD: Ryota Norling
Document ID: 1000079

Upper Endoscopy

PREOPERATIVE DIAGNOSIS:

Anemia.

PROCEDURE:

Upper gastrointestinal endoscopy.

POSTOPERATIVE DIAGNOSIS:

1. Severe duodenitis.
2. Small gastroesophageal junction ulceration seen.
3. No major bleeding seen in the stomach.

PROCEDURE IN DETAIL:

The patient was put in left lateral position. Olympus scope was inserted from the mouth, under direct visualization advanced to the upper part of the stomach, upper part of esophagus, middle of esophagus, GE junction, and some intermittent bleeding was seen at the GE junction. Advanced into the upper part of the stomach into the antrum. The duodenum showed extreme duodenitis and the scope was then brought back. Retroflexion was performed, which was normal. Scope was then brought back slowly. Duodenitis was seen and a little bit of ulceration seen at GE junction.

FINDING:

Severe duodenitis, may be some source of bleeding from there, but no active bleeding at this time.



CITY HOSPITAL CLINIC

2600 Laurier Avenue
Waltham, MA 02451
Telephone: 617-555-1212

Patient ID: 11110002**Name:** Arabella Gabrielson**DOB:** 1960-05-23**Gender:** female**Attending Physician:** Dr. Ratna Ahmad**Document ID:** 1000090**Document Date:** 2022-01-11

SOAP Note

SUBJECTIVE:

Mrs. Gabrielson presents today for followup. She notes no dysuria, gross hematuria, fever, or chills. She continues to have urinary incontinence, especially while changing position from sitting to standing, as well as urge incontinence. She is voiding during the daytime every 1 hour in the morning, which tapers off in the afternoon, but no nocturia. No fecal incontinence. No straining to urinate. Good urinary stream, emptying well. No bowel issues, however, she also indicates that while using her vaginal cream, she has difficulty doing this as she feels a protrusion in her vagina, and is very concerned that she has possible vaginal prolapse. Finally, she believes her abdomen is distended, although on examination I could not notice this.

ASSESSMENT:

1. Improvement but ongoing urinary retention, status post vaginal reconstruction, with ongoing possible vaginal prolapse.
2. Rule out ascites/mass, with no noted lower extremity edema.

PLAN:

Following a detailed discussion with the patient, she wishes to proceed with continuing the Flomax and Urecholine. She will check-in next week with ob/gyn for a pelvic exam, and in the meantime, she will obtain a CT abdomen and pelvis to further investigate the cause of her perceived abdominal distention. All questions were answered.

City Hospital**ULTRASOUND DEPARTMENT**

1598 Norwood Street
Bethlehem, PA 18015

Tel: 866-555-1212
Fax: 866-555-1213

Accession #: 1000101	MRN: 11110002 Gender: female Procedure date: 2022-05-18 DOB: 1960-05-23	Unit #: n/a Admission ID: 110001112
Arabella Gabrielson 333 Anytown Street Anystate, USA 55511		Dictating Physician: Mukhtar Sherazi Ordering Physician: Eun-Young Abategiovanni
HISTORY: Menorrhagia. TECHNIQUE: Endovaginal ultrasound of the pelvis. COMPARISON: None. FINDINGS: The uterus is enlarged measuring 11.0 x 7.5 x 11.0 cm. There are numerous, ill-defined fibroids. The endometrial stripe was not visualized due to distortion by the fibroids. The right ovary measures 3.9 x 1.9 x 2.3 cm. The left ovary could not be visualized. No adnexal masses were identified, however. There was no free fluid. The visualized portion of the bladder appeared normal. There were some small nabothian cysts in the cervix. IMPRESSION: Numerous uterine fibroids. They are difficult to measure given their heterogenous and ill-defined appearance. MRI of the pelvis could be performed if uterine fibroid embolization is being considered.		

FINAL

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City Hospital

3200 Hospital Drive, Lodi, CA 95240

MRN: 11110002

Patient Name: Arabella Gabrielson

Date of Birth: 1960-05-23 15:04:07

Gender: female

Referred by: Dr. Bhaskar Dolan

Study Date: 2022-08-25 09:26:28

Accession #: 1000112

MRI LEFT SHOULDER

INDICATION:

62-year-old female with left shoulder pain and restricted external rotation and abduction x 6 months.

TECHNIQUE:

Multiplanar multisequence non-contrast MRI of the left shoulder.

COMPARISON:

Left shoulder x-ray from December 2021.

FINDINGS:

There is a flat undersurface of the acromion (Type I) morphology, with anterior downsloping orientation.

There is inflammation of the anterior rotator interval capsule with peritendinous edema involving the intracapsular long biceps tendon best appreciated on the (series #3 images #6-9), best seen on the axial T2 series. There is edema with thickening of the superior glenohumeral ligament (series #3 image #7). There is flattening of the long biceps tendon as it enters the bicipital groove (series #3 image #9-10), but no subluxation. The findings suggest early changes of a hidden lesion of the subscapularis tendon.

Within the humeral head, there is a 1.7 cm lesion that is hypointense on T1/bright on T2 with punctate low T1/T2 signal foci within, and no surrounding edema that is likely an enchondroma.

Normal biceps labral complex and superior labrum, and there is no demonstrated superior glenoid labral tear.

There is minimal tendinitis with intratendinous edema of the insertion of the subscapularis tendon (series #3 image #10). There is minimal fluid within the glenohumeral joint capsule within normal physiologic volume limits.

Normal anterior and posterior glenoid labra.

The supraspinatus tendon, teres minor tendon and infraspinatus tendon are normal.

The rotator cuff muscles are normal. No muscular atrophy is seen.

There is minimal fluid loculated within the labral ligamentous capsular complex along the posterior-superior labrum (series #7 image #5; series #5 image #7), but there is no demonstrated posterior-superior labral tear or paralabral cyst or ganglion.

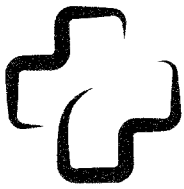
Normal acromioclavicular articulation.

IMPRESSION:

1. Inflammation of the anterior rotator interval capsule with interstitial edema of the superior glenohumeral ligament.
2. Flattening of the long biceps tendon as it enters the bicipital groove, but no subluxation. Findings suggest early changes of a hidden lesion of the subscapularis tendon.
3. Mild tendinitis of the distal insertion of the subscapularis tendon, but no tendon tear.
4. Normal supraspinatus, infraspinatus, and teres minor tendons and muscular complexes.
5. Type I acromion, but no inferior acromial osteophyte.
6. 1.7 cm lesion in the humeral head that is likely an enchondroma, but follow-up with x-ray within 3 months is advised.

Dr. Bryson Stark
Consultant Radiologist

Note: This is a digitally verified report and does not require manual signature



RADIOLOGY REPORT

Accession: 1000122

MRN: 11110002
Name: Arabella Gabrielson
DOB: 1960-05-23
Gender: female
Location: RAD
Doctor: Bryson Stark, MD

Examination:
SCREENING MAMMOGRAM

Date Reported:
2022-06-09

INDICATION: Right breast mass palpable and seen on bedside ultrasound. Breast cancer was reported in her maternal aunt. FNAB suspicious for malignant cells. Please add ultrasound-guided core biopsy if indicated.

TECHNIQUE: Bilateral diagnostic mammogram.

COMPARISON: Comparison is made to mammogram from 2019/10/01.

FINDINGS: There are scattered fibroglandular densities. In the inner lower quadrant of the right breast, there is a 2.3 x 3.9 cm ovoid mass (series 1, image 1) new since the previous mammogram. There is skin thickening of the inferomedial right breast surrounding the nipple. Several punctate calcifications are seen within the mass itself.

In the left breast, multiple foci of benign-appearing calcifications are seen, some of which contain central lucencies consistent with oil cysts. These calcification have increased since October 1, 2019. No suspicious mass, microcalcifications, or area of architectural distortion is seen in the left breast.

IMPRESSION: 2.3 x 3.9 cm mass lesion in the inferomedial right breast, consistent with breast cancer given that the cytology of this lesion from original FNAB was suspicious for malignant cells.

BI-RADS 5. A follow-up biopsy should be performed of this mass within 1 week as per institutional protocol.

The findings regarding the breast mass were telephoned to Dr. Hsu at 12:05 pm.

Note: This report has been electronically signed & verified by the radiologist and does not require a manual signature

CITY HOSPITAL CLINIC

2600 Laurier Avenue
Waltham, MA 02451
Telephone: 617-555-1212

Patient ID: 11110002**Name:** Arabella Gabrielson**DOB:** 1960-05-23**Gender:** female**Attending Physician:** Dr. Junpei Matsumoto**Document ID:** 1000128**Document Date:** 2022-07-20

SOAP Note

SUBJECTIVE:

Overall, she has been doing well. Her blood sugars have usually been less than or equal to 135 by home glucose monitoring. Her fasting blood sugar today is 120 via Accu-Chek. She is exercising multiple times per week. Review of systems is otherwise unremarkable.

OBJECTIVE:

Her blood pressure is 110/60. Other vitals are stable. HEENT: Unremarkable. Neck: Unremarkable. Lungs: Normal. Heart: Regular. Abdomen: Unchanged. Extremities: Unchanged. Neurologic: Unchanged.

ASSESSMENT:

1. NIDDM with improved control.
2. Hypertension.
3. Coronary artery disease with coronary artery bypass graft in 2018.
4. Degenerative arthritis.
5. Hyperlipidemia.
6. Hyperuricemia.
7. Renal azotemia.
8. Anemia.

PLAN:

We will get follow-up labs today. We will continue with current medications and treatment. We will arrange for a follow-up mammogram as recommended by the radiologist in six months. The patient is advised to proceed with previous recommendations. She is to follow-up with an Ophthalmology consult for diabetic monitoring within 2 months and to return as directed.