MEDICAL CHRONOLOGY - INSTRUCTIONS TO FOLLOW

General Instructions:

Brief Summary/Flow of Events:
In the beginning of the chronology, a Brief Summary/Flow of Events outlining the significant medical events is provided which will give a general picture of the focus points in the case

Patient History:
Details related to the patient's past history (medical, surgical, social and family history)
Present in the medical records

Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information capture (all details/zoom-out model and relevant details/zoom-in model) is as per the demands of the case which will be elaborated under the 'Specific Instructions'

Reviewer's Comments:
Comments on contradicting information and misinterpretations in the medical records, illegible handwritten notes, missing records, clarifications needed, etc. are given in italics and red font color and will appear as *Reviewer's Comment

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy* ***format)***

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as* ***"Illegible Notes" in the heading of the particular consultation/report.***

Specific Instructions:
•The medical chronology focuses in detail on patient's medical records from 07/23/2014 until 04/05/2021.
• Initial and final visits of physical therapy visits have been elaborated in detail. All other visits are summarized.
• Repetitive details have been avoided.
• Records not related to case focus have not been included. It can be elaborated upon request.
• Case specific information has been highlighted with yellow color.

Brief Summary/Flow of Event

Mount Sinai Hospital

07/23/2014: Discharge Summary**.** Admission Date: 07/22/2014**.** Discharge Date: 07/23/2014**.** Plan: Patient

discharged to home. Prescribed Azelastine-Fluticasone 137-50 mcg, Bupropion 150 mg, Levocetirizine 5 mg, Levothyroxine 25 mcg, Nicotine 2 mg, Olopatadine 0.6% Nasal Spray, Olopatadine 0.1% drops, Prevacid 30 mg, Sodium Bicard-Sodium Chloride, Sucralfate 1 gm. Recommended to hold aspirin or other anti-inflammatory medications for 7 days. Advised to avoid gassy and spicy food today. Avoid soda/carbonated drinks. Drink plenty of fluids for first 24 hours.
(Jill Doe-page 42/ 48-54/ 25-26/ 28-32/ 55-56)

09/24/2014: Operative Note**.** Procedure: Laparoscopic Toupet fundoplication.
(Jill Doe-page 105-106)

Procedure Note**.** Procedure: Laparoscopic hiatal hernia repair and toupet fundoplication.
(Jill Doe-page 108-109)

Fountain Pulmonary, P.C.

08/06/2019: SOAP Note**.** CC: Problem using CPAP. HPI: Patient awakened with the mask ripped off on most days. On some days, she was able to tolerate CPAP therapy for more than 4 hours, but this was rarely the case. Review of her compliance report showed she had very low usage compliance of 16%. She still awakened in the middle of the night, felt like her "breathing was cut off" on the days she did not use the machine. This did not happen on the days that she managed to tolerate CPAP. She had never dozed off while driving. She had a history of PTSD and thought this might be contributory, her ESS score was 8 suggesting mild sleepiness. Patient's chronic rhinitis was poorly controlled despite of multiple nasal sprays prescribed by her ENT and she constantly cleared her throat and makes grunting noises most of the day. Diagnoses: Obstructive sleep apnea, hypothyroidism, temporomandibular joint disorder, gastroesophageal reflux disease without esophagitis and joint disorder. Plan: Recommended trial of Benadryl at nighttime to improve control of the postnasal drip. If this issue persisted, she might be a candidate for referral to be evaluated for the Inspire Upper Airway Stimulation System. Advised to follow up in 30 days
(Jill Doe-page 132-137)

09/03/2019: SOAP Note**.** CC: Obstructive sleep apnea follow up. HPI: Patient was menopausal and wondered if some of these symptoms were related to this stage of her life. She also had a history of iron deficiency anemia. She received iron shots at one time several years ago. Assessment: Obstructive sleep apnea. Chronic daytime somnolence and fatigue likely related to sub-optimal hours and days of CPAP usage. Plan: Patient educated on proper CPAP use and better compliance scores. Advised to follow up in 3 months.
(Jill Doe-page 138-142)

12/03/2019: SOAP Note**.** CC: Obstructive Sleep Apnea. HPI: Patient reported she was intolerant of a full face mask. She had issues even with the nasal mask. She did not like the idea of having to sleep attached to a machine. Assessment: Obstructive sleep apnea patient with insomnia likely due to underlying anxiety/stress and chronic pain. She had adequate CPAP adherence. Plan: Prescribed Flonase 50 mcg nasal suspension.

Recommended to consider referral to Psychiatry for Anxiety/Stress management. Recommended to consider pain management referral and continue CPAP. Advised to follow up in 3-4 months.
(Jill Doe-page 143-147)

Sunil H. Patel, M.D.

08/21/2019: Evaluation Report**.** CC: Abdominal pain and GERD. HPI: Patient reported throbbing upper abdomen pain daily after meals. Impression: Abdominal pain, r/o PVD and GERD. Plan: Recommended screening colonoscopy.
(Jill Doe-page 163-164)

11/13/2019: Progress Note**.** HPI: Patient reported she still had symptoms of GERD and was off meds, status post EGD. Impression: H. pylori positive. GERD. Benign colon polyp. Plan: Recommended to restart Protonix. Advised to repeat EGD in one year and follow up in 6 weeks.
(Jill Doe-page 157)

04/16/2020: Progress Note**.** CC: Persistent GERD, Rectal bleeding. Patient presented via telehealth and stated that she still had GERD, was on Protonix and also had rectal bleeding with mild difficulty in bowel movements. Impression: Persistent GERD. Rectal bleeding, hemorrhoidal and history of H. pylori. Plan: Prescribed Dexilant 60 mg. Advised to increase fiber in diet and follow up in 1 month.
(Jill Doe-page 156)

12/09/2020: Progress Note**.** CC: GERD**.** HPI: Patient stated that she still had persistent GERD, on Dexilant and had history of H. pylori. Impression: Persistent GERD. History of H. Pylori. Plan: Prescribed Carafate. Recommended to continue Dexilant and repeat EGD.
(Jill Doe-page 155)

04/05/2021: Progress Note**.** CC: GERD. HPI: Patient stated she still had mild GERD. Impression: GERD and H. pylori. Plan: Prescribed Aciphex. Ordered lab studies. Advised to follow up in 8 weeks.
(Jill Doe-page 151)

Richmond University Medical Center

10/24/2019: Colonoscopy Report**.** Impression: Benign neoplasm of ascending colon. Diverticulosis of large intestine without perforation or abscess without bleeding. Benign neoplasm of sigmoid colon. Other hemorrhoids. Plan: Advised to wait for pathology report. Recommended high fiber diet. Advised to follow up colonoscopy in 3 years pending biopsy results.
(Jill Doe-page 158)

Esophagogastroduodenoscopy Report**.** Impression: Acute gastritis without bleeding. Chronic superficial gastritis without bleeding. Diaphragmatic hernia without obstruction of gangrene. Esophagitis, unspecified. Plan: Recommended to wait for pathology report. Recommended proton pump inhibitors (PPI), diet and anti-reflux regimen.
(Jill Doe-page 159)

Surgical Pathology Report**.** Final Diagnoses: Duodenum Biopsy: Small intestinal mucosa with preserved architecture. No significant microscopic findings. Antrum Biopsy: chronic active gastritis. Helicobacter pylori organisms were present. There was no evidence of intestinal metaplasia or dysplasia. Giemsa stain was positive. Fundus Biopsy: Chronic focally active gastritis. Helicobacter pylori organisms were not seen. There was no evidence of intestinal metaplasia or dysplasia. Giemsa stain was negative. EG Junction Biopsy: Chronic focally active carditis with focal incomplete intestinal metaplasia. Squamous mucosa with no significant microscopic findings. Helicobacter pylori organisms were not seen. There was no evidence of dysplasia. Alcian blue stain was positive. Mid Esophagus Biopsy: Fragments of unremarkable squamous epithelium. Sigmoid Biopsy: Colonic mucosa with focal adenomatous change. Ascending Biopsy: Tubular adenoma.
(Jill Doe-page 160-162)

03/18/2021: Esophagogastroduodenoscopy**.** Impression: Duodenitis without bleeding. Acute gastritis without bleeding. Chronic superficial gastritis without bleeding. Esophagitis, unspecified. Plan: Advised to wait for pathology report and follow diet and anti-reflux regimen.
(Jill Doe-page 152)

Surgical Pathology Report**.** Final Diagnoses: Duodenum: Duodenal mucosa with normal villous architecture and with no intraepithelial lymphocytosis. No evidence of celiac disease or pathologic microorganisms. Antrum: Chronic active (Helicobacter) gastritis, moderate to marked. Special stain (Giemsa) was positive for H. Pylori microorganisms. Fundus: Chronic active (Helicobacter) gastritis, mild to moderate. Special strain (Giemsa) was positive for H. Pylori microorganisms. EG Junction: Squamocolumnar junctional mucosa showed mild reflux change (non-erosive reflux disease) and moderate chronic gastritis with focal hyperplastic changes. No intestinal metaplasia and no dysplasia identified. Alcian blue stain was focal positive in gastric mucosa and negative for intestinal metaplasia. Mid Esophagus: Benign squamous mucosa with no significant pathological changes.
(Jill Doe-page 153-154)

Patient History

Past Medical History: Nissens fundoplication.. Hiatal Hernia. OSA. GERD.
(Jill Doe-page 135/ 164)

Past Surgical History: Thyroidectomy for nodules 30 years ago. Left hip replacement few years ago. History breast implants Surgery. History of Nissens funduplication surgery in 2014.

(Jill Doe-page 136)

Family History: Father had liver disease. Maternal grandmother, aunt, and nephew had breast cancer.
(Jill Doe-page 164)

Social History: Tobacco use and moderate cigarette smoker. Social Drinker.
(Jill Doe-page 135)

Allergies: Ciprofloxacin caused hives. Penicillin. Latex caused rash and swelling.
(Jill Doe-page 133/ 28)

THE MEDICAL RECORD

The following excerpts from the medical record are representative of the information contained therein and are pertinent to the issues being addressed.

DATE	PROVIDER	OCCURRENCE	PDF Ref
07/23/2014	Mount Sinai Hospital Gina Sam, M.D.	**Discharge Summary** **Admission Date**: 07/22/2014 **Discharge Date**: 07/23/2014 **Plan:** Patient discharged to home. Prescribed Azelastine-Fluticasone 137-50 mcg, Bupropion 150 mg, Levocetirizine 5 mg, Levothyroxine 25 mcg, Nicotine 2 mg, Olopatadine 0.6% Nasal Spray, Olopatadine 0.1% drops, Prevacid 30 mg, Sodium Bicard-Sodium Chloride, Sucralfate 1 gm. Recommended to hold aspirin or other anti-inflammatory medications for 7 days. Advised to avoid gassy and spicy food today. Avoid soda/carbonated drinks. Drink plenty of fluids for first 24 hours.	Jill Doe-page 42/ 48-54/ 25-26/ 28-32/ 55-56
09/24/2014	Mount Sinai Hospital Edward H. Chin, M.D.	**Operative Note** **Clinical indication:** Patient with severe GERD and dysphagia. Upper endoscopy showed a significant hiatal hernia. She had a positive pH study, but also some dysmotility on manometry, specifically 100% incomplete bolus clearance with intact peristalsis. She	Jill Doe-page 105-106

		was referred for anti reflux surgery. **Pre/Post Operative Diagnosis:** Severe Gastroesophageal reflux disease. **Procedure:** Laparoscopic Toupet fundoplication.	
09/24/2014	Mount Sinai Hospital Joseph Kim, M.D.	**Procedure Note** **Clinical Indication:** 52F hiatal hernia and GERD refractory to medical management. **Pre/Post Operative Diagnoses:** GERD and hiatal hernia. **Procedure:** Laparoscopic hiatal hernia repair and toupet fundoplication.	Jill Doe-page 108-109
09/24/2014 - 09/25/2014	Mount Sinai Hospital Jeeten Singha, M.D.	**Inpatient Progress Note** Medical records were reviewed.	Jill Doe-page 110-117
08/06/2019	Fountain Pulmonary, P.C. Adebambo Olajitan, M.D.	**SOAP Note** **CC:** Problem using CPAP. **HPI:** Patient awakened with the mask ripped off on most days. On some days, she was able to tolerate CPAP therapy for more than 4 hours, but this was rarely the case. Review of her compliance report showed she had very low usage compliance of 16%. She still awakened in the middle of the night, felt like her “breathing was cut off” on the days she did not use the machine. This did not happen on the days that she managed to tolerate CPAP. She had never dozed off while driving. She had a history of PTSD and thought this might be contributory, her ESS score was 8 suggesting mild sleepiness. Patient’s chronic rhinitis was poorly controlled despite of multiple nasal sprays prescribed by her ENT and she constantly cleared her	Jill Doe-page 132-137

		throat and makes grunting noises most of the day. **Current Medications:** Atorvastatin Calcium 20 mg, Budesonide 32 mcg/ACT, Famotidine 40 mg, Fluticasone Propionate 50 mcg, Levothyroxine Sodium 75 mcg, Montelukast Sodium 10 mg, and Omeprazole 40 mg. **Diagnoses:** Obstructive sleep apnea, hypothyroidism, temporomandibular joint disorder, gastroesophageal reflux disease without esophagitis and joint disorder. **Plan:** Recommended trial of Benadryl at nighttime to improve control of the postnasal drip. If this issue persisted, she might be a candidate for referral to be evaluated for the Inspire Upper Airway Stimulation System. Advised to follow up in 30 days	
08/21/2019	Sunil H. Patel, M.D.	**Evaluation Report "Illegible Notes"** **CC:** Abdominal pain and GERD. **HPI:** Patient reported throbbing upper abdomen pain daily after meals. **Exam:** Mild epigastric tenderness. **Impression:** Abdominal pain, r/o PVD and GERD. **Plan**: Recommended screening colonoscopy.	Jill Doe-page 163-164
09/03/2019	Fountain Pulmonary, P.C. Adebambo Olajitan, M.D.	**SOAP Note** **CC:** Obstructive sleep apnea follow up. **HPI:** Patient was menopausal and wondered if some of these symptoms were related to this stage of her life. She also had a history of iron deficiency anemia. She received iron shots at one time several years ago. Patient with continued use of CPAP with a compliance of >80% and usage hours of 6-8 hours/day should	Jill Doe-page 138-142

		alleviate the daytime fatigue, and sleepiness **Exam:** Deviated nasal septum, mild. **Assessment:** Obstructive sleep apnea. Chronic daytime somnolence and fatigue likely related to sub-optimal hours and days of CPAP usage. **Plan:** Patient educated on proper CPAP use and better compliance scores. Advised to follow up in 3 months.	
10/24/2019	Richmond University Medical Center Sunil H. Patel, M.D.	**Colonoscopy Report** **Clinical Indication:** Encounter for screening for malignant neoplasm of colon. **Findings:** Normal Anal Canal. Rectum other hemorrhoids. Sigmoid Colon 1 cm Polyp. Polypectomy done using biopsy forceps. Descending Colon: Diverticulosis of large intestine without perforation or abscess without bleeding. Normal splenic flexure, transverse colon, Hepatic Flexure, Ascending Colon: 1 cm polyp. Polypectomy done using biopsy forceps. Normal cecum and ileocecal valve. Lieum not seen. **Impression:** Benign neoplasm of ascending colon. Diverticulosis of large intestine without perforation or abscess without bleeding. Benign neoplasm of sigmoid colon. Other hemorrhoids. **Plan:** Advised to wait for pathology report. Recommended high fiber diet. Advised to follow up colonoscopy in 3 years pending biopsy results.	Jill Doe-page 158
10/24/2019	Richmond University Medical Center Sunil H. Patel, M.D.	**Esophagogastroduodenoscopy Report** **Clinical Indication:** Gastro-esophageal reflux disease without esophagitis. **Findings:** Normal Oropharynx. Esophagitis, unspecified. Biopsy taken. EG-Junction:	Jill Doe-page 159

		Diaphragmatic hernia without obstruction or gangrene. Irregular Z line. Biopsy taken. Normal Cardia. Fundus with chronic superficial gastritis without bleeding. Body: chronic superficial gastritis without bleeding. Antrum: Acute gastritis without bleeding. Biopsy taken. Normal pylorus and duodenum bulb. 2nd portion randon biopsy taken. 3rd portion not seen. **Impression:** Acute gastritis without bleeding. Chronic superficial gastritis without bleeding. Diaphragmatic hernia without obstruction of gangrene. Esophagitis, unspecified. **Plan:** Recommended to wait for pathology report. Recommended proton pump inhibitors (PPI), diet and anti-reflux regimen.	
10/24/2019	Richmond University Medical Center Svetoslav Bardarov, M.D.	**Surgical Pathology Report** **Clinical History:** GERD, screening, r/o celiac, r/o. Pylori, and r/o Barrett's. Colon Polyp. **Specimen:** Duodenum, antrum, fundus, EG junction, mid esophagus, sigmoid, and ascending. **Final Diagnoses:** Duodenum Biopsy: Small intestinal mucosa with preserved architecture. No significant microscopic findings. Antrum Biopsy: chronic active gastritis. Helicobacter pylori organisms were present. There was no evidence of intestinal metaplasia or dysplasia. Giemsa stain was positive. Fundus Biopsy: Chronic focally active gastritis. Helicobacter pylori organisms were not seen. There was no evidence of intestinal metaplasia or dysplasia. Giemsa stain was negative. EG Junction Biopsy: Chronic focally active carditis with focal incomplete intestinal metaplasia. Squamous mucosa with no significant microscopic findings. Helicobacter pylori organisms were not seen. There was no evidence of dysplasia. Alcian blue stain was positive. Mid Esophagus Biopsy: Fragments of unremarkable squamous epithelium. Sigmoid Biopsy:	Jill Doe-page 160-162

		Colonic mucosa with focal adenomatous change. Ascending Biopsy: Tubular adenoma.	
11/13/2019	Sunil H. Patel, M.D.	**Progress Note "Illegible Notes"** **CC:** GERD. **HPI:** Patient reported she still had symptoms of GERD and was off meds, status post EGD. Lab and diagnostic studies were reviewed. **Impression:** H. pylori positive. GERD. Benign colon polyp. **Plan:** Recommended to restart Protonix. Advised to repeat EGD in one year and follow up in 6 weeks.	Jill Doe-page 157
12/03/2019	Fountain Pulmonary, P.C. Adebambo Olajitan, M.D.	**SOAP Note** **CC:** Obstructive Sleep Apnea. **HPI:** Patient reported she was intolerant of a full face mask. She had issues even with the nasal mask. She did not like the idea of having to sleep attached to a machine. The observed AHI was less than 5. Negligible mask leakage. **Assessment:** Obstructive sleep apnea patient with insomnia likely due to underlying anxiety/stress and chronic pain. She had adequate CPAP adherence. **Plan:** Prescribed Flonase 50 mcg nasal suspension. Recommended to consider referral to Psychiatry for Anxiety/Stress management. Recommended to consider pain management referral and continue CPAP. Advised to follow up in 3-4 months.	Jill Doe-page 143-147
04/16/2020	Sunil H. Patel, M.D.	**Progress Note "Illegible Notes"** **CC:** Persistent GERD, Rectal bleeding.	Jill Doe-page 156

		Patient presented via telehealth and stated that she still had GERD, was on Protonix and also had rectal bleeding with mild difficulty in bowel movements. **Impression:** Persistent GERD. Rectal bleeding, hemorrhoidal and history of H. pylori. **Plan:** Prescribed Dexilant 60 mg. Advised to increase fiber in diet and follow up in 1 month.	
12/09/2020	Sunil H. Patel, M.D.	**Progress Note "Illegible Notes"** **CC:** GERD **HPI**: Patient stated that she still had persistent GERD, on Dexilant and had history of H. pylori. **Impression:** Persistent GERD. History of H. Pylori. **Plan**: Prescribed Carafate. Recommended to continue Dexilant and repeat EGD.	Jill Doe-page 155
03/18/2021	Richmond University Medical Center Sunil H. Patel, M.D.	**Esophagogastroduodenoscopy** **Clinical Indication:** Gastroesophageal reflux disease without esophagitis. **Findings:** Normal Oropharynx. Esophagitis, unspecified. Biopsy taken. Irregular Z line EG-Junction. Normal Cardia. Fundus with chronic superficial gastritis without bleeding. Biopsy taken. Body with chronic superficial gastritis without bleeding. Antrum with acute gastritis without bleeding. Biopsy taken. Normal Pylorus. Duodenitis without bleeding. 2nd portion random biopsy taken. 3rd portion not seen. **Impression:** Duodenitis without bleeding. Acute gastritis without bleeding. Chronic superficial gastritis without bleeding. Esophagitis, unspecified.	Jill Doe-page 152

		Plan: Advised to wait for pathology report and follow diet and anti-reflux regimen.	
03/18/2021	Richmond University Medical Center Yanyu Sun, M.D.	**Surgical Pathology Report** **Clinical History:** GERD, r/o Celiac, and H pylori, Barrett's. **Specimen:** Duodenum, antrum, and fundus. **Final Diagnoses:** Duodenum: Duodenal mucosa with normal villous architecture and with no intraepithelial lymphocytosis. No evidence of celiac disease or pathologic microorganisms. Antrum: Chronic active (Helicobacter) gastritis, moderate to marked. Special stain (Giemsa) was positive for H. Pylori microorganisms. Fundus: Chronic active (Helicobacter) gastritis, mild to moderate. Special strain (Giemsa) was positive for H. Pylori microorganisms. EG Junction: Squamocolumnar junctional mucosa showed mild reflux change (non-erosive reflux disease) and moderate chronic gastritis with focal hyperplastic changes. No intestinal metaplasia and no dysplasia identified. Alcian blue stain was focal positive in gastric mucosa and negative for intestinal metaplasia. Mid Esophagus: Benign squamous mucosa with no significant pathological changes.	Jill Doe-page 153-154
04/05/2021	Sunil H. Patel, M.D.	**Progress Note** **CC:** GERD. **HPI:** Patient stated she still had mild GERD. **Impression:** GERD and H. pylori. **Plan:** Prescribed Aciphex. Ordered lab studies. Advised to follow up in 8 weeks.	Jill Doe-page 151

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