

Montgomery Cancer Center
645 McQueen Smith Rd N
Suite 207
Prattville, AL 36066



Montgomery Cancer Center
4145 Carmichael Rd
Montgomery, AL 36106

August 06, 2024

LINDSEY BARTON,
7461 East Dr
Montgomery, AL 36117

Re: MICHAEL ROY

Date of Visit: 8/5/2024

Dear LINDSEY BARTON

Enclosed is the Transition of Care Document related to the stay of this patient. This document is confidential and intended solely for the use of the individual or entity to which it is addressed. If you are not the named addressee, please disregard and do not disseminate, distribute or copy this information. If you are not the intended recipient any disclosure of this information and its contents is strictly prohibited.

If you have additional questions regarding this information, please contact:

Nimmagadda, Susmitha, MD
4145 Carmichael Road
Montgomery, AL 36106
(334) 273-7000

Sincerely,

Susmitha Nimmagadda
BARTON, LINDSEY

BARTON, LINDSEY

Referring Physician

Referring Physician: Rasheed (HPS), Khalid, MD

Chief Complaint

New Patient

History of Present Illness

Is a 78-year-old Caucasian gentleman who presents to the clinic for a new patient consultation for further evaluation of history of VTE. He was recently hospitalized after he had presented with symptoms concerning for a TIA. Had additional lab workup which was negative for stroke. Given his prior history of factor V Leiden abnormality he presents today for additional evaluation. Had previously had left lower extremity DVT for which he was treated with anticoagulation for short duration with no subsequent recurrences. He was noted to have a heterozygous factor V Leiden mutation but no other coexisting thrombophilias.

Oncology Treatment History**Oncology Treatment History**

08/06/24 19:36:00

PAST MEDICAL SURGICAL HISTORY:

Hypertension

Renal calculi

Heterozygous factor V Leiden

A single episode of left lower extremity DVT-treated with finite anticoagulation

Status post skin cancer removal-basal cell

Dyslipidemia

S/p cholecystectomy 1979.

FAMILY HISTORY: Father deceased from lung cancer. Family history of brain tumor and has a grandfather. Denies any other malignancies. There is a mention of factor V Leiden + positive-heterozygous mutations in the family.

SOCIAL HISTORY: Married, has 2 children, is currently retired, prior remote history of smoking, social alcohol consumption.

PCP: Ms. Lindsey Barton @ AUM

CONTACT# 2513277974

Review of Systems

Review of Systems negative unless specifically mentioned in the HPI.

Physical Exam**Vital Signs and Measurements****T:** 97.2 °F (Tympanic) **HR:** 64 (Monitored) **RR:** 18 **BP:** 129/81**SpO2:** 98%**HT:** 68 in **WT:** 77.9 kg (Dosing) **BMI:** 26.11

Numeric Rating Pain Scale: 0 = No pain (08/05/24 11:55:00)

PHYSICAL EXAMINATION:**GENERAL:** Alert and oriented in no acute distress**HEAD:** No alopecia. Non-traumatic.**EYES:** PERLA, EOMI, No Pallor, No Icterus.**Home Medications**

Alive Men's Complete Multivitamin oral tablet

apixaban 5 mg oral tablet, 5 mg= 1 Tab,

PO, Twice Daily

aspirin, 81 mg, PO, DAILY

calcium (as carbonate and lactate)-

vitamin D 200 mg-6.25 mcg oral tablet,

1 Tab, Chewed, DAILY

ginger

Lipitor 40 mg oral tablet, 40 mg= 1 Tab,

PO, Bedtime

Norvasc 10 mg oral tablet, 10 mg= 1

Tab, PO, DAILY

Turmeric

Vitamin B-12

Vitamin B6

Vitamin C

Vitamin D2

Allergies

codeine

Social History**Alcohol**

Alcohol Use: Yes. Alcohol Type:

Beer. Frequency of Alcohol Use:

Weekly.

Substance Abuse

Drug Use: No.

Tobacco

Tobacco Use: Never (less than 100

in lifetime). Non-Smoking Literature:

Non-smoker.

Family History

Cancer: Father and Brother.

LUNG CANCER: Father.

LabsWBC: 6.1 X10³/uL (08/05/24)RBC: 4.29 X 10⁶/uL Low (08/05/24)

Hemoglobin: 13.3 gm/dl (08/05/24)

Hematocrit: 40.4 % (08/05/24)

MCV: 94 fL (08/05/24)

MCH: 31 pg (08/05/24)

MCHC: 33 gm/dl (08/05/24)

Platelet Count: 196 X10³/uL (08/05/24)

RDW: 11.9 % (08/05/24)

MPV: 9.1 fL (08/05/24)

Neutro Auto: 62 % (08/05/24)

Lymph Auto: 25 % (08/05/24)

Mono Auto: 10 % (08/05/24)

Eos Auto: 2 % (08/05/24)

Basophil Auto: 1 % (08/05/24)

Immature Gran Auto: 0.2 % (08/05/24)

Neutro Abs: 3.84 X10³/uL (08/05/24)

EARS, NOSE, MOUTH, THROAT: Mucosa is moist, No ulcers, No mucositis, No thrush.
 NECK: Supple without masses. Symmetrical. No thyromegaly.
 LYMPHATICS: No lymphadenopathy.
 CARDIAC: Regular rate and rhythm. No murmurs.
 RESPIRATORY: Clear to auscultation bilaterally.
 GI: Soft, non-tender, non-distended, bowel sounds present. No masses or organomegaly noted.
 EXTREMITIES: No clubbing, cyanosis or edema.
 MUSCULOSKELETAL: Gait and station normal. Moves all extremities well.
 CUTANEOUS: Warm and dry. No ecchymosis or rashes noted.
 NEUROLOGIC: Without gross focal cranial nerve deficits.

Immature Gran Abs: 0 X10³/uL (08/05/24)
 NRBC: 0 /100 WBC (08/05/24)
 NRBC Abs: 0 X10³/uL (08/05/24)
 Gluc: 93 mg/dL (08/05/24)
 BUN: 24 mg/dL High (08/05/24)
 Creat: 1.24 mg/dL (08/05/24)
 eGFR CKD-EPI: 60 mL/min/1.73m² Low (08/05/24)
 eCrCl: 47 mL/min (08/05/24)
 Sodium lvl: 136 mmol/L (08/05/24)
 Potassium lvl: 4.4 mmol/L (08/05/24)
 Chloride: 109 mmol/L High (08/05/24)
 CO2: 25 mmol/L (08/05/24)
 Anion Gap: 2 Low (08/05/24)
 Calcium: 9.4 mg/dL (08/05/24)
 Total Protein: 7.5 gm/dl (08/05/24)
 Albumin: 4 gm/dl (08/05/24)
 Alk Phos: 70 unit/L (08/05/24)
 ALT: 21 unit/L (08/05/24)
 AST: 9 unit/L (08/05/24)
 Bili Total: 0.7 mg/dL (08/05/24)

Assessment/Plan

History of factor V Leiden heterozygous gene abnormality. He had had repeat hypercoagulable workup done earlier in July when he had presented to the hospital with a TIA. No new changes were noted. He does have a confirmed test-heterozygous for factor V Leiden abnormality with no other coexisting abnormalities. At the current time I have informed him that it is not uncommon for the general population to have a heterozygous factor V Leiden mutation, which increases the risk of VTE by about 2-3 fold when compared to the general population without any gene abnormalities. This does not warrant for him to be on lifelong anticoagulation. He was not discharged on Eliquis and was recommended to use his 30-day supply and subsequently discontinued. On reviewing his discharge documentation no specific reason for the anticoagulation with Eliquis. Does recommended for him to discontinue the same. Recommended for him to continue with aspirin prophylaxis

TIA. This appears to be more orthostatic as secondary to clinical dehydration. Encouraged for him to continue with medical management.

Stage II chronic kidney disease. Continue with medical management.

History of nonmelanomatous skin cell cancers. I recommended for him to keep his follow-up appointments with dermatology at least on an annual basis for continued screening.

Age-appropriate malignancy screening-recommended for him to adhere with the same.

ORDERS:

Follow Up as Needed, 08/05/24 12:17:00 CDT

Signature Line

(Electronically Signed On 08.06.24 19:42 CDT)

Nimmagadda, Susmitha, MD

8/13/24
 Reviewed
 J. B. [Signature]

D: 08.05.24 19:35 CDT