



Health Information Services Patient Extract

From 1/1/2003 through 8/12/2011

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Partners HealthCare System, Inc.
BRIGHAM & WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Cardiology From 1/1/2003 through 8/12/2011

09/08/2008 16:03

ECG

Final

Report Number: K0900021L

Report Status: Final

Type: ECG

Date: 09/08/2008 16:03

Ordering Provider:

Electrocardiogram Report for Accession # 09-00021L 09/08/08 16:03

VENT. RATE 56 BPM

PR INTERVAL 134 ms

QRS DURATION 102 ms

QT/QTc 430 414 ms

P-R-T AXES 56 81 65

SINUS BRADYCARDIA

INCOMPLETE RIGHT BUNDLE BRANCH BLOCK

BORDERLINE ECG

WHEN COMPARED WITH ECG OF 02-MAR-2008 04:52,

SIGNIFICANT CHANGES HAVE OCCURRED

REFERRED BY: [REDACTED]

REVIEWED BY: [REDACTED]



Cardiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 04:52

ECG

Final

Report Number: K0824797L

Report Status: Final

Type: ECG

Date: 03/02/2008 04:52

Ordering Provider:

Electrocardiogram Report for Accession # 08-24797L 03/02/08 04:52

VENT. RATE 60 BPM

PR INTERVAL 138 ms

QRS DURATION 100 ms

QT/QTc 408 408 ms

P-R-T AXES 62 86 67

NORMAL SINUS RHYTHM

NORMAL ECG

WHEN COMPARED WITH ECG OF 24-FEB-2006 15:31,

NO SIGNIFICANT CHANGE WAS FOUND

REFERRED BY: [REDACTED]

REVIEWED BY: [REDACTED]



Cardiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 01:54

ECG

Final

Report Number: K0824664L

Report Status: Final

Type: ECG

Date: 03/02/2008 01:54

Ordering Provider:

Electrocardiogram Report for Accession # 08-24664L 03/02/08 01:54

VENT. RATE 70 BPM

PR INTERVAL 140 ms

QRS DURATION 106 ms

QT/QTc 374 403 ms

P-R-T AXES 70 84 72

SINUS RHYTHM WITH MARKED SINUS ARRHYTHMIA

INCOMPLETE RIGHT BUNDLE BRANCH BLOCK

BORDERLINE ECG

WHEN COMPARED WITH ECG OF 24-FEB-2006 15:31,

NO SIGNIFICANT CHANGE WAS FOUND

REFERRED BY [REDACTED]

REVIEWED BY: [REDACTED]



Cardiology from 1/1/2003 through 8/12/2011 (cont)

03/16/2006

ECHO

Final

Report Number: 0605274L

Report Status: Final

Type: ECHO

Date: 03/16/2006 09:43

Ordering Provider: [REDACTED]

Echocardiogram Report for Accession # 06-05274L 03/16/06

Diagnosis:

Cardiac dysrhythmia.

Information Requested:

Assess left/right ventricular function.

Height: 72 in. Weight: 177 lbs. BSA: 2.02

Blood Pressure:

Testing performed: 2D, DOPPLER, COLOR DOPPLER

M-Mode: 2D Quality:

Conclusion:

2D MEASUREMENTS

LV diam, d: 4.95 cm Aortic Root, d: 3.11 cm

LV diam, s: 3.50 cm LA, s: 3.88 cm

IVS, d: 0.86 cm

PWT, d: 0.75 cm

Left Ventricle: The left ventricle is normal in size. There is normal left ventricular wall thickness. Overall left ventricular function is normal. The estimated ejection fraction is 55-60%. There are no regional wall motion abnormalities.

Right Ventricle: Normal right ventricular size, wall thickness, and contractility.

Left Atrium: Normal left atrial size.

Right Atrium: Normal right atrial size.

Aortic Valve: The aortic valve is trileaflet, without detected stenosis or insufficiency.

Mitral Valve: Structurally normal mitral valve without stenosis or prolapse. There is trace mitral regurgitation.

Tricuspid Valve: The tricuspid valve is structurally normal. There is trace tricuspid regurgitation. The tricuspid regurgitant velocity is 1.8 m/s, consistent with normal pulmonary artery systolic pressure of 12 mmHg plus right atrial pressure.

Pulmonic Valve: There is trace pulmonic regurgitation.

Aorta: The aortic root size is normal.

Pulmonary Artery: The main pulmonary artery appears normal in size.

Venous: The inferior vena cava is normal in size with respirophasic variation (suggestive of normal right atrial pressure).

Pericardium/Pleura: There is no significant pericardial effusion.



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Cardiology from 1/1/2003 through 8/12/2011 (cont)

Prior studies: No prior BWH studies or reports for comparison.

[REDACTED] assisted in the interpretation of this echocardiogram.
ATTENDING STAFF: [REDACTED]



Cardiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2006 08:16

MR Angio Abd w/o & w/Cont

Final

Exam Number: A07466594 Report Status: Final

Type: MR Angio Abd w/o & w/Cont

Date/Time: 03/02/2006 08:16

Exam Code: M4185/GAD/CV

Ordering Provider: [REDACTED]

Associated Reports:

A07476434: 3D Holographic Reconstruction

A07476437: ADDITIONAL GAD +11-20cc

A07476464: ADDITIONAL POST SCAN

REPORT:

HISTORY: LEFT UPPER QUADRANT PULSATION. EVALUATE FOR ANEURYSM.

TECHNIQUE: Multiplanar, multisequence imaging of the abdomen was performed both pre and post IV administration of 40 cc of gadolinium contrast. Infusion imaging as well as multiplanar reformations were performed.

PRIOR STUDIES: None.

FINDINGS:

VASCULAR: There is no evidence of abdominal aortic aneurysm. The celiac axis, superior and inferior mesenteric arteries are widely patent. Two single renal arteries are seen bilaterally and are widely patent. There is no renal artery aneurysm. Both kidneys are normal in size with the right measuring 10.3 cm and the left measuring 10.5 cm in craniocaudal dimensions.

INCIDENTAL FINDINGS: Multiple subcentimeter rounded areas of decreased signal intensity are seen on T1 weighted images which are hyperintense on T2 weighted images and do not enhance, therefore representing simple hepatic cysts. Additionally, in segment 6 of the liver, there is a 1.9 x 1.5 cm rounded area of increased signal intensity on T2 weighted images which demonstrates brisk enhancement and may represent an adenoma or focal nodular hyperplasia. There is marked dilatation of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

IMPRESSION:

1. Normal abdominal aorta and major branch vessels without evidence of aneurysm.
2. 1.9 x 1.5 cm lesion in segment 6 of the liver which may represent an adenoma or focal nodular hyperplasia. Further evaluation with a triple phase CT scan should be performed as well as short-term follow-up.
3. Simple hepatic cysts.
4. Prominence of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

END OF IMPRESSION:



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Cardiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



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Cardiology from 1/1/2003 through 8/12/2011 (cont)

02/24/2006 15:31

ECG

Final

Report Number: K0622554L

Report Status: Final

Type: ECG

Date: 02/24/2006 15:31

Ordering Provider:

Electrocardiogram Report for Accession # 06-22554L 02/24/06 15:31

VENT. RATE 51 BPM

PR INTERVAL 130 ms

QRS DURATION 100 ms

QT/QTc 430 396 ms

P-R-T AXES 66 81 63

SINUS BRADYCARDIA

INCOMPLETE RIGHT BUNDLE BRANCH BLOCK

MINIMAL VOLTAGE CRITERIA FOR LVH, MAY BE NORMAL VARIANT

BORDERLINE ECG

NO PREVIOUS ECGS AVAILABLE

REFERRED BY: [REDACTED]

REVIEWED BY: [REDACTED]



Discharge Reports From 1/1/2003 through 8/12/2011

03/02/2008

left flank pain

Admission Date: 03/02/2008
 Discharge Date: 03/03/2008

Report Status:

***** FINAL DISCHARGE ORDERS *****
 LAUERMAN, JOHN 184-22-02-2
 M49 Room: 14A-142
 Service: MED

DISCHARGE PATIENT ON: 03/03/08 AT 04:00 PM
 CONTINGENT UPON Not Applicable
 WILL D/C ORDER BE USED AS THE D/C SUMMARY: YES
 Attending: [REDACTED]
 CODE STATUS:
 Full code
 DISPOSITION: Home

MEDICATIONS ON ADMISSION:

1. PATIENT IS NOT KNOWN TO BE TAKING ANY MEDICATIONS

MEDICATIONS ON DISCHARGE:

OXYCODONE 5-10 MG PO Q4H Starting Today (03/03) PRN Pain
 COMPAZINE (PROCHLORPERAZINE) 10 MG PO Q6H PRN Nausea

DIET: No Restrictions

RETURN TO WORK: Immediately

NO FOLLOW-UP APPOINTMENT REQUIRED

ALLERGY: NKA

ADMIT DIAGNOSIS:

left flank pain

PRINCIPAL DISCHARGE DIAGNOSIS ;Responsible After Study for Causing Admission)

left flank pain

OTHER DIAGNOSIS;Conditions,Infections,Complications,affecting Treatment/Stay

left flank pain (flank pain)

OPERATIONS AND PROCEDURES:

none

OTHER TREATMENTS/PROCEDURES (NOT IN O.R.)

BRIEF RESUME OF HOSPITAL COURSE:

Mr. Lauerman is a 49 year-old male who presents with sudden onset of left flank pain. Pain began on night prior to admission before he played tennis. He noticed a discomfort on his left side, but played anyway. Afterwards he was unable to drive home or sleep as he was constantly moving. The pain is characterized as deep, constant, and feeling like he is being "pounded by a 2x4". It has increased in intensity to 10/10. The pain began in his left abd and left back, and radiated up and down his axilla, but not his chest or testes. He c/o also of mild tachypnea, diaphoresis, and finger tingling when the pain was at its worse. He denies fever, rigors, nausea, vomiting, wt loss, constipation, diarrhea, urinary symptoms, h/o kidney stones.

HOSPITAL COURSE



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Discharge Reports from 1/1/2003 through 8/12/2011 (cont)

Pain well controlled with opiates. Had concomitant nausea and relieved with antiemetics. Films reviewed with radiology and findings most consistent with muscular strain. Initial concern of adrenal pathology unlikely. Cortisol within normal. Initial elevated WBC and PLT count resolved on discharge. If symptoms persist we would recommend repeat CT scan of the abdomen.

FULL CODE

ADDITIONAL COMMENTS: You were admitted with left flank pain likely secondary to a muscle

strain. We would ask you to continue pain medication as needed and use local heat/ice. Restrict vigorous physical activity over the next week. Please follow up with your primary care provider in the next month and we would recommend a repeat CT as needed.

DISCHARGE CONDITION: Stable

TO DO/PLAN:

- repeat CT scan abdomen if symptoms; consider repeat in 2-4 weeks to ensure straining resolved.

No dictated summary

ENTERED BY: [REDACTED] 03/03/08 @ 04:42 PM

***** END OF DISCHARGE ORDERS *****



Endoscopy From 1/1/2003 through 8/12/2011

10/31/2008 06:52

COLONOSCOPY

Signed

Report Number: 17915
 Type: COLONOSCOPY
 Date: 10/31/2008 06:52

Report Status: Signed

Brigham and Women's Endoscopy Center
 Gastroenterology
 Patient Name: John Lauerman
 Gender: M
 Procedure Date: 10/31/2008 7:50 AM
 MRN: 18422022
 Date of Birth: 9/25/1958
 Age: 50
 Room: 12

Note Status: Finalized

Attending MD: [REDACTED]

Procedure: Colonoscopy

Indications: Average risk screening for malignant neoplasm in the colon

Providers: [REDACTED]

Referring MD: [REDACTED]

Medicines: Midazolam 4 mg IV, Fentanyl 100 micrograms IV

Complications: No immediate complications

Procedure: - All questions were answered and informed consent was obtained.
 - ASA Grade Assessment: I - A normal, healthy patient.
 - Airway Examination: Mallampati Class I (tonsillar pillars visualized).
 After informed consent was obtained, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. -
 Prep Type: HalfLytely The Colonoscope was introduced through the anus and advanced to the cecum, identified by appendiceal orifice & ileocecal valve. The terminal ileum was intubated. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.

Findings:

The perianal and digital rectal examinations were normal. Internal, non-bleeding, small hemorrhoids were found during retroflexion. A sessile polyp was found in the sigmoid colon. The polyp was 5 mm in size. The polyp was removed with a cold snare. Resection and retrieval were complete. Estimated blood loss was minimal. The exam was otherwise without abnormality.

Impression: - Non bleeding, small, internal hemorrhoids.
 - One 5 mm polyp in the sigmoid colon.
 Resected and retrieved.

Recommendation: - Await pathology results.
 - Return to referring physician as previously scheduled.

Signed Date: 10/31/2008 1:15 PM
 Number of Addenda: 0



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Endoscopy from 1/1/2003 through 8/12/2011 (cont)

This report has been signed electronically.
Note initiated on 10/31/2008 7:52 AM



Laboratory From 1/1/2003 through 8/12/2011

CHEMISTRY								
Date/Time	NA	K	CL	CO2	BUN	CRE	EGFR	GLU
09/08/2008 19:36 ⁽¹⁾								101 (54-118)
(1)DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
03/03/2008 09:37	139 (136-142)	3.9 (3.5-5.0)	105 (98-108)	29 (23-32)	12 (9-25)	0.83 (0.7-1.3)	98⁽¹⁾	103 (54-118)
(1)Abnormal If <60 mL/min/1.73m2 If patient is black, multiply by 1.21)								
03/03/2008 04:12		4.0(#) (3.5-5.0)						
03/02/2008 03:51	140 (136-142)	3.3(*#) (3.5-5.0)	104 (98-108)	26 (23-32)	22 (9-25)	1.07 (0.7-1.3)	73⁽¹⁾	122(*) (54-118)
(1)Abnormal If <60 mL/min/1.73m2 If patient is black, multiply by 1.21)								
02/10/2006 09:37	142 (136-142)	4.5 (3.5-5.0)	105 (98-108)	32 (23-32)	15 (9-25)	1.1 (0.7-1.3)	76⁽¹⁾	82 (54-118)
(1)Abnormal If <60 mL/min/1.73m2 If patient is black, multiply by 1.21)								
07/01/2003 08:34								81 (54-118)
Date/Time	ANION							
03/03/2008 09:37	5 (3-15)							
03/02/2008 03:51	10 (3-15)							
02/10/2006 09:37	5 (3-15)							
Date/Time	CA	TBILI	DBILI	TP	ALB	GLOB	AMY	LIPS
10/08/2008 13:52		0.8 (0.2-1.2)	0.2 (0.1-0.3)	7.4 (6.0-8.0)	4.3 (3.7-5.4)	3.1 (2.0-4.0)		
09/08/2008 19:36 ⁽¹⁾		0.6 (0.2-1.2)	0.2 (0.1-0.3)	7.7 (6.0-8.0)	4.5 (3.7-5.4)	3.2 (2.0-4.0)		
(1)DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
03/03/2008 09:37	8.4(*) (8.8-10.5)							
03/02/2008 03:51	10.0 (8.8-10.5)	1.2(#) (0.2-1.2)	0.2 (0.1-0.3)	7.8 (6.0-8.0)	4.6 (3.7-5.4)	3.2 (2.0-4.0)	72(*) (20-70)	43⁽¹⁾ (3-60)
(1)NEW REF RANGE 3-60 U/L AS OF 3/26/01 OLD REF RANGE WAS 114-286 U/L.								
02/10/2006 09:37	8.7(*)⁽¹⁾ (8.8-10.5)	0.7 (0.2-1.2)	0.2 (0.1-0.3)	6.9 (6.0-8.0)	4.2 (3.7-5.4)	2.7 (2.0-4.0)		
(1)VERIFIED								
Date/Time	ALT/SGPT	AST/SGOT	ALKP	TBILI	DBILI			
10/08/2008 13:52	18 (7-52)	20 (9-30)	81 (36-118)	0.8 (0.2-1.2)	0.2 (0.1-0.3)			

Flag Key: * (Abnormal Value) # (Significant Change) C (Corrected)



Laboratory from 1/1/2003 through 8/12/2011 (cont)

09/08/2008 19:36 ⁽¹⁾	21 (7-52)	24 (9-30)	86 (36-118)	0.6 (0.2-1.2)	0.2 (0.1-0.3)			
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
03/02/2008 03:51	22 (7-52)	23 (9-30)	77 (36-118)	1.2(#) (0.2-1.2)	0.2 (0.1-0.3)			
02/10/2006 09:37	21 (7-52)	28 (9-30)	75 (36-118)	0.7 (0.2-1.2)	0.2 (0.1-0.3)			
Date/Time	CHOL	TRIG	HDL	LDL CAL	VLDL			
09/08/2008 19:36 ⁽¹⁾	197 (140-199)	101 (35-150)	70(*) (40-60)	107 (50-129)	20			
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
07/01/2003 08:34	175⁽¹⁾ (140-240)		57 (40-60)					
(1) (Desirable <200, High >240)								
Date/Time	TSH							
09/08/2008 19:36 ⁽¹⁾	1.639 (0.5-5.0)							
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
02/10/2006 14:03 ⁽¹⁾	2.001 (0.5-5.0)							
(1) DONE AT BWH CLIN LABS, BOSTON								
Date/Time	CORT	HGBA1C	TU-METNEPHS(MG)	T/UNORMT				
03/03/2008 09:37	20.63⁽¹⁾ (3-24)							
(1) 8AM: 6-24 UG/DL, 4PM: 3-12 UG/DL EXOGENOUS GLUCOCORTICOIDS, WILL FALSELY ELEVATE VALUES								
02/27/2006 10:46 ⁽¹⁾			154⁽²⁾ (30-350)	298⁽²⁾ (50-650)				
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████ (2) TEST PERFORMED AT ARUP-SALT LAKE CITY, UT (note new reference range, effective 11/14/05)								
07/01/2003 10:29 ⁽¹⁾		5.2 (4.4-6.1)						
(1) DONE AT BWH CLIN LABS, BOSTON								
Date/Time	UTVOL	UTIME						
02/27/2006 10:46 ⁽¹⁾	1675 (800-1800)	24						
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
02/27/2006 08:53	1675 (800-1800)	24						
Date/Time	UTVOL	UTIME						
02/27/2006 10:46 ⁽¹⁾	1675 (800-1800)	24						
(1) DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
02/27/2006 08:53	1675 (800-1800)	24						

HEMATOLOGY

Flag Key: * (Abnormal Value) # (Significant Change) C (Corrected)



Laboratory from 1/1/2003 through 8/12/2011 (cont)

Date/Time	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	PLT
03/03/2008 09:37	8.33 (#) ⁽¹⁾ (4-10)	4.59 (#) (4.5-6.4)	13.8 (#) (13.5-18.0)	41.6 (40-54)	90.8 (80-95)	30.1 (27-32)	33.2 (32-36)	503 (*#) (150-450)
(1)VERIFIED								
03/02/2008 20:12				40.4 (#) (40-54)				
03/02/2008 03:51	12.39 (*#) (4-10)	5.54 (#) (4.5-6.4)	16.7 (13.5-18.0)	49.0 (#) (40-54)	88.4 (80-95)	30.2 (27-32)	34.1 (32-36)	779 (*#) (150-450)
02/10/2006 09:37	6.21 (4-10)	4.95 (4.5-6.4)	15.4 (13.5-18.0)	43.8 (40-54)	88.6 (80-95)	31.2 (27-32)	35.2 (32-36)	501 (*) ⁽¹⁾ (150-450)
(1)VERIFIED								
Date/Time	RDW							
03/03/2008 09:37	13.0 (11.5-14.5)							
03/02/2008 03:51	13.4 (11.5-14.5)							
02/10/2006 09:37	13.3 (10-14.5)							
Date/Time	%POLY-A	%LYMPH-A	%MONO-A	%EOS-A	%BASO-A			
03/03/2008 09:37	82.5 (*) (48-76)	9.6 (*) (18-41)	6.9 (2.5-8.5)	0.8 (0-5)	0.1 (0-1.5)			
03/02/2008 03:51	82.2 (*) (48-76)	12.4 (*) (18-41)	4.7 (2.5-8.5)	0.5 (0-5)	0.3 (0-1.5)			
02/10/2006 09:37	72.2 (48-76)	19.4 (18-41)	5.1 (2.5-8.5)	2.9 (0-5)	0.4 (0-1.5)			
Date/Time	ANEUT-A	ALYMP-A	AMONO-A	AEOS-A	ABASO-A			
03/03/2008 09:37	6.87 (1.9-7.6)	.81 (0.8-4.1)	0.57 (.10-0.8)	0.07 (0-0.5)	0.01 (0.00-0.15)			
03/02/2008 03:51	10.19 (*) (1.9-7.6)	1.52 (0.8-4.1)	0.58 (.10-0.8)	0.06 (0-0.5)	0.03 (0.00-0.15)			
02/10/2006 09:37	4.49 (1.9-7.6)	1.21 (0.8-4.1)	0.32 (.10-0.8)	0.18 (0-0.5)	0.02 (0.00-0.15)			
COAGULATION								
Date/Time	PT	PT-INR	PTT	DDIMER-NG/ML				
03/02/2008 05:03 ⁽¹⁾	14.1 (12.2-14.8)	1.1 (0.9-1.1)	29.5 (23.8-36.6)	274 (0-499)				
(1)PT/PTT ADDED PER BA11 1630 VRR								
Date/Time	PROTSF	PRTC-ACT	ATIII-%N	COAGINTERP				
03/03/2008 13:42	147 (*) (70-134)	116 (66-140)	111 (69-127)	SEE DETAIL ⁽¹⁾⁽²⁾				
(1)INTERPRETATION BY [REDACTED] (2)GENETIC TESTING REVEALED THAT THE PATIENT IS HETEROZYGOUS FOR THE PROTHROMBIN G20210A MUTATION. THIS MUTATION CONFERS AN INCREASED RISK OF CEREBRAL VEIN AND DEEP VENOUS THROMBOSIS. CLINICAL CORRELATION ADVISED. NORMAL LEVELS OF ANTITHROMBIN III AND								

Flag Key: * (Abnormal Value) # (Significant Change) C (Corrected)



Laboratory from 1/1/2003 through 8/12/2011 (cont)

PROTEIN C. SLIGHTLY ELEVATED LEVEL OF FREE PROTEIN S, UNLIKELY TO BE OF ADVERSE CLINICAL SIGNIFICANCE.								
Date/Time	B2GP1	ACLtGg	ACLtGM					
03/03/2008 13:42	<20 ⁽¹⁾ (0-20)	<15 ⁽²⁾ (0-15)	<15 (0-15)					
(1)NOTE NEW REFERENCE RANGE AS OF 1/1/04 (2)METHODOLOGY CHANGE 8/23/99. PRE CHANGE REFERENCE RANGE 0-22 GPL, POST CHANGE REFERENCE RANGE 0-15 GPL.								
Date/Time	COAGINTERP							
03/03/2008 13:42	SEE DETAIL ⁽¹⁾⁽²⁾							
(1)INTERPRETATION BY ██████████ (2)GENETIC TESTING REVEALED THAT THE PATIENT IS HETEROZYGOUS FOR THE PROTHROMBIN G20210A MUTATION. THIS MUTATION CONFERS AN INCREASED RISK OF CEREBRAL VEIN AND DEEP VENOUS THROMBOSIS. CLINICAL CORRELATION ADVISED. NORMAL LEVELS OF ANTITHROMBIN III AND PROTEIN C. SLIGHTLY ELEVATED LEVEL OF FREE PROTEIN S, UNLIKELY TO BE OF ADVERSE CLINICAL SIGNIFICANCE.								
Date/Time	F2GENE							
03/03/2008 13:42	SEE DETAIL ⁽¹⁾							
(1)SEE PATHOLOGY REPORT								
URINALYSIS								
Date/Time	UA-COLOR	UA-GLUC	UA-BILI	UA-KET	UR-SPGR	UA-BLD	UA-PH	UA-PROT
03/02/2008 03:51	YELLOW ⁽¹⁾	NEG (0-0)	NEG (0-0)	2+ ^(*) (0-0)	1.022 (1.003-1.035)	NEG (0-0)	8.5 ^(*) (4.5-8.0)	TR ^(*) (0-0)
(1)CLEAR								
02/03/2006 15:20	YELLOW ⁽¹⁾	NEG (0-0)	NEG (0-0)	NEG (0-0)	1.007 (1.003-1.035)	NEG (0-0)	7.5 (4.5-8.0)	NEG (0-0)
(1)CLEAR								
Date/Time	UA-UROBI	UA-NIT	LEUK-EST					
03/02/2008 03:51	NEG (0-0)	NEG (0-0)	NEG (0-0)					
02/03/2006 15:20	NEG (0-0)	NEG (0-0)	NEG (0-0)					
Date/Time	MIC-SED	UAS-RBC	UAS-WBC	UAS-BACT	UAS-SQHI	OCAST	HCAST	UAS-CRYS
03/02/2008 03:51	NEG	1 (0-3)	1 (0-4)	NEG	NEG	NEG (0-0)	0 (0-2)	NEG
Date/Time	UA-EPIS							
03/02/2008 03:51	NEG							
IMMUNOLOGY								
Date/Time	CRP-MG/L							
09/08/2008 19:36 ⁽¹⁾	0.7 (0.0-3.0)							
(1)DONE AT BWH CLIN LABS, BOSTON Lab Dir: ██████████								
Date/Time	B2GP1							
03/03/2008 13:42	<20 ⁽¹⁾ (0-20)							

Flag Key: * (Abnormal Value) # (Significant Change) C (Corrected)



Laboratory from 1/1/2003 through 8/12/2011 (cont)

(1)NOTE NEW REFERENCE RANGE AS OF 1/1/04								
CELL MARKERS								
Date/Time	PSATOT							
09/08/2008 19:36 ⁽¹⁾	0.9 (0-4)							
(1)DONE AT BWH CLIN LABS, BOSTON Lab Dir: [REDACTED]								

Flag Key: * (Abnormal Value) # (Significant Change) C (Corrected)



Partners HealthCare System, Inc.
BRIGHAM & WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Microbiology From 1/1/2003 through 8/12/2011

03/02/2008 04:52

URINE

F

Specimen: 2428004

Collected 02-Mar-08 03:20

Received 02-Mar-08 04:52

Ordering Provider:

Specimen Group: URINE

Specimen Type: URINE

AEROBIC CULTURE, URINE

Reported: 03-Mar-08

Total Colony Count 1,000

MIXED FLORA (3 OR MORE COLONY TYPES)



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Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Microbiology from 1/1/2003 through 8/12/2011 (cont)

02/03/2006 14:37

URINE

F

Specimen: 2132753 Received 03-Feb-06 14:37

Ordering Provider: [REDACTED]

Specimen Group: URINE

Specimen Type: URINE

AEROBIC CULTURE, URINE

Reported: 05-Feb-06

NO GROWTH



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LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Microbiology from 1/1/2003 through 8/12/2011 (cont)

04/07/2003 21:19

THROAT

F

Specimen: 1769038 Received 07-Apr-03 21:19

Ordering Provider: [REDACTED]

Specimen Group: THROAT

Specimen Type: THROAT

AEROBIC CULTURE, THROAT

NO BETA HEMOLYTIC STREPTOCOCCI ISOLATED



Notes From 1/1/2003 through 8/12/2011

07/12/2011

Genetic Counseling Visit

Final

Reason for Visit

Mr. Lauerman is a 52 yo M who presents today regarding genomic sequencing.

He is a reporter and is doing a story on getting his genome sequenced. This will be done by Dr. Church at BWH. He would like to know if I have any objections to him doing the test. He will meet with a research genetic counselor and will receive an interpretation of his testing. The information obtained will be placed on the internet as part of the study. He has reviewed this with his family and there are no concerns there.

He does voice some concerns regarding his occasional word finding difficulties which he had reviewed with me previously in regards to development of Alzheimer's disease. He would be interested in seeing the results of his ApoE4 testing because of this.

On questioning regarding whether or not gene testing might change how he lives or what he does, he indicates that he already feels that he lives a healthy lifestyle and would not likely make changes there but the discovery of a potentially devastating illness such as Huntington's disease might cause him to change his financial and work future.

He incidentally notes FHx of thyroid d/o and indicates he would like to have screening for this. Was feeling tired recently but now better.

Otherwise doing well. His dtr has finished freshman year at local college and he and his son are going to California in near future for video gaming contest.

Problems

Seasonal allergies
H/O pneumonia x 1
Ocular migraines
Herpes labialis
Anxiety
PAST smoker - 12 pk yr, quit age 30

Allergies

NKA

Medications Text

none

Review of Systems

per HPI. All other systems reviewed were negative

Vital Signs

BLOOD PRESSURE 100/70
PULSE 64
WEIGHT 181.6 lb
BMI 24.3

Physical Exam

General Appearance

well-appearing, NAD.

Assessment and Plan

1. Genetic counseling. Discussed general issues with screening and genetic testing. Specifically, we discussed scenarios in which positive gene testing could result in proactive rx or intervention (such as BRCA testing) or situations in which there is no clear intervention (ApoE4 testing). I reviewed the concerns about equivocal testing. Generally, I told him that I did not feel that genomic sequencing (as opposed to targeted gene screening) for individuals was a good idea generally at this point due to the questions and concerns above but recognized that this was a different scenario given that this is part of a story that he is reporting. Advised him to consider the possible implications of surprising or uninterpretable results prior to proceeding. Also discussed other general concerns such as use of this information by 3rd parties and privacy issues.

2. HM. Given lab slip for FLP, glucose, TSH to be checked prior to his next PE.

RTC 9/2011 for PE or prn.



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Notes from 1/1/2003 through 8/12/2011 (cont)

Greater than 50% of this 20 minute visit was spent in genetic counseling.

He did ask if he could allude to our conversation in a general sense in his reporting without use of my name or direct quotation and I did agree.



Notes from 1/1/2003 through 8/12/2011 (cont)

07/06/2011

Email from Patient

Final

Hi!

Hope you are well.

I am happy to discuss your genome sequencing with you if you wish. I'll be frank that this is not my area of greatest expertise but would be happy to give you my perspective and answer any questions or concerns that I can. Please feel free to make an appointment with me at your convenience.

In regards to your other request, I would prefer not to participate directly in your news story. I fear that this might interfere in our "patient-doctor relationship" which I feel is very important. I hope you understand my concerns.

Looking forward to seeing you soon,

P.S. It also looks like you are due for a routine physical exam so please schedule this at your convenience as well!

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]

Sent: Wednesday, July 06, 2011 2:01 PM

Subject: Want to set up an appointment

Hi Dr. Lee: How are you? As you may know, I'm a reporter with Bloomberg News. I'm working on a story about having my genome sequenced, and I was thinking it might be a good idea for us to meet for a few minutes and talk about it. Would you be willing to have a discussion about this? And if so, I'd like to see whether you would object to my reporting on the discussion itself? If you'd prefer to talk on the phone about this for a few minutes before we meet give me a call or let me know when and at what number to call you. Look forward to hearing from you! JL

John Lauerman, Education reporter, Bloomberg News/Businessweek, 100 Summer St., Boston, MA, 02110 tel. 1-617-210-4630 cell 1-617-308-5806



Notes from 1/1/2003 through 8/12/2011 (cont)

10/02/2009

Email from Patient

Final

Hi -

Glad to hear you are doing better. Sorry to hear you aren't even better though!

Not sure why this was so much worse either - sometimes there is no rhyme or reason.

Please feel free to make an appointment to see me if things do not completely resolve.

Take care,

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]

Sent: Friday, October 02, 2009 11:48 AM

Subject: cold sores

Hi [REDACTED] Wanted to give you an update on my status, which is overall improved. I got the Valtrex on Tuesday and took doses at 12:40 pm and am. Not sure how much it helped -- just because of the issues we discussed, that it relieves symptoms that are bound to improve on their own -- but I'm glad we gave it a shot since I was feeling so poorly. Little surprised that I had such a bad outbreak since they seem to have become milder over the past decades. Also surprising since I used Abreva liberally on Monday, when the outbreak was just beginning. Could I have bred an Abreva resistant strain by using it persistently over the last few years? Not sure how this works with herpes. I've been working at home Monday because of pain and lack of desire to be in public. Anyway, can't thank you enough for your help with this. Really appreciate your quick response to my emails, and I hope it isn't a burden for you. Thanks and regards, JL



Notes from 1/1/2003 through 8/12/2011 (cont)

09/29/2009

Email from Patient

Final

I think that for the time being, an empiric trial of Valtrex for presumed herpes (cold sore) is reasonable for now. It is two doses - one now and one in 12 hrs. It will not make the lesions disappear immediately, but should shorten the overall duration by a day or so and hopefully reduce the symptoms.
What pharmacy should I send the prescription to?
Of course, if your symptoms worsen or you develop new symptoms, please feel free to make an appointment to see me.

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]
Sent: Tuesday, September 29, 2009 10:40 AM

Subject: RE: Cold sores

All the way across upper lip. There are no rashes. Should I make an appt?

Sent From Bloomberg Mobile MSG

----- Original Message -----

From: [REDACTED]
At: 9/29/2009 10:36

The particular reason for concern is that if this is zoster (shingles), it needs to be treated with a longer course of medication and there are other sequelae that would need to be monitored for.

Does the rash go across your entire upper lip or is it confined to one side?

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]
Sent: Tuesday, September 29, 2009 10:24 AM

Subject: RE: Cold sores

Appeared yesterday morning. I could come in if you have a few minutes, but don't want to take your time unnecessarily. Its all on my upper lip so I'm assuming its just bad cold sore and not zoster. Would be happy to try oral valtrex if you think it might help

Sent From Bloomberg Mobile MSG

----- Original Message -----

From: [REDACTED]
At: 9/29/2009 10:16

Hi -

How long ago did the cold sores appear?

We could consider treatment with oral Valtrex (two doses) but this is generally most effective when taken within 1-2 days of the onset of symptoms. If it has been longer than that, the treatment is not likely to be effective.

If it has been longer, generally, there is not much to do but "wait it out" if it is simple herpes.

However, if this seems out of character for your "normal" cold sores, you should make an appointment to see me for an evaluation, to rule out other possible causes, such as zoster (shingles) or other infections, etc.

Let me know,

-----Original Message-----



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75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN,JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [\[mailto:jlauerman@bloomberg.net\]](mailto:jlauerman@bloomberg.net)

Sent: Tuesday, September 29, 2009 9:51 AM

[REDACTED]
Subject: Cold sores

[REDACTED] I was just getting over a cold when I got a massive (for me) eruption of cold sores. My top lip was so swollen I could see it without a mirror. It was a little odd because I'd felt them coming on and applied abreva. Anyway, is there anything else I could or should be doing besides resting? Nerves in my face and neck feel tender and inflamed. Thanks! JL



Notes from 1/1/2003 through 8/12/2011 (cont)

05/06/2009

Leg Pain Visit

Final

Reason for Visit

Mr. Lauerman is a 50 yo M who presents today regarding pain in right calf.

He had emailed me regarding these sxs previously as noted on chart. Briefly, fairly acute onset of localized right posterior calf pain 1 wk ago. Had been doing a bit of walking but no acute injury. As he was in Mexico at the time, he sought medical attention locally and records (in Spanish) were reviewed. He had a D-Dimer that was mildly elevated. LENI was negative for DVT. CXR, EKG were unremarkable.

He continues to have pain which has worsened. He has remained active and took a 3 mile walk the day after his pain started. Taking ASA without improvement in sxs. He has had similar pain in past in the same area.

Problems

Seasonal allergies
H/O pneumonia x 1
Ocular migraines
Herpes labialis
Anxiety
PAST smoker - 12 pk yr, quit age 30

Allergies

NKA

Review of Systems

per HPI. All other systems reviewed were negative

Physical Exam

General Appearance
well-appearing, NAD.

Extremity
warm, no C/C/E.

Musc Skel
Normal muscle bulk and tone. Knee without effusion. No joint line tenderness. Joint is stable. There is discrete significant tenderness in area of right medial posterior calf. Thompson squeeze test is negative indicating that Achilles tendon is intact.

Assessment and Plan

Calf pain. Previous evaluation was negative for DVT. Sxs more suggestive of process such as muscle strain/tear. Advised rest, ibuprofen in place of ASA and heat (or ice) prn. Contact me if sxs worsen or no improvement in next week for consideration of further evaluation such as MRI. He voices understanding and agreement with plan.



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LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

05/06/2009

Email from Patient

Final

Welcome back!

Please call my office to make an appointment to see me at your convenience to review your leg pain.

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]

Sent: Wednesday, May 06, 2009 7:28 AM

Subject: Back

I'm back now and my calf remains very painful to walk on or touch. Do you think I should come in and see you or do you have any suggestions? Thanks, John Lauerman. 617 308 5806



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Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

05/03/2009

Addendum: Email

Final

[REDACTED]

ADDENDUM

f/u email 5/4/09:

I'm glad to hear you are okay!

I hope that you have smooth sailing from now on!

[REDACTED]

-----Original Message-----

From: JOHN LAUERMAN, BLOOMBERG/ NEWSROOM: [mailto:jlauerman@bloomberg.net]

Sent: Sunday, May 03, 2009 4:23 PM

[REDACTED]

Subject: thanks for your help

[REDACTED] I went to a hospital, got \$700 worth of testing and attention, and I'm fine. Thanks very much for all your help with this, I'm very relieved and I probably would still be worrying if you hadn't called. Best regards, John Lauerman



Notes from 1/1/2003 through 8/12/2011 (cont)

05/03/2009

Email

Final

called pt back after receiving email below.

Unilateral calf pain x2d. Recent airline travel to Mexico City. On questioning, does recollect climbing multiple stairs and wonders if this is causing pain. Has had similar pains in leg in past. Had mild bilateral foot swelling after recent flight but this is resolved. Pain worse with pulling back on toe.

We discussed concern of possible DVT esp in light of recent travel and the serious nature of this condition. On the other hand, may possibly be muscular strain. Dx is complicated given that he is in Mexico which is site of current swine flu outbreak and concerns of receiving medical care there and potential exposures that might occur.

Per our discussion, he is going to see about obtaining medical care there. Consider return to US for evaluation if sx's persist and esp if unilateral edema or other new sx's occur.

He is to feel free to contact me if I can be of assistance.

I'm in Mexico City and yesterday started having pain in my right calf. It hurts worse when I straighten my leg and pull my toe up and Judi's concerned that it's a clot. I thought I'd ask your opinion before seeking medical attention. Should we talk about this? I have a US cell phone here, 908 552 8896. Thanks, John Lauerman

John Lauerman, Education reporter, Bloomberg News, 100 Summer St., Boston, MA, 02110 tel. 1-617-210-4630 cell 1-617-308-5806



Notes from 1/1/2003 through 8/12/2011 (cont)

04/27/2009

Phone Call

Final



Phone Call

spoke with patient after receiving email from his wife that he is traveling to Mexico City to report on current swine flu outbreak in Mexico and asking about precautions, and specifically, antivirals.

He will be leaving tomorrow and will likely stay for 2-4 wks. He has obtained respirator masks to wear and is aware of handwashing precautions and general strategies to reduce transmission.

At the moment, no strict guidelines are available from CDC website though available info indicates that current strains of swine flu are susceptible to all antivirals and prophylaxis with Tamiflu and Relenza could be considered.

We discussed possible strategies of daily prophylaxis vs no prophylaxis. He prefers daily prophylaxis and 30d supply of Tamiflu 75 mg qd was sent to pharmacy.



Notes from 1/1/2003 through 8/12/2011 (cont)

10/31/2008

Patient Letter

Final

[REDACTED]

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE MA 02445

November 5, 2008

Dear Mr. Lauerman:

This letter is to summarize the important findings of your recent colonoscopy. The bowel preparation was good and the exam was completed. One small hyperplastic polyp was completely removed. These polyps are benign and generally not associated with an increased risk of colon cancer. Hemorrhoids were seen which can be associated with constipation or straining during a bowel movement. For this, I recommend either a high fiber diet or fiber supplement and avoidance of straining when having a bowel movement.

Based on these findings, you are recommended to undergo a repeat colonoscopy in 10 years. An exam may be needed sooner for any gastrointestinal or any other worrisome symptoms as rarely polyps can be missed with a colonoscopy or if there is a change in your family history for any type of cancer. This can be scheduled by either calling my or [REDACTED] office. This letter is being forwarded to [REDACTED]

Please do not hesitate to contact me if you have any questions.

Thank you,

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]



Notes from 1/1/2003 through 8/12/2011 (cont)

10/31/2008

Routine Visit

Final

[REDACTED]

[18422022 (BWH)] M

Patient Name: LAUERMAN, JOHN

Date of Visit: 10/31/2008

Reason for Visit

Mr. Lauerman is a 50 yo M who presents today regarding the following issues. He is accompanied today by his wife. He has just had a colonoscopy procedure done.

1. Memory loss. States he doesn't think this is worrisome and didn't schedule appt with neuropsych.
2. Anxiety. Was given script for citalopram at last visit that he did not take. Has ongoing issues with ruminating about stressful things and persistent concerns about being a poor father, etc. His wife appears to corroborate this.
3. Onychomycosis. Taking Lamisil. F/u LFTs WNL.
4. Diarrhea. Ongoing issues with loose BMs occurring primarily with stressful situations. Colonoscopy today reportedly showed only single polyp.
5. Right sided hip pain. Had been going to PT who sent me letter. I had referred him to ortho but he has not yet made appt.

Past Medical History

reviewed and unchanged from prior note 9/8/08

Allergies

NKA

Medications

Lamisil (TERBINAFINE Hcl) 250 MG (250MG TABLET take 1) PO QD #30 Tablet(s)

Review of Systems

per HPI. All other systems reviewed were negative

Vital Signs

BLOOD PRESSURE 125/87

PULSE 76

WEIGHT 178 lb

Physical Exam

General Appearance

appears slightly groggy from recent colonoscopy

Assessment and Plan

1. R/o memory loss. I think that he has "normal" or age related memory loss as opposed to early Alzheimer's or other dementia. He can make appt with neuropsychiatry if he is interested. Monitor.
2. Anxiety. Reviewed use of SSRIs again. Advised that if he wishes to try citalopram to make appt with me about 1 month after starting for monitoring. Prozac 40 mg was helpful but caused flattened affect and GI upset.
3. Onychomycosis. Continue Lamisil. F/u LFTs were WNL.
4. Diarrhea. Sounds most c/w IBS-type pattern. No worrisome features. Await final colonoscopy results.
5. Tinnitus. Previously referred for audiometry.
6. HM. Testicular and prostate exams done 9/2008. PSA testing WNL 2008. UTD on immunizations. He was interested in getting Flu mist and he was given script. First colonoscopy done earlier today - await results.



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Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

RTC prn.





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MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

10/15/2008

Phone Call

Final

[REDACTED]

Per [REDACTED] pt was called, l/m with pt to sched appt to f/u with Orthopedist, left name and phone number so pt could sched appt. [REDACTED] notified.

*** [Original Message was sent 10/10/2008 12:57:39] ***

From: [REDACTED]

To: [REDACTED]

Subject: Phone Call

pls contact pt - I rec'd the copy of the letter from his PT regarding his right hip pain. I suggest that he see orthopedics for evaluation. Pls put note on chart.



Notes from 1/1/2003 through 8/12/2011 (cont)

10/10/2008

Result Manager Letter

Final

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE, MA 02445

October 10, 2008

Dear Mr. Lauerman,

I have reviewed your test results which are shown below.

Your liver function tests were normal. Details as follows:

AST (SGOT): 20 (Normal Range = 9 to 30)
ALT (SGPT) (U/L): 18 (Normal Range = 7 to 52)
Alk Phos: 81 (Normal Range = 36 to 118)
Bilirubin (Total): 0.8 (Normal Range = 0.2 to 1.2)
Bilirubin (Direct): 0.2 (Normal Range = 0.1 to 0.3)
Albumin: 4.3 (Normal Range = 3.7 to 5.4)
Globulin: 3.1 (Normal Range = 2.0 to 4.0)
Total Protein: 7.4 (Normal Range = 6.0 to 8.0)

Please feel free to contact me at the office with any questions or concerns. I look forward to seeing you again at your next visit. I hope you are doing well.

Sincerely,

[Redacted Signature]



Notes from 1/1/2003 through 8/12/2011 (cont)

09/09/2008

Result Manager Letter

Final

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE, MA 02445

September 9, 2008

Dear Mr. Lauerman,

I have reviewed your test results which are shown below.

Your cholesterol results performed on 09/08/2008 are as follows:

Total Cholesterol (nonfasting) = 197

HDL (the 'good' cholesterol) = 70, good

LDL (the 'bad' cholesterol) = 107

Triglycerides = 101

My records indicate that your total cholesterol has increased compared to the last value of 175 on 07/01/2003. Given your medical history, we would like to keep your LDL (the 'bad' cholesterol) below 160, optimal is less than 100. Goal HDL is greater than 40, optimal is greater than 60. Normal triglycerides are 35-150.

Your blood electrolytes were normal. Details as follows:

Glucose (nonfasting): 101 (Normal Range = 54 to 118)

Your liver function tests were normal. Details as follows:

AST (SGOT): 24 (Normal Range = 9 to 30)

ALT (SGPT) (U/L): 21 (Normal Range = 7 to 52)

Alk Phos: 86 (Normal Range = 36 to 118)

Bilirubin (Total): 0.6 (Normal Range = 0.2 to 1.2)

Bilirubin (Direct): 0.2 (Normal Range = 0.1 to 0.3)

Albumin: 4.5 (Normal Range = 3.7 to 5.4)

Globulin: 3.2 (Normal Range = 2.0 to 4.0)

Total Protein: 7.7 (Normal Range = 6.0 to 8.0)

Your thyroid function tests were normal. Details as follows:

TSH: 1.639 (Normal Range = 0.5 to 5.0)



Notes from 1/1/2003 through 8/12/2011 (cont)

Details of other blood chemistry tests as follows:

PSA, Total: 0.9 (Normal Range = 0 to 4)

CRP (mg/L): 0.7 (Normal Range = 0.0 to 3.0)

Your PSA (prostate) test was normal.

A C-reactive protein (CRP) of < 1 is associated with "low risk" for cardiovascular disease. 1.0-3.0 is "average risk" and greater than 3.0 is "high risk."

Please feel free to contact me at the office with any questions or concerns. I look forward to seeing you again at your next visit. I hope you are doing well.

Sincerely,



Notes from 1/1/2003 through 8/12/2011 (cont)

09/08/2008	Physical Exam	Final	[REDACTED]
------------	---------------	-------	------------

[18422022 (BWH)] M

Patient Name: LAUERMAN, JOHN
 Date of Visit: 09/08/2008

Reason for Visit

Mr. Lauerman is a 49 yo M who presents today for physical exam and regarding the following issues.

1. Memory loss. States he has had ongoing problems with memory loss and wonders if this is "a problem." Has had problems remembering names of casual acquaintances. Previously was very good at memorizing phone numbers and now sometimes forgets. No problems with long-term memories or with tasks. Sister has always called him "sieve head" since they were children but otherwise no worries by family members.
2. Anxiety. Has been lifelong worrier. Worries about children, work, finances etc. States work is very busy and therefore his worries do not affect his work. Does worry about family. Friend of his who is psychiatrist previously prescribed Prozac - he believes dose was 40 mg qd. Found that he was anxiety-free and this "felt like a vacation" but also left him flat and unmotivated as well as causing considerable GI upset.
3. Onychomycosis. Restarted Lamisil - has noted some clearing at base of great toenail.
4. Diarrhea. Notes ongoing issues with loose BMs occurring primarily at work. No problems at home or on vacation. No BRBPR, melena, unintentional wt loss.
5. Tinnitus. Longstanding issues with intermittent tinnitus. Finds that this is helped by cerumen removal.
6. Cardiac risks. Generally voices concerns about cardiac risks. Paternal uncle had MI around this age. He himself is relatively asx. Has occasional "gurgle" when he plays tennis. No other CP. No palpitations. No DOE.
7. Ocular migraines. Notes that frequency is slightly increased - now once monthly. Usually occurs during exercise. No other triggers. No headaches.

Problems

- Anxiety
- Seasonal allergies
- H/O pneumonia x 1
- Ocular migraines
- Herpes labialis
- PAST smoker - 12 pk yr, quit age 30

Past Medical History

No h/o STDs.

Allergies

NKA

Medications

Lamisil (TERBINAFINE Hcl) 250 MG (250MG TABLET take 1) PO QD #30 Tablet(s)

Medications Text

No OTCs, vitamins or herbals.

Family History

Brother has type II DM. Mother, brother and sister have hypothyroidism. GF died of ? brain ca. No prostate or colon ca. Uncle died of MI in his 40s.

Social History



Notes from 1/1/2003 through 8/12/2011 (cont)

Married. Has children. He is a reporter and covers health issues.
Advance directives: no - info given

Habits

Tobacco: none currently, 1 ppd x 12 yrs, quit age 30
EtOH: max 1-2 drinks/day
Exercise: "active", plays tennis, bikes to work
Diet: healthy
Seat belts: yes
Firearms: no

Review of Systems

Per HPI. No change in wt. No headaches. No dyspnea, cough, or wheezing. No dysuria or difficulty with urination. No urethral discharge. No problems with sexual functioning. No joint pain or swelling. No skin changes or rash.

BLOOD PRESSURE 111/67
PULSE 60
HEIGHT 72.5 in
WEIGHT 170 lb
BMI 22.8

Physical Exam

General Appearance

well-appearing, NAD. Mood and affect WNL.

Skin

Light slightly raised tan papule right temple - unchanged for years. No rashes or suspicious lesions.

HEENT

NCAT. PERRL. EOMI. Sclerae non-icteric. TMs are clear bilaterally. OP is clear without erythema or exudate. Neck is supple. No LAD. No thyromegaly.

Chest

CTA&P bilaterally with good air movement.

Cor/Cardiac

regular rate, normal S1, S2. No rubs, gallops, or murmurs.

Abdomen

soft, nontender, nondistended, +bowel sounds, no HSM

Genito-Urinary

Normal phallus. No urethral discharge. Testes are without nodules.

Rectal Exam

normal tone. Prostate without tenderness or nodules. Stool is brown.

Extremity

warm, no C/C/E. Great toenail shows clearing at base.

Neurological

A+Ox3. CN II-XII intact. Grossly non-focal.

Laboratory Data

EKG: NSR at 55, normal axis, incomplete RBBB, No acute ST changes. No priors for comparison.

Assessment and Plan

1. R/o memory loss. Advised that history so far seems more consistent with "normal" or age related memory loss as opposed to early Alzheimer's or other dementia. As he is somewhat concerned, I did give him phone number for neuropsychiatry for testing if he is interested. Monitor.
2. Anxiety. Reviewed options including therapy/counseling, relaxation techniques and medications including SSRIs and benzos prn. He is interested in re-trial of SSRI "at



Notes from 1/1/2003 through 8/12/2011 (cont)

a low dose." Will try citalopram 10 mg qd. Reviewed adverse effects and timecourse of improvement. He will RTC in 6 wks for f/u.

3. Onychomycosis. Improvement on Lamisil. Lab slip for LFTs given.
4. Diarrhea. Sounds most c/w IBS-type pattern. No worrisome features. He is due for colonoscopy screening in the next month or so anyway. Monitor sx's on SSRI.
5. Tinnitus. Referred for audiometry.
6. Cardiac risks. No significant risk factors for CAD at this time. Lab slip for lipids and glucose given. Per our discussion today, will also check CRP - reviewed pros and cons of testing.
7. Ocular migraines. Reviewed avoidance of triggers. Monitor.
8. HM. Testicular and prostate exams done today 9/2008. Reviewed pros and cons of PSA testing - he would like to have this done and lab slip given. UTD on immunizations. Referred for first colonoscopy - ordered.

RTC 6 wks or prn.

Health Maintenance
Td Booster 07/01/2003





Notes from 1/1/2003 through 8/12/2011 (cont)

08/15/2008

Routine Visit

Final

[REDACTED]

[18422022 (BWH)] M

Patient Name: LAUERMAN, JOHN

Date of Visit: 08/15/2008

Reason for Visit

Mr. Lauerman is a 49 yo M who presents today regarding the following issues. I have not seen him personally since 2003 but he has been seen by Dr. Chiang-Roy in the interim.

1. Left flank pain. He presented to BWH ED in March 2008 with acute onset of severe left flank pain. Pt states he was "convinced it was a heart attack." Evaluation included an abdominal CT which showed thickening of the left adrenal and some perinephric fat stranding which was thought to be due to muscular strain. Sxs resolved. He had f/u abd CT scan done 3/20/08 which showed interval resolution of fat stranding and normal adrenal. On questioning today, he confirms that he has not had any recurrent symptoms but did want to come in today for f/u as he had not scheduled this previously. He was not aware of results of f/u abdominal CT scan.
2. Abdominal palpitations. He had seen Dr. Chiang-Roy previously regarding a sensation of palpitations in left upper abdominal wall that occurred primarily with urination or defecation. Evaluation including MRA of abdomen, 24-hr urine to r/o pheo and RUQ U/S were negative. He states that these symptoms have markedly improved and now he just has occasional sxs. He never sch'd previously ordere Holter monitor.
3. Onychomycosis. Previously given Lamisil by Dr. Chiang-Roy for PAS positive (2/2006) onychomycosis. Improved but he d/c'd after 2 months and sxs have recurred.

Problems

- Seasonal allergies
- H/O pneumonia x 1
- PAST smoker - 12 pk yr, quit age 30
- Ocular migraines
- Herpes labialis
- H/O depression

Allergies

NKA

Medications Text

none

Review of Systems

per HPI. All other systems reviewed were negative

Vital Signs

BLOOD PRESSURE 119/75
 PULSE 60
 TEMPERATURE 98.3 F
 WEIGHT 171 lb

Physical Exam

General Appearance
 well-appearing, NAD.
 Abdomen
 soft, nontender, nondistended, +bowel sounds, no HSM, no masses
 Extremity
 thickened yellow right great toenail and 5th toenail



Notes from 1/1/2003 through 8/12/2011 (cont)

Assessment and Plan

1. Left flank pain. Resolved. Reviewed results of f/u abd CT and he was given copy. Contact me if sxs recur.
2. Abdominal palpitations. Sxs improved. Evaluation negative to date. Monitor.
3. Onychomycosis. Script for Lamisil given. Lab slip for LFTs in 1 month given.

RTC for previously sch'd PE 9/2008.





Notes from 1/1/2003 through 8/12/2011 (cont)

03/02/2008

Free Form Text

Final [REDACTED]

EDVISIT^18422022^LAUERMAN, JOHN^03/02/08^ [REDACTED]
I saw this patient with the resident physician, [REDACTED]. I confirmed I interviewed and examined the patient, reviewed the resident's documentation on the patient's chart, and discussed the evaluation, plan of care, and disposition with the patient.
CHIEF COMPLAINT: Sudden sharp left flank pain.
HISTORY OF PRESENT ILLNESS: A 49-year-old male presents with sudden onset of sharp sudden pain to the left flank. This started as the patient was playing tennis. He describes the pain as 10/10. It was initially intermittent and is now constant. He has no history of similar pain. He has had no nausea or vomiting, no hematuria, dysuria, no constipation or diarrhea, no shortness of breath. Pain started in the left flank and the left upper quadrant and has migrated to the left flank. There is no radiation to the testicle, no radiation to the chest. He has no history of kidney stones. The resident's note states that he had pain in the chest and abdomen, but I had spoken with the patient and cleared that he did not have pain there. The patient reports that it is deep pain in his left upper quadrant and left flank. Please see patient's chart for past history, social history, surgeries, family history, review of systems. Of note, the patient does not have significant past medical history, is in good health.
PHYSICAL EXAMINATION: Vital signs: Within normal limits, SpO2 100% on room air. Respiratory: No distress. Chest: Nontender, normal breath sounds. Cardiovascular: Regular rate and rhythm. No murmur, gallop, or friction rub. Abdomen: Soft. There is mild tenderness to palpation in the left lateral abdomen. No point tenderness. No rebound, no guarding. Otherwise, the exam is as documented by [REDACTED].
LABORATORY DATA: White count 12.3, hematocrit of 49. Electrolytes normal except for potassium of 3.3. D-dimer is within normal limits at approximately 270. UA was within normal limits. ECG shows a right sinus rhythm with right bundle-branch block with T-wave flattening. These are nonspecific changes. CT of the abdomen without contrast shows no AAA, no signs of kidney stones but there is some stranding above the left kidney. This will be followed up with an abdomen contrast CT.
IMPRESSION: A 49-year-old male with sudden onset of left flank pain. This is most consistent with a renal colic. Therefore, we started out with renal CT that did not reveal any signs of or evidence of a renal calculus. There is evidence of stranding around the left kidney, which could explain the patient's symptoms but to further delineate the cause of this stranding, we are obtaining a CT of the abdomen with contrast. After one dose of morphine, the patient felt significantly improved with the pain going from 10/10 down to 2/10. He has not required further medication. Additionally, we sent a D-dimer but the patient was low probability for PE and that was normal and a UA which was within normal limits.
PRIMARY DIAGNOSIS: Left flank pain.
DISPOSITION: We will discharge the patient to follow up with primary care.

[REDACTED]
D: 03/02/08

T: 03/02/08

Dictated By: [REDACTED]



Partners HealthCare System, Inc.
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A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

eScripton document:4-9200562 HFFocus
***** Not reviewed by Attending Physician *****



Notes from 1/1/2003 through 8/12/2011 (cont)

05/23/2006

Addendum:

Final



Pt. called back would like lab slip mailed to home.



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MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

05/23/2006

Final

[REDACTED]

Spoke with pt.'s wife and will inform husband to come in this week to have LFT's drawn. Lab slip will be left at front desk.

*** [Reply was sent 05/23/2006 13:04:57] ***

From: [REDACTED]

To: [REDACTED]

no RF until LFTs done

*** [Original Message was sent 05/23/2006 11:25:48] ***

From: [REDACTED]

To: [REDACTED]

Pt. calling for refill of Lamisil 250 mg PO Daily. Script was given by Dr. CCR on 2/28/06 Pt was rec. to check LFT's in 1 month and has not. Last LFT was drawn on 2/10/06 was 28.



Notes from 1/1/2003 through 8/12/2011 (cont)

03/28/2006

Patient Letter

Final

[REDACTED]

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE MA 02445

03/28/2006

Dear Mr. Lauerman:

I am pleased to let you know that your test results, listed below, were normal.

Echocardiogram : Normal

Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,

[REDACTED]



Notes from 1/1/2003 through 8/12/2011 (cont)

03/08/2006

Patient Letter

Final



JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE MA 02445

03/08/2006

Dear Mr. Lauerman:

I am pleased to let you know that your test results, listed below, were normal.

24-Hour Urine Metanephrines : Normal

Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,





Notes from 1/1/2003 through 8/12/2011 (cont)

02/24/2006

Addendum: Patient Note

Final



pas stain pos for fungus given oral lamisil, rec f/u lfts in one mo next appt can do



Notes from 1/1/2003 through 8/12/2011 (cont)

02/24/2006

Patient Note

Final

palpitation, abdominal

feels beating/palpitation, sees it when his shirt is up, sees it below left rib cage
thought it was under his ribs
occurs with erection, when urinating, when defecating
exercising doesn't notice it
did some strenuous exercise didn't feel palpitation then
says wife says he should have ekg
dr friends thought was kidney stone, pheochromocytoma
no pain
u/s was negative except one small gallstone
labs normal

Problems

Seasonal allergies
H/O pneumonia x 1
PAST smoker - 12 pk yr, quit age 30
Ocular migraines
Herpes labialis
H/O depression

Medications

none

Allergies

NKA

PE; sitting bit irritable

Vital Signs

BP 121/77, P 55, Wt 178 lb

chest ctab

card rrr s1s2 no mrg

abd no pulsation noted nontender no masses felt +bs no rebound no guarding

ekg inc rbbb 51

imp: feels palpitation and sees it luq of abdomen. abd u/s was negative. neg exam. rec echo, 24
hr holter as cardiac w/u and mra to r/o any other aneurysm. doubted was pheo, ordered 24 hr
urine for metanephrines.
f/u one mo to f/u on tests



Notes from 1/1/2003 through 8/12/2011 (cont)

02/13/2006

Patient Letter

Final

[REDACTED]

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE MA 02445

02/13/2006

Dear Mr. Lauerman:

I am pleased to let you know that your test results, listed below, were normal.

Kidney Function : Normal

Glucose : 82

Liver Function : Normal

Blood Chemistry : Normal

TSH (Thyroid) : 2.001

Complete Blood Count : Normal

Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,

[REDACTED]



Notes from 1/1/2003 through 8/12/2011 (cont)

02/06/2006

Patient Letter

Final

[REDACTED]

JOHN LAUERMAN
266 TAPPAN ST
BROOKLINE MA 02445

02/06/2006

Dear Mr. Lauerman:

Urinalysis : Negative

I am pleased to let you know that your test results, listed below, were normal.
Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,

[REDACTED]



Notes from 1/1/2003 through 8/12/2011 (cont)

02/03/2006

Patient Note

Final

abdominal palpitation

feels palpitation under his rib when he urinates. doesn't hurt before. palpitates when urinates then stop urinating it stops. also can feel it if contracts rectum mostly on left side, sometimes it moves around under his ribs, sometimes lower. also happens when he is having sex, not the entire time. doesn't wake him up at night. the past month. no pain. no radiation to the front. has had diarrhea or constipation from time to time but doesn't seem related to that. no nausea. appetite is fine. doesn't feel it with exercise, runs once a day, rides bike and plays tennis. no lightheadedness. wonders about diabetes, has noticed more frequent urination, but does drink lot of coffee and water. sits at work. doesn't change w/ movement. ?when defecating also not sure

Problems

Seasonal allergies
H/O pneumonia x 1
PAST smoker - 12 pk yr, quit age 30
Ocular migraines
Herpes labialis
H/O depression

Medications

None
coritsone on face

Allergies

NKA

Family / Social History

Uncoded information: Comments: Brother has type II DM. Mother, brother and sister have hypothyroidism. GF died of ?brain ca. No prostate or colon ca. Uncle died of MI in his 40s. sochx: reporter for bloomberg. married. wife and 2 kids. wife has type one dm. no cigs. h/o cigs. 1 d etoh a day.

PE: 100/70 62 98.3

sitting bit irritable nad

chest ctab

card rrr s1s2 no mrg

abd +bs soft tender when i examine abd aorta although no pulsation or enlargement appreciated no other abdominal tenderness no hsm no masses appreciated

ext no c/c/e

neuro gnf

imp: sensation is below the diaphragm, and only physical finding is some tenderness in his abdomen. since feels w/ urination will check renal ultrasound. also will eval abd aorta. if negative, sx's persisting consider reevaluation for next step. today didn't seem cardiac since sensation and findings were below the diaphragm,.



Notes from 1/1/2003 through 8/12/2011 (cont)

07/10/2003

Free Form Text

Final

[REDACTED]

July 10, 2003

Mr. John Lauerman
264 Tappan St
Brookline, MA 02445

Dear Mr. Lauerman:

I am pleased to let you know that your test results, listed below, were normal.

Total Cholesterol : 175 Normal

HDL 'Good Cholesterol' : 57 Normal

Glucose (Sugar) : 81 Normal

HgA1C (long term blood sugar test) : 5.2 Normal

Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,

[REDACTED]

[REDACTED]



Notes from 1/1/2003 through 8/12/2011 (cont)

07/01/2003

Physical Exam

Final

Patient Name: LAUERMAN,JOHN [MR [REDACTED]]
Date of Visit: 07/01/03

Reason for Visit

Mr. Lauerman returns today for physical examination.

Problems

PAST smoker - 12 pk yr, quit age 30
Ocular migraines
Herpes labialis
H/O depression
Seasonal allergies
H/O pneumonia x 1

Allergies

NKDA

Medications Text

None. No OTCs, vitamins or herbals.

Family History

Brother has type II DM. Mother, brother and sister have hypothyroidism. GF died of ?brain ca. No prostate or colon ca. Uncle died of MI in his 40s.

Social History

Married. He is a reporter and covers health issues.

Habits

Tobacco: 1 ppd x 12 yrs, quit age 30
EtOH: max 1-2 drinks/day, but not daily
Exercise: "active", plays tennis, golf
Diet: not low fat
Seat belts:
Firearms:

Review of Systems

No headaches, hearing problems. No chest pain or palpitations. No dyspnea or dyspnea on exertion. No cough or wheezing. No abdominal pain, nausea, vomiting, constipation, diarrhea, BRBPR, or melena. No dysuria or difficulty with urination. No urethral discharge. No joint pain or swelling. No skin changes or rash.

Vital Signs

Blood Pressure: 120/74 Left Arm
Pulse: 66 Regular
Height: 73 Inches
Weight: 179 Pounds

Physical Exam

General Appearance
well-appearing, NAD.



Notes from 1/1/2003 through 8/12/2011 (cont)

Skin

No rashes or suspicious lesions.

HEENT

NCAT. PERRL. EOMI. Sclerae non-icteric. TMs are clear bilaterally. OP is clear without erythema or exudate. Neck is supple. No LAD. No thyromegaly.

Chest

CTA bilaterally with good air movement.

Cor/Cardiac

regular rate, normal S1, S2. No rubs, gallops, or murmurs.

Abdomen

soft, nontender, nondistended, +bowel sounds, no HSM

Genito-Urinary

Normal phallus. No urethral discharge. Testes are without nodules.

Extremity

warm, no C/C/E. Bilateral knees without effusion.

Musc Skel

Normal muscle bulk and tone.

Neurological

A+Ox3. CN II-XII intact. Grossly non-focal.

Assessment and Plan

Healthy 44 yo M

HM. Check nonfasting cholesterol. Td booster given today. He is requesting screening for DM - check random glucose and HgA1C. Advised healthy diet, regular CV exercise.

RTC 1-2 yrs.





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75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Notes from 1/1/2003 through 8/12/2011 (cont)

04/12/2003

Free Form Text

Final

April 12, 2003

Mr. John Lauerman
264 Tappan St
Brookline, MA 02445

Dear Mr. Lauerman:

I am pleased to let you know that your test results, listed below, were normal.

Throat Culture : Negative

Please let me know if you have any questions, and if no other problems arise, I look forward to seeing you at the time of your next visit.

Sincerely,



Notes from 1/1/2003 through 8/12/2011 (cont)

04/07/2003

New Patient Visit

Final

Patient Name: LAUERMAN, JOHN [REDACTED]
Date of Visit: 04/07/03

Reason for Visit

44 yo M presents with sore throat and fever x 5d. New pt visit - last PCP was Dr. Bill Rosenberg - was supposed to change to Dr. Grinspoon, but never saw him.

History of Present Illness

5d ago had onset of severe sore throat and swollen glands. Fever to 100. Called Dr. Grinspoon's covering MD over weekend - thought to have URI. Has had difficulty swallowing due to pain, but is taking PO fluids. Using Tylenol, Motrin, NyQuil without significant relief. Has diffuse HA and muscle soreness in shoulders. No nasal congestion, sinus sx's, ear pain or cough. Dtr had sore throat but was culture negative.

Problems

Seasonal allergies
H/O pneumonia x 1

Allergies

NKDA

Medications Text

none

Social History

h/o 1ppd x 12 yrs, quite 14 yrs ago, none currently. He is a reporter and covers health issues.

Review of Systems

per HPI and otherwise negative.

Vital Signs

Blood Pressure: 118/70 Left Arm
Temperature: 98.3 Fahrenheit
Pulse: 78 Regular

Physical Exam

General Appearance

fatigued
HEENT

Conjunctivae clear. TMs clear. No sinus tenderness. Nasal turbinates with mild bulge on right, o/w clear. OP with erythematous and moderately swollen, no exudate. Throat swab taken. Neck supple. Subcentimeter anterior cervical adenopathy.

Chest

CTA&P bilaterally with good air movement

Cor/Cardiac

regular rate, nl S1, S2, no r/g/m



Notes from 1/1/2003 through 8/12/2011 (cont)

Assessment and Plan

Pharyngitis: Will treat with PCN VK x 10 d - instructions given. Also given script for viscous lidocaine. Will check throat cx because dtr is developing another sore throat. Push PO fluids. If he cont's to have sig pain, consider Percocet prn. To call or RTC if worse, unable to tolerate POs or no better after abx.

He will schedule PE in future.





Pathology From 1/1/2003 through 8/12/2011

10/31/2008

Surgical Pathology

Final

Accession Number: BS08F48312
Type: Surgical Pathology
Specimen Type: Polyp, colorectal
Procedure Date: 10/31/2008
Ordering Provider: [REDACTED]

Report Status: Final

CASE: BS-08-F48312
PATIENT: JOHN LAUERMAN

Resident: [REDACTED]
Pathologist: [REDACTED]

PATHOLOGIC DIAGNOSIS:

SPECIMEN DESIGNATED "SIGMOID COLON, POLYP":
Hyperplastic polyp.

CLINICAL DATA:

History: Average risk screening.
Operation: Excision.
Operative Findings: 5 mm polyp.
Clinical Diagnosis: Not provided.

TISSUE SUBMITTED:

A/1. Sigmoid.

GROSS DESCRIPTION:

The specimen is received in formalin, labeled with the patient's name, unit number, and "A. Sigmoid", and consists of a 0.3 cm tan/pink polypoid mucosal tissue fragment.

Micro A1: 1 frag, ESS.

DB/mmm

CASE NUMBER: 48312

By his/her signature below, the senior physician certifies that he/she personally conducted a microscopic examination ("gross only" exam if so stated) of the described specimen(s) and rendered or confirmed the diagnosis(es) related thereto.

Final Diagnosis by [REDACTED], Electronically signed on 11/4/2008



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75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Pathology from 1/1/2003 through 8/12/2011 (cont)

03/03/2008

Interpretive Lab Test

Final

Accession Number: BL08K02444
Type: Interpretive Lab Test
Specimen Type: Molec Dx Factor 2 Mutation
Procedure Date: 03/03/2008
Ordering Provider: [REDACTED]

Report Status: Final

CASE: BL-08-K02444
PATIENT: JOHN LAUERMAN

Pathologist: [REDACTED]

CLINICAL DATA:

Clinical History: None given.
Clinical Diagnosis: None given.

DNA was isolated from peripheral blood cells and analyzed by an Invader Assay (Third Wave Technologies, Madison, WI). Duplicated testing is routinely performed when the result of the first test indicated a mutant or heterozygous genotype.

RESULT:

Factor II (G20210A): Heterozygous

These tests were developed and their performance characteristics determined by the Molecular Diagnostics Laboratory, Brigham and Women's Hospital. They have not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary.

Final Diagnosis by [REDACTED] Electronically signed on 3/14/2008



Pathology from 1/1/2003 through 8/12/2011 (cont)

02/03/2006

Surgical Pathology

Final

Accession Number: BS06N05007

Report Status: Final

Type: Surgical Pathology

Specimen Type: Nail Clippings or Excision

Procedure Date: 02/03/2006

Ordering Provider: [REDACTED]

CASE: BS-06-N05007

PATIENT: JOHN LAUERMAN

Resident: [REDACTED]

Pathologist: [REDACTED]

PATHOLOGIC DIAGNOSIS:

TOENAIL CLIPPING:

Fragments of keratin with fungus identified on PAS stain.

CLINICAL DATA:

History: PAS stain.

Operation: None given.

Clinical Diagnosis: None given.

TISSUE SUBMITTED:

A/1. Toenail.

GROSS DESCRIPTION:

The specimen is received fresh, labeled with the patients name and unit number only, and consists of a brown/yellow, ragged, firm tissue fragment (1.1 x 0.5 x 0.2 cm), grossly consistent with a nail clipping. The specimen is fixed and placed in Tween prior to processing.

Micro A1: Nail clipping, 1 frag, ESS.

By his/her signature below, the senior physician certifies that he/she personally conducted a microscopic examination ("gross only" exam if so stated) of the described specimen(s) and rendered or confirmed the diagnosis(es) related thereto.

Resident Review by [REDACTED] on 2/14/2006

Final Diagnosis by [REDACTED], Electronically signed on 2/14/2006



Radiology From 1/1/2003 through 8/12/2011

03/20/2008 08:57 CT SCAN ABDOMEN W CONTRAST Final

Exam Number: A08857504 Report Status: Final
Type: CT SCAN ABDOMEN W CONTRAST
Date/Time: 03/20/2008 08:57
Exam Code: CT008
Ordering Provider: [REDACTED]
Associated Reports:
A08892275: CT SCAN PELVIS W CONTRAST
A08892276: 623/100ml vial
A08892278: CT SCAN MULTIPLANAR REFORMAT

REPORT:

HISTORY: Abnormal prior imaging, left lower quadrant pain.

TECHNIQUE: CT scans of the abdomen and pelvis were obtained following the administration of 100 cc of Ultravist 300 IV contrast and oral contrast. 5mm axial images from the lung bases to the pelvic floor are available for review. Additional 3mm coronal images were obtained for additional evaluation.

COMPARISON: CT abdomen pelvis and 3/2/2008.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: Multiple, subcentimeter low attenuation lesions are again visualized within the liver. The largest, well circumscribed fluid attenuation lesion is seen on series 2 image 26 at the segment 5 of the liver, measuring 0.9 x 0.7 cm. An additional segment 6, irregular the hypoattenuating lesion, measuring 1.4 cm with apparent peripheral discontinuous nodular enhancement of similar degree to the portal venous contrast, suggestive of a hemangioma. There is focal fat adjacent to the falciform ligament. The spleen appears unremarkable. The pancreas is within normal limits. The right adrenal gland appears normal. The left adrenal gland appears normal. There has been interval resolution of the adjacent left perinephric fat stranding. A punctate gallbladder wall calcification is visualized. The kidneys appear within normal limits.

PELVIS: Contrast opacified loops of large and small bowel are normal caliber. There is no evidence of a bowel obstruction. There is no pelvic free fluid. No significant retroperitoneal lymphadenopathy is visualized. There is no inguinal lymphadenopathy. There are no suspicious lytic or blastic bony lesions.

IMPRESSION:

1. Interval resolution of left perinephric fat stranding. Left adrenal gland appears normal.
2. Stable size of the 1.4 cm hypodense lesion in segment 6 of the liver, likely a hemangioma.
3. Stable subcentimeter hepatic hypodense lesions, likely representing simple hepatic cysts.
4. Stable punctate gallbladder wall calcification, likely benign.



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MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:



SIGNATURES:





Radiology from 1/1/2003 through 8/12/2011 (cont)

03/20/2008 08:57 CT SCAN PELVIS W CONTRAST Final

Exam Number: A08892275 Report Status: Final
Type: CT SCAN PELVIS W CONTRAST
Date/Time: 03/20/2008 08:57
Exam Code: CT011
Ordering Provider: [REDACTED]
Report Below from Associated Order A08857504: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: Abnormal prior imaging, left lower quadrant pain.

TECHNIQUE: CT scans of the abdomen and pelvis were obtained following the administration of 100 cc of Ultravist 300 IV contrast and oral contrast. 5mm axial images from the lung bases to the pelvic floor are available for review. Additional 3mm coronal images were obtained for additional evaluation.

COMPARISON: CT abdomen pelvis and 3/2/2008.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: Multiple, subcentimeter low attenuation lesions are again visualized within the liver. The largest, well circumscribed fluid attenuation lesion is seen on series 2 image 26 at the segment 5 of the liver, measuring 0.9 x 0.7 cm. An additional segment 6, irregular the hypoattenuating lesion, measuring 1.4 cm with apparent peripheral discontinuous nodular enhancement of similar degree to the portal venous contrast, suggestive of a hemangioma. There is focal fat adjacent to the falciform ligament. The spleen appears unremarkable. The pancreas is within normal limits. The right adrenal gland appears normal. The left adrenal gland appears normal. There has been interval resolution of the adjacent left perinephric fat stranding. A punctate gallbladder wall calcification is visualized. The kidneys appear within normal limits.

PELVIS: Contrast opacified loops of large and small bowel are normal caliber. There is no evidence of a bowel obstruction. There is no pelvic free fluid. No significant retroperitoneal lymphadenopathy is visualized. There is no inguinal lymphadenopathy. There are no suspicious lytic or blastic bony lesions.

IMPRESSION:

1. Interval resolution of left perinephric fat stranding. Left adrenal gland appears normal.
2. Stable size of the 1.4 cm hypodense lesion in segment 6 of the liver, likely a hemangioma.
3. Stable subcentimeter hepatic hypodense lesions, likely representing simple hepatic cysts.
4. Stable punctate gallbladder wall calcification, likely benign.



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Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/20/2008 08:57

623/100ml vial

Final

Exam Number: A08892276

Report Status: Final

Type: 623/100ml vial

Date/Time: 03/20/2008 08:57

Exam Code: CT181/BD

Ordering Provider: [REDACTED]

Report Below from Associated Order A08857504: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: Abnormal prior imaging, left lower quadrant pain.

TECHNIQUE: CT scans of the abdomen and pelvis were obtained following the administration of 100 cc of Ultravist 300 IV contrast and oral contrast. 5mm axial images from the lung bases to the pelvic floor are available for review. Additional 3mm coronal images were obtained for additional evaluation.

COMPARISON: CT abdomen pelvis and 3/2/2008.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: Multiple, subcentimeter low attenuation lesions are again visualized within the liver. The largest, well circumscribed fluid attenuation lesion is seen on series 2 image 26 at the segment 5 of the liver, measuring 0.9 x 0.7 cm. An additional segment 6, irregular the hypoattenuating lesion, measuring 1.4 cm with apparent peripheral discontinuous nodular enhancement of similar degree to the portal venous contrast, suggestive of a hemangioma. There is focal fat adjacent to the falciform ligament. The spleen appears unremarkable. The pancreas is within normal limits. The right adrenal gland appears normal. The left adrenal gland appears normal. There has been interval resolution of the adjacent left perinephric fat stranding. A punctate gallbladder wall calcification is visualized. The kidneys appear within normal limits.

PELVIS: Contrast opacified loops of large and small bowel are normal caliber. There is no evidence of a bowel obstruction. There is no pelvic free fluid. No significant retroperitoneal lymphadenopathy is visualized. There is no inguinal lymphadenopathy. There are no suspicious lytic or blastic bony lesions.

IMPRESSION:

1. Interval resolution of left perinephric fat stranding. Left adrenal gland appears normal.
2. Stable size of the 1.4 cm hypodense lesion in segment 6 of the liver, likely a hemangioma.
3. Stable subcentimeter hepatic hypodense lesions, likely representing simple hepatic cysts.
4. Stable punctate gallbladder wall calcification, likely benign.



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Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/20/2008 08:57 CT SCAN MULTIPLANAR REFORMAT Final

Exam Number: A08892278 Report Status: Final
Type: CT SCAN MULTIPLANAR REFORMAT
Date/Time: 03/20/2008 08:57
Exam Code: CT053/BD
Ordering Provider: [REDACTED]
Report Below from Associated Order A08857504: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: Abnormal prior imaging, left lower quadrant pain.

TECHNIQUE: CT scans of the abdomen and pelvis were obtained following the administration of 100 cc of Ultravist 300 IV contrast and oral contrast. 5mm axial images from the lung bases to the pelvic floor are available for review. Additional 3mm coronal images were obtained for additional evaluation.

COMPARISON: CT abdomen pelvis and 3/2/2008.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: Multiple, subcentimeter low attenuation lesions are again visualized within the liver. The largest, well circumscribed fluid attenuation lesion is seen on series 2 image 26 at the segment 5 of the liver, measuring 0.9 x 0.7 cm. An additional segment 6, irregular the hypoattenuating lesion, measuring 1.4 cm with apparent peripheral discontinuous nodular enhancement of similar degree to the portal venous contrast, suggestive of a hemangioma. There is focal fat adjacent to the falciform ligament. The spleen appears unremarkable. The pancreas is within normal limits. The right adrenal gland appears normal. The left adrenal gland appears normal. There has been interval resolution of the adjacent left perinephric fat stranding. A punctate gallbladder wall calcification is visualized. The kidneys appear within normal limits.

PELVIS: Contrast opacified loops of large and small bowel are normal caliber. There is no evidence of a bowel obstruction. There is no pelvic free fluid. No significant retroperitoneal lymphadenopathy is visualized. There is no inguinal lymphadenopathy. There are no suspicious lytic or blastic bony lesions.

IMPRESSION:

1. Interval resolution of left perinephric fat stranding. Left adrenal gland appears normal.
2. Stable size of the 1.4 cm hypodense lesion in segment 6 of the liver, likely a hemangioma.
3. Stable subcentimeter hepatic hypodense lesions, likely representing simple hepatic cysts.
4. Stable punctate gallbladder wall calcification, likely benign.



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Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 09:01 CT SCAN ABDOMEN W CONTRAST Final

Exam Number: A08854294 Report Status: Final
Type: CT SCAN ABDOMEN W CONTRAST
Date/Time: 03/02/2008 09:01
Exam Code: ECT008
Ordering Provider: [REDACTED]
Associated Reports:
A08854402: CT SCAN PELVIS W CONTRAST
A08854403: CT SCAN MULTIPLANAR REFORMAT
A08854404: 623/100ml vial

REPORT:

HISTORY: 49-year-old male with history of sudden onset of left-sided pain, with left renal fat-stranding on noncontrast CT scan earlier this morning.

TECHNIQUE: CT scans were acquired through the abdomen and pelvis after the administration of 100 mL Ultravist 300 and oral contrast.

COMPARISON: Prior noncontrasted abdomen from 3:55 a.m., March 2, 2008.

FINDINGS:

Lung bases: The imaged portions of the lung bases are clear. No pleural or pericardial effusions are present.

Abdomen: The liver again demonstrates an ill-defined hypodensity measuring 1.3 cm in diameter in segment 6, as well as multiple smaller ill-defined circular hypodensities throughout the liver. The region of the left wall of the gallbladder demonstrates a 3 mm calcification versus gallstone. The left adrenal gland is thickened, with surrounding fat stranding. The fat stranding extends to the upper pole of the left kidney. The kidneys themselves demonstrate no abnormality, with no difference in renal enhancement between the 2 kidneys. The spleen, pancreas, and right adrenal gland demonstrate no focal lesions. Retroperitoneal lymph nodes are not enlarged. The vasculature enhances normally.

Pelvis: The prostate, seminal vesicles, and urinary bladder appear within normal limits. The small and large bowel are normal in caliber. Pelvic and inguinal lymph nodes are not enlarged. The appendix is visualized and is normal.

Bones: There is mild osteophyte formation in the thoracic spine. No bony lesions concerning for malignancy are seen.

IMPRESSION:

1. Thickening of the left adrenal gland with surrounding fat stranding. This fat stranding extends to the upper pole of the left kidney. Differential includes adrenal hemorrhage, although no underlying lesion was seen on previous abdominal MRI. Trauma or less likely, infection are also in the differential.
2. Stable 1.3 cm ill-defined lesion in segment 6 of the liver. Multiple small hepatic cysts.
3. Small gallstone versus gallbladder wall calcification.



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Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 09:01 CT SCAN PELVIS W CONTRAST Final

Exam Number: A08854402 Report Status: Final
Type: CT SCAN PELVIS W CONTRAST
Date/Time: 03/02/2008 09:01
Exam Code: ECT011
Ordering Provider: [REDACTED]
Report Below from Associated Order A08854294: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: 49-year-old male with history of sudden onset of left-sided pain, with left renal fat-stranding on noncontrast CT scan earlier this morning.

TECHNIQUE: CT scans were acquired through the abdomen and pelvis after the administration of 100 mL Ultravist 300 and oral contrast.

COMPARISON: Prior noncontrasted abdomen from 3:55 a.m., March 2, 2008.

FINDINGS:

Lung bases: The imaged portions of the lung bases are clear. No pleural or pericardial effusions are present.

Abdomen: The liver again demonstrates an ill-defined hypodensity measuring 1.3 cm in diameter in segment 6, as well as multiple smaller ill-defined circular hypodensities throughout the liver. The region of the left wall of the gallbladder demonstrates a 3 mm calcification versus gallstone. The left adrenal gland is thickened, with surrounding fat stranding. The fat stranding extends to the upper pole of the left kidney. The kidneys themselves demonstrate no abnormality, with no difference in renal enhancement between the 2 kidneys. The spleen, pancreas, and right adrenal gland demonstrate no focal lesions. Retroperitoneal lymph nodes are not enlarged. The vasculature enhances normally:

Pelvis: The prostate, seminal vesicles, and urinary bladder appear within normal limits. The small and large bowel are normal in caliber. Pelvic and inguinal lymph nodes are not enlarged. The appendix is visualized and is normal.

Bones: There is mild osteophyte formation in the thoracic spine. No bony lesions concerning for malignancy are seen.

IMPRESSION:

1. Thickening of the left adrenal gland with surrounding fat stranding. This fat stranding extends to the upper pole of the left kidney. Differential includes adrenal hemorrhage, although no underlying lesion was seen on previous abdominal MRI. Trauma or less likely, infection are also in the differential.
2. Stable 1.3 cm ill-defined lesion in segment 6 of the liver. Multiple small hepatic cysts.
3. Small gallstone versus gallbladder wall calcification.



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Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 09:01 CT SCAN MULTIPLANAR REFORMAT Final

Exam Number: A08854403 Report Status: Final
Type: CT SCAN MULTIPLANAR REFORMAT
Date/Time: 03/02/2008 09:01
Exam Code: ECT053
Ordering Provider: [REDACTED]
Report Below from Associated Order A08854294: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: 49-year-old male with history of sudden onset of left-sided pain, with left renal fat-stranding on noncontrast CT scan earlier this morning.

TECHNIQUE: CT scans were acquired through the abdomen and pelvis after the administration of 100 mL Ultravist 300 and oral contrast.

COMPARISON: Prior noncontrasted abdomen from 3:55 a.m., March 2, 2008.

FINDINGS:

Lung bases: The imaged portions of the lung bases are clear. No pleural or pericardial effusions are present.

Abdomen: The liver again demonstrates an ill-defined hypodensity measuring 1.3 cm in diameter in segment 6, as well as multiple smaller ill-defined circular hypodensities throughout the liver. The region of the left wall of the gallbladder demonstrates a 3 mm calcification versus gallstone. The left adrenal gland is thickened, with surrounding fat stranding. The fat stranding extends to the upper pole of the left kidney. The kidneys themselves demonstrate no abnormality, with no difference in renal enhancement between the 2 kidneys. The spleen, pancreas, and right adrenal gland demonstrate no focal lesions. Retroperitoneal lymph nodes are not enlarged. The vasculature enhances normally.

Pelvis: The prostate, seminal vesicles, and urinary bladder appear within normal limits. The small and large bowel are normal in caliber. Pelvic and inguinal lymph nodes are not enlarged. The appendix is visualized and is normal.

Bones: There is mild osteophyte formation in the thoracic spine. No bony lesions concerning for malignancy are seen.

IMPRESSION:

1. Thickening of the left adrenal gland with surrounding fat stranding. This fat stranding extends to the upper pole of the left kidney. Differential includes adrenal hemorrhage, although no underlying lesion was seen on previous abdominal MRI. Trauma or less likely, infection are also in the differential.
2. Stable 1.3 cm ill-defined lesion in segment 6 of the liver. Multiple small hepatic cysts.
3. Small gallstone versus gallbladder wall calcification.



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Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]

Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 09:01

623/100ml vial

Final

Exam Number: A08854404 Report Status: Final
Type: 623/100ml vial
Date/Time: 03/02/2008 09:01
Exam Code: ECT181
Ordering Provider: [REDACTED]
Report Below from Associated Order A08854294: CT SCAN ABDOMEN W CONTRAST

REPORT:

HISTORY: 49-year-old male with history of sudden onset of left-sided pain, with left renal fat-stranding on noncontrast CT scan earlier this morning.

TECHNIQUE: CT scans were acquired through the abdomen and pelvis after the administration of 100 mL Ultravist 300 and oral contrast.

COMPARISON: Prior noncontrasted abdomen from 3:55 a.m., March 2, 2008.

FINDINGS:

Lung bases: The imaged portions of the lung bases are clear. No pleural or pericardial effusions are present.

Abdomen: The liver again demonstrates an ill-defined hypodensity measuring 1.3 cm in diameter in segment 6, as well as multiple smaller ill-defined circular hypodensities throughout the liver. The region of the left wall of the gallbladder demonstrates a 3 mm calcification versus gallstone. The left adrenal gland is thickened, with surrounding fat stranding. The fat stranding extends to the upper pole of the left kidney. The kidneys themselves demonstrate no abnormality, with no difference in renal enhancement between the 2 kidneys. The spleen, pancreas, and right adrenal gland demonstrate no focal lesions. Retroperitoneal lymph nodes are not enlarged. The vasculature enhances normally.

Pelvis: The prostate, seminal vesicles, and urinary bladder appear within normal limits. The small and large bowel are normal in caliber. Pelvic and inguinal lymph nodes are not enlarged. The appendix is visualized and is normal.

Bones: There is mild osteophyte formation in the thoracic spine. No bony lesions concerning for malignancy are seen.

IMPRESSION:

1. Thickening of the left adrenal gland with surrounding fat stranding. This fat stranding extends to the upper pole of the left kidney. Differential includes adrenal hemorrhage, although no underlying lesion was seen on previous abdominal MRI. Trauma or less likely, infection are also in the differential.
2. Stable 1.3 cm ill-defined lesion in segment 6 of the liver. Multiple small hepatic cysts.
3. Small gallstone versus gallbladder wall calcification.

[REDACTED]

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 04:03 CT URETERS W/O CONTRAST Final

Exam Number: A08854256 Report Status: Final
 Type: CT URETERS W/O CONTRAST
 Date/Time: 03/02/2008 04:03
 Exam Code: ECT063
 Ordering Provider: [REDACTED]
 Associated Reports: [REDACTED]
 A08854263: CT SCAN MULTIPLANAR REFORMAT

REPORT:

HISTORY: 49-year-old man with left-sided renal colic.

TECHNIQUE: Noncontrast CT scan of the abdomen and pelvis per renal stone protocol.

COMPARISON: MRI from 3/2/2006.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: There is diffuse stranding within the left suprarenal region and around the upper pole of the left kidney. The left adrenal gland is mildly thickened. There is no evidence of nephrolithiasis or hydronephrosis bilaterally. There is a 7 mm simple appearing cyst in hepatic segment 5. Additional ill-defined lesion in segment 6 of the liver measures 1.3 x 1.1 cm, similar in size to prior MRI from 3/2/2006. There is a small gallstone versus a calcification within the gallbladder wall. The unenhanced spleen, pancreas and right adrenal gland are normal appearing.

PELVIS: The unopacified bowel is normal appearing. The bladder, prostate gland and seminal vesicles are unremarkable. No significant adenopathy.

IMPRESSION:

1. Nonspecific fat stranding in the left suprarenal region of unclear etiology. Given mild adrenal gland thickening, this may be related to adrenal hemorrhage either due to trauma or underlying lesion although no lesion was seen on prior MRI. Contrast CT scan may help with further evaluation. Alternatively, findings could be secondary to infection.
2. Stable 1.3 cm ill-defined lesion in hepatic segment 6 better defined on prior MRI form 3/2/2006. Additional hepatic cysts.
3. Small gallstone vs. gallbladder wall calcification.

Initial findings of fat stranding of unclear etiology were discussed with Dr. C Baugh by me at 5:30 a.m.

RADIOLOGISTS: [REDACTED]

SIGNATURES: [REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2008 04:03 CT SCAN MULTIPLANAR REFORMAT Final

Exam Number: A08854263 Report Status: Final
 Type: CT SCAN MULTIPLANAR REFORMAT
 Date/Time: 03/02/2008 04:03
 Exam Code: ECT053
 Ordering Provider: [REDACTED]
 Report Below from Associated Order A08854256: CT URETERS W/O CONTRAST

REPORT:

HISTORY: 49-year-old man with left-sided renal colic.

TECHNIQUE: Noncontrast CT scan of the abdomen and pelvis per renal stone protocol.

COMPARISON: MRI from 3/2/2006.

FINDINGS:

LUNG BASES: The lung bases are clear.

ABDOMEN: There is diffuse stranding within the left suprarenal region and around the upper pole of the left kidney. The left adrenal gland is mildly thickened. There is no evidence of nephrolithiasis or hydronephrosis bilaterally. There is a 7 mm simple appearing cyst in hepatic segment 5. Additional ill-defined lesion in segment 6 of the liver measures 1.3 x 1.1 cm, similar in size to prior MRI from 3/2/2006. There is a small gallstone versus a calcification within the gallbladder wall. The unenhanced spleen, pancreas and right adrenal gland are normal appearing.

PELVIS: The unopacified bowel is normal appearing. The bladder, prostate gland and seminal vesicles are unremarkable. No significant adenopathy.

IMPRESSION:

1. Nonspecific fat stranding in the left suprarenal region of unclear etiology. Given mild adrenal gland thickening, this may be related to adrenal hemorrhage either due to trauma or underlying lesion although no lesion was seen on prior MRI. Contrast CT scan may help with further evaluation. Alternatively, findings could be secondary to infection.
2. Stable 1.3 cm ill-defined lesion in hepatic segment 6 better defined on prior MRI form 3/2/2006. Additional hepatic cysts.
3. Small gallstone vs. gallbladder wall calcification.

Initial findings of fat stranding of unclear etiology were discussed with Dr. C Baugh by me at 5:30 a.m.

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2006 08:20

3D Holographic Reconstruction

Final

Exam Number: A07476434 Report Status: Final
 Type: 3D Holographic Reconstruction
 Date/Time: 03/02/2006 08:20
 Exam Code: M6375/CV
 Ordering Provider: [REDACTED]
 Report Below from Associated Order A07466594: MR Angio Abd w/o & w/Cont

REPORT:

HISTORY: LEFT UPPER QUADRANT PULSATION. EVALUATE FOR ANEURYSM.

TECHNIQUE: Multiplanar, multisequence imaging of the abdomen was performed both pre and post IV administration of 40 cc of gadolinium contrast. Infusion imaging as well as multiplanar reformations were performed.

PRIOR STUDIES: None.

FINDINGS:

VASCULAR: There is no evidence of abdominal aortic aneurysm. The celiac axis, superior and inferior mesenteric arteries are widely patent. Two single renal arteries are seen bilaterally and are widely patent. There is no renal artery aneurysm. Both kidneys are normal in size with the right measuring 10.3 cm and the left measuring 10.5 cm in craniocaudal dimensions.

INCIDENTAL FINDINGS: Multiple subcentimeter rounded areas of decreased signal intensity are seen on T1 weighted images which are hyperintense on T2 weighted images and do not enhance, therefore representing simple hepatic cysts. Additionally, in segment 6 of the liver, there is a 1.9 x 1.5 cm rounded area of increased signal intensity on T2 weighted images which demonstrates brisk enhancement and may represent an adenoma or focal nodular hyperplasia. There is marked dilatation of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

IMPRESSION:

1. Normal abdominal aorta and major branch vessels without evidence of aneurysm.
2. 1.9 x 1.5 cm lesion in segment 6 of the liver which may represent an adenoma or focal nodular hyperplasia. Further evaluation with a triple phase CT scan should be performed as well as short-term follow-up.
3. Simple hepatic cysts.
4. Prominence of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

END OF IMPRESSION:

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2006 08:20

ADDITIONAL GAD +11-20cc

Final

Exam Number: A07476437 Report Status: Final
 Type: ADDITIONAL GAD +11-20cc
 Date/Time: 03/02/2006 08:20
 Exam Code: MR114
 Ordering Provider: [REDACTED]
 Report Below from Associated Order A07466594: MR Angio Abd w/o & w/Cont

REPORT:

HISTORY: LEFT UPPER QUADRANT PULSATION. EVALUATE FOR ANEURYSM.

TECHNIQUE: Multiplanar, multisequence imaging of the abdomen was performed both pre and post IV administration of 40 cc of gadolinium contrast. Infusion imaging as well as multiplanar reformations were performed.

PRIOR STUDIES: None.

FINDINGS:

VASCULAR: There is no evidence of abdominal aortic aneurysm. The celiac axis, superior and inferior mesenteric arteries are widely patent. Two single renal arteries are seen bilaterally and are widely patent. There is no renal artery aneurysm. Both kidneys are normal in size with the right measuring 10.3 cm and the left measuring 10.5 cm in craniocaudal dimensions.

INCIDENTAL FINDINGS: Multiple subcentimeter rounded areas of decreased signal intensity are seen on T1 weighted images which are hyperintense on T2 weighted images and do not enhance, therefore representing simple hepatic cysts. Additionally, in segment 6 of the liver, there is a 1.9 x 1.5 cm rounded area of increased signal intensity on T2 weighted images which demonstrates brisk enhancement and may represent an adenoma or focal nodular hyperplasia. There is marked dilatation of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

IMPRESSION:

1. Normal abdominal aorta and major branch vessels without evidence of aneurysm.
2. 1.9 x 1.5 cm lesion in segment 6 of the liver which may represent an adenoma or focal nodular hyperplasia. Further evaluation with a triple phase CT scan should be performed as well as short-term follow-up.
3. Simple hepatic cysts.
4. Prominence of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

END OF IMPRESSION:

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2006 08:20 ADDITIONAL POST SCAN Final

Exam Number: A07476464 Report Status: Final
 Type: ADDITIONAL POST SCAN
 Date/Time: 03/02/2006 08:20
 Exam Code: M351/CV
 Ordering Provider: [REDACTED]
 Report Below from Associated Order A07466594: MR Angio Abd w/o & w/Cont

 REPORT:

HISTORY: LEFT UPPER QUADRANT PULSATION. EVALUATE FOR ANEURYSM.

TECHNIQUE: Multiplanar, multisequence imaging of the abdomen was performed both pre and post IV administration of 40 cc of gadolinium contrast. Infusion imaging as well as multiplanar reformations were performed.

PRIOR STUDIES: None.

FINDINGS:

VASCULAR: There is no evidence of abdominal aortic aneurysm. The celiac axis, superior and inferior mesenteric arteries are widely patent. Two single renal arteries are seen bilaterally and are widely patent. There is no renal artery aneurysm. Both kidneys are normal in size with the right measuring 10.3 cm and the left measuring 10.5 cm in craniocaudal dimensions.

INCIDENTAL FINDINGS: Multiple subcentimeter rounded areas of decreased signal intensity are seen on T1 weighted images which are hyperintense on T2 weighted images and do not enhance, therefore representing simple hepatic cysts. Additionally, in segment 6 of the liver, there is a 1.9 x 1.5 cm rounded area of increased signal intensity on T2 weighted images which demonstrates brisk enhancement and may represent an adenoma or focal nodular hyperplasia. There is marked dilatation of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

IMPRESSION:

1. Normal abdominal aorta and major branch vessels without evidence of aneurysm.
2. 1.9 x 1.5 cm lesion in segment 6 of the liver which may represent an adenoma or focal nodular hyperplasia. Further evaluation with a triple phase CT scan should be performed as well as short-term follow-up.
3. Simple hepatic cysts.
4. Prominence of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

END OF IMPRESSION:

RADIOLOGISTS: [REDACTED]

SIGNATURES: [REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

03/02/2006 08:16

MR Angio Abd w/o & w/Cont

Final

Exam Number: A07466594 Report Status: Final
Type: MR Angio Abd w/o & w/Cont
Date/Time: 03/02/2006 08:16
Exam Code: M4185/GAD/CV
Ordering Provider: [REDACTED]
Associated Reports:
A07476434: 3D Holographic Reconstruction
A07476437: ADDITIONAL GAD +11-20cc
A07476464: ADDITIONAL POST SCAN

REPORT:

HISTORY: LEFT UPPER QUADRANT PULSATION. EVALUATE FOR ANEURYSM.

TECHNIQUE: Multiplanar, multisequence imaging of the abdomen was performed both pre and post IV administration of 40 cc of gadolinium contrast. Infusion imaging as well as multiplanar reformations were performed.

PRIOR STUDIES: None.

FINDINGS:

VASCULAR: There is no evidence of abdominal aortic aneurysm. The celiac axis, superior and inferior mesenteric arteries are widely patent. Two single renal arteries are seen bilaterally and are widely patent. There is no renal artery aneurysm. Both kidneys are normal in size with the right measuring 10.3 cm and the left measuring 10.5 cm in craniocaudal dimensions.

INCIDENTAL FINDINGS: Multiple subcentimeter rounded areas of decreased signal intensity are seen on T1 weighted images which are hyperintense on T2 weighted images and do not enhance, therefore representing simple hepatic cysts. Additionally, in segment 6 of the liver, there is a 1.9 x 1.5 cm rounded area of increased signal intensity on T2 weighted images which demonstrates brisk enhancement and may represent an adenoma or focal nodular hyperplasia. There is marked dilatation of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

IMPRESSION:

1. Normal abdominal aorta and major branch vessels without evidence of aneurysm.
2. 1.9 x 1.5 cm lesion in segment 6 of the liver which may represent an adenoma or focal nodular hyperplasia. Further evaluation with a triple phase CT scan should be performed as well as short-term follow-up.
3. Simple hepatic cysts.
4. Prominence of the inferior vena cava and hepatic veins which may be related to right-sided heart failure.

END OF IMPRESSION:



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BRIGHAM & WOMEN'S HOSPITAL
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75 Francis Street, Boston, Massachusetts 02115

MRN: 18422022 (BWH)
LAUERMAN, JOHN
Date of Birth: 09/25/1958
Age: 52 yrs. Sex: M

Radiology from 1/1/2003 through 8/12/2011 (cont)

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]



Radiology from 1/1/2003 through 8/12/2011 (cont)

02/10/2006 08:59

Abdominal Ultrasound

Final

Exam Number: A07440761

Report Status: Final

Type: Abdominal Ultrasound

Date/Time: 02/10/2006 08:59

Exam Code: B501

Ordering Provider: [REDACTED]

REPORT:

INDICATION

Abdominal pain (789.00)
 left side

FINDINGS

Liver

Normal

Gallbladder

Gallstone

Size: .4 cm

Gallbladder wall

Normal thickness

No sonographic Murphy's sign
 freely moveable.

Biliary tree

Common bile duct

Normal

Intrahepatic ducts

Normal

Right kidney

Size: 9.8 cm

Normal, no hydronephrosis

Left kidney

Size: 11.2 cm

Normal, no hydronephrosis

Pancreas

Normal

Spleen

Normal

Aorta

Normal

Other findings/Comments

IVC imaged.

Bladder normal.

IMPRESSION

Single freely moveable gallstone.

RADIOLOGISTS:

[REDACTED]

SIGNATURES:

[REDACTED]