SOAP #1:

Identifying data:
Full name: Ms. DP
Address: Springfield Gardens, NY
MRN#: [redacted]
Date & Time: 1/5/24 at 10:06am
Location: QHC OR1
Religion: Unspecified
Source of Information: EMR and Self
Reliability: Reliable

S:
24YOF with no PMH presents today for scheduled B/L breast excision. Pt first complained of painful L breast mass present for several years at annual GYN appt on 10/26/23. She was referred to the QHC Breast Clinic for work-up and imaging and subsequent breast imaging and biopsies revealed multiple fibroadenomas B/L. Pt opted to pursue surgical excision to remove two large masses causing pain, L>R. She underwent all PSTs and is cleared for today's procedure. Denies recent illness, fever, chills, N/V, pain 0/10 in severity at this time.

O:
Vitals:
Temp: 97.4F
Pulses: 73bpm
Resp: 20bpm
BP: 127/81
SpO2: 100%
HT: 5'10 ft WT: 203lbs

Physical Examination:
Gen: No apparent distress, AxO x 3
Resp: Chest expansion symmetrical.
Neuro: Gait steady with no ataxia
Breast: Breasts appear symmetrical.
- Right: No swelling, bleeding, skin changes, or nipple discharge. Round, mobile mass palpable at 11 o'clock 3cm from the nipple
- Left: No swelling, bleeding, skin changes, or nipple discharge. Round, mobile mass palpable at 6 o'clock 3cm from nipple.

Extremities: Soft calves with SCDs on. No tenderness or swelling.

Medications given in OR:

Propofol PRN
Midazolam PRN
Lactated Ringers 125ml/hr
Cefazolin 2g IV
Fentanyl 50mcg IV push PRN

A:
24 y/o F w/ no PMH presents for elective B/L breast excision of painful fibroadenomas. The PT was properly draped and placed under general anesthesia with LMA. One fibroadenoma was removed from each breast through a transverse incision. Both masses sent for pathology. Wounds were closed with primary intention using a combination of deep and superficial sutures. Pt was extubated without complication and was sent to the PACU for recovery. Total 5 cc of blood loss.

P:
- Q2hr checks until discharge home
- Encourage ambulation and feeding
- Pain control with Fentanyl until d/c
- Continue IVF until d/c
- F/U in breast clinic in 3 weeks
- Discharge instructions

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SOAP #2

Identifying data:
Full name: Ms. MRDS
Address: Queens Village, NY
MRN#: [redacted]
Date & Time: 1/5/24 at 9:04pm
Location: QHC 4BW
Religion: Unspecified
Source of Information: EMR, Self
Reliability: Reliable

S:
63YOF w/ PMH of DMT2 evaluated at bedside s/p R hallux amputation completed by podiatry service at approx 1545 this afternoon (POD0). Pt initially presented to the ED on 12/27/23 with R 1st toe pain and discoloration x a few weeks and was admitted to podiatry service for evaluation of dry gangrene that

ultimately required amputation. At this time, she is A&Ox3 and appears to be in no acute distress. She reports tolerating solids and liquids PO, voiding x1, BM x1 since admission to PACU. She c/o incisional pain 1/10 in severity and some mild nausea without vomiting. Denies headache, dizziness, CP, palpitations, SOB, or difficulty breathing. Pt was evaluated with the assistance of Spanish interpreter #23830.

O:
Vitals:
Temp: 97.5F
Pulses: 72bpm
Resp: 18
BP: 145/63
SpO2: 100% RA
HT: WT:

Physical Examination:
Gen: A&Ox3, no apparent distress, appears comfortable in bed
CVS: S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated. RRR.
Lungs: Chest expansion symmetrical. CTA B/L.
Abdomen: Non-tender, non distended, soft abdomen without guarding or rebound.
Extremities: Soft calves with SCDs on. No tenderness or swelling.
LE: Wound is dressed –

Medications:
APAP 650mg Q4H PRN
APAP#3 300-30mg Q6H PRN
Ampicillin-Sulbactam (Unasyn) 3g in 100ml NS q6H
Atorvastatin 20mg QD
D50W 25g IVP q15m PRN
Enoxaparin 40mg SQ QD
Gabapentin 300mg PO q12h
Glucagon 1mg IM q15m PRN
Insulin Lispro 0-8 units SQ Q6H
Losartan-HCTZ (Hyzaar) 100-12.mg PO QD
Morphine 2mg IVP q4h PRN
Nifedipine ER 60mg PO QD
Sitagliptin-Metformin (Janumet) 50-500mg PO BID with meals

A: 63YOF POD0 s/p R hallux amputation recovering well without any signs of postoperative complications at this time.
More specific signs – dont be generic

P:

- Continue pain meds PRN
- Continue perioperative ABX
- Encourage use of incentive spirometer
- Regular diet as tolerated
- GI prophylaxis with Protonix
- DVT Prophylaxis with Lovenox
- Encourage OOB and early ambulation to chair

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SOAP #3

Identifying data:
Full name: Mr. TC
Address: Fresh Meadows, NY
MRN#: [redacted]
Date & Time: 1/8/24 at 8:00am
Location: QHC OR3
Religion: Unspecified
Source of Information: EMR
Reliability: Reliable

S:
63YOM w/ PMH of HTN and HLD presents today for scheduled repair of painful R groin mass x 4 years. Mass was initially evaluated by QHC surgery team on 12/1/23 and diagnosed with R inguinal hernia. He has undergone all PAT and is cleared for today's procedure. Denies recent illness, fever, chills, N/V/D. Reports pain 0/10 at this time. Mass is easily reducible without signs of complication.

O:
Outpatient Medications:
Amlodipine 10mg tablet
Rosuvastatin 5mg tablet

Vitals:
Temp: 97.4F
Pulses: 68bpm
Resp: 20bpm
BP: 153/83
SpO2: 100%
HT: 5'9" WT: 155lbs

Physical Examination:
Gen: No apparent distress, AxO x 3
Neuro: Gait steady with no ataxia
GI: Mass palpable in the right groin above and medial to the pubic tubercle. Approximately 2cm in diameter, soft in consistency and reducible. Non-tender, non distended, soft abdomen without guarding or rebound.
Extremities: Soft calves with SCDs on. No tenderness or swelling.

Medications given in OR:
Clindamycin 900mg
Propofol 200mg
Rocuronium 40mg
Midazolam IV Push 2mg
Lactated Ringers 125ml/hr
Fentanyl 50mcg IV push PRN

A:
63YOM with PMH of HTN and HLD presents for R inguinal hernia repair. The PT was properly draped, anesthetized, and intubated. An indirect hernia sac was isolated and reduced, and the fascial defect was corrected with a propylene plug and mesh. The excess hernia sac was excised and sent for pathology. Wounds were closed with primary intention using a combination of deep and superficial sutures. Pt was extubated without complication and was sent to the PACU for recovery. Total 3 cc of blood loss.
Add reducibility

P:
- Q2hr rechecks until discharge home
- Encourage ambulation and feeding
- Pain control with Fentanyl until d/c
- Continue IVF until d/c
- F/U in Surgery clinic in 2 weeks
- Discharge instructions

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SOAP #4

Identifying data
Full name: Mr. ES
Address: Jamaica, NY
MRN#: [redacted]
Date & Time: 1/9/24 at 7:45am
Location: QHC 4BW

Religion: Unspecified
Source of Information: EMR/Self
Reliability: Reliable

S:
89YOM w/ PMH of DM2, HTN, HLD, and BPH seen and evaluated at bedside with Dr. Bartolotta and the surgery team on morning rounds. Pt is on day 7 of hospital admission for diagnosed SBO. NG was removed yesterday after marked improvement in presentation and on serial XRs since admission. Pt states he is feeling well this morning and has no complaints at this time. Endorses flatus and BM x 1 overnight. Denies anorexia, N/V, constipation. Reports pain 0/10 in severity. Pt is scheduled for d/c later this afternoon.
Pt denies pain**
HD7 admitted with SBO being managed non-operatively.

O:
Medications:
Ciprofloxacin 400mg IV Q12h
Enoxaparin 40mg SQ QD
Insulin Lispro 10mg PO Q6h
Metronidazole 500mg Q8h
Pantoprazole 40mg IV QD
Tamsulosin .4mg PO QD
Benzocaine-Menthol PRN
Dextrose PRN
Ondansetron PRN

Vitals:
BP: 141/68
Temp: 97.7F
Pulses: 67bpm
Resp: 18bpm
BP: 153/83
SpO2: 95%
HT: 5'9" WT: 169lbs

Physical Exam:
Gen: A&Ox3, no apparent distress, appears comfortable in bed
CVS: S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated. RRR.
Lungs: Chest expansion symmetrical. CTA B/L.
Abdomen: Non-tender, non distended, soft abdomen without guarding or rebound.

Extremities: Soft calves with SCDs on. No tenderness or swelling.

A:
89YOM w/ PMH of DM2, HTN, HLD, and BPH continues to make progress indicative of successful treatment of SBO, without complication.

Indicative of non-operative management of SBO

P:

- Continue Regular diet as tolerated
- Continue IV Abx, Protonix until d/c
- Continue with Lovenox and SCDs until d/c
- Encourage ambulation OOB to chair
- Arrange Discharge and Discharge Instructions

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1. Cefazolin (Ancef)
    - Drug Class
        - First generation cephalosporin antibiotic
    - Mechanism of Action
        - Cell wall synthesis inhibitor → Binds penicillin-binding proteins, which inhibits the final step of peptidoglycan synthesis in bacterial cell walls
    - Indications
        - Gram positive bacterial infections (Bloodstream infections, endocarditis, intra-abdominal infection, osteomyelitis, peritonitis, PNA, prostatitis, joint infection, TSS, complicated UTIs)
        - Surgical prophylaxis
    - Contraindications
        - Immediate hypersensitivity to cefazolin, other cephalosporin antibiotics, penicillins, other beta-lactams, or any component of the formulation
    - Adverse Reactions
        - CV: Hypotension, syncope
        - GI: Abdominal cramps, anorexia, C. Diff, diarrhea, epigastric pain, flatulence, nausea, oral candidiasis, oral mucosal ulcer, vomiting
        - Heme/Immune: Hemolytic anemia, Hypersensitivity reactions (immediate and delayed)
    - Monitoring
        - Renal function and hepatic function periodically
        - CBC
        - Signs of anaphylaxis during first dose
    - Dosing
        - Bacterial Infections: 1-2g q8 hrs
        - Surgical prophylaxis: 2g for patients <120 kg, 3g for patients >120kg

        - Max dose: 12g/day
        - Dose adjustment for kidney impairment
2. Midazolam
    - Drug Class
        - Benzodiazepine (short-acting)
    - Mechanism of Action
        - Binds to stereospecific benzodiazepine receptors on postsynaptic GABA neuron in the CNS → Enhances neuronal membrane permeability to Cl-, causing influx → hyperpolarization of neuron → less excitable state
    - Indications
        - Induction and Maintenance of General anesthesia
        - Sedation of intubated and mechanically ventilated patients
        - Procedural sedation outside the operating room
        - Intermittent seizures (Intranasal)
        - Status epilepticus (IM)
    - Contraindications
        - Hypersensitivity to midazolam or any component of the formulation
        - Acute narrow-angle glaucoma
        - Concurrent use with protease inhibitors
    - Adverse Reactions
        - Respiratory: Respiratory depression, apnea, hypoxia
        - CV: bradycardia, hypotension
        - GI: Vomiting, dysgeusia, hiccups, nausea
        - Immune: Injection site reaction, hypersensitivity reaction
        - Nervous: Agitation, drowsiness, impaired consciousness, mental status changes
        - Renal: Acute renal failure
        - MSK: Laryngospasm, muscle rigidity, tremor
    - Monitoring
        - Level of sedation, respiratory rate, heart rate, blood pressure, oxygen saturation
    - Dosing
        - General anesthesia or monitored anesthesia care (IV)
            - 0.5 to 2 mg
        - Mechanically ventilated patients in the ICU, sedation (IV)
            - 0.5 to 5 mg or 0.01 to 0.05 mg/kg
        - Procedural sedation, outside the operating room (IV)
            - 0.5 to 2.5 mg, maximum total dose: 5 mg
        - Seizures (Intranasal)
            - 5 mg, maximum dose: 10 mg
        - Status epilepticus (IM)
            - 10 mg once or 0.2 mg/kg once, maximum dose: 10 mg
3. Propofol
    - Drug Class

        - General Anesthetic
    - Mechanism of Action
        - Causes global CNS depression, presumably through agonism of GABAA receptors and reduced glutamatergic activity through NMDA receptor blockade
    - Indications
        - General anesthesia
        - Mechanically ventilated patients in the ICU, sedation
        - Monitored anesthesia care sedation.
        - Sedation and regional anesthesia
    - Contraindications
        - Hypersensitivity to propofol or any component of the formulation
        - Hypersensitivity to eggs, egg products, soybeans, or soy products
    - Adverse Reactions
        - CV: Conduction disturbances, bradycardia, QT abnormalities, hypotension
        - Immune: Immediate hypersensitivity reactions
        - GI: Hypertriglyceridemia (pancreatitis)
        - Propofol-related infusion syndrome (PRIS) → (dysrhythmia (bradycardia or tachycardia), widening of the QRS complex, heart failure, hypotension, asystole, lipemia and hypertriglyceridemia, metabolic acidosis, and/or rhabdomyolysis or myoglobinuria with acute kidney injury and hyperkalemia
    - Monitoring
        - Cardiac monitor, BP, oxygen saturation
        - Signs and symptoms of propofol-related infusion syndrome (ABG and BMP)
        - Serum triglyceride levels
        - Zinc levels in patients predisposed to deficiency or after 5 days of treatment
    - Dosing
        - General anesthesia
            - Induction (IV)
                - 0.5 to 2.5 mg/kg depending on health status
            - Maintenance (IV gtt)
                - 50 to 200 mcg/kg/minute depending on health status
        - Rapid sequence intubation outside the operating room (IV)
            - 1 to 3 mg/kg once
        - Sedation of mechanically ventilated patients in the ICU (gtt)
            - 5 mcg/kg/minute, maximum dose: 60 to 80 mcg/kg/minute
        - Monitored anesthesia care
            - Initial: 25 to 75 mcg/kg/minute
        - Dosage must be individualized and titrated to the desired clinical effect. Consider body weight and age in dosing.
4. Rocuronium
    - Drug Class
        - Neuromuscular Blocker Agent, Nondepolarizing

- Mechanism of Action
    - Blocks acetylcholine from binding to receptors on motor endplate inhibiting depolarization
- Labeled Indications
    - Endotracheal intubation or mechanical ventilation during surgery
    - As an adjunct to general anesthesia
- Contraindications
    - Hypersensitivity to rocuronium, other neuromuscular-blocking agents, or any component of the formulation
- Adverse Reactions
    - Cardiovascular: Increased PVR, tachycardia, hypertension, transient hypotension
    - Hypersensitivity: Anaphylaxis
- Monitoring
    - Heart rate, blood pressure, respiratory rate
    - Degree of muscle paralysis
- Dosing
    - Endotracheal intubation or mechanical ventilation during surgery
        - Rapid sequence intubation: IV: 1 to 1.2 mg/kg once
        - Tracheal intubation, non-emergent: IV: 0.6 to 1 mg/kg
        - Maintenance: IV: 0.1 to 0.2 mg/kg
    - Mechanically ventilated patients in the ICU
        - Continuous infusion: IV: Initial: Loading dose of 0.6 to 1 mg/kg, followed by continuous infusion of 3 to 8 mcg/kg/minute
        - Intermittent dosing: IV: Initial: Loading dose of 0.6 to 1 mg/kg (or 50 mg)

5. Fentanyl
    - Drug Class
        - Analgesic opioid
    - MOA
        - Binds with stereospecific receptors at many sites within the CNS → increases pain threshold, alters pain perception, and inhibits ascending pain pathway
    - Indications
        - Acute pain, including postoperative pain
        - Chronic cancer pain
        - Pain and sedation in ICU patients
        - Procedural sedation and analgesia
        - Rapid sequence intubation
        - General anesthesia
        - Neuraxial analgesia
    - Contraindications
        - Hypersensitivity to fentanyl or its components
        - Significant respiratory depression
        - Acute or severe bronchial asthma in an unmonitored setting

    - GI obstruction/paralytic ileus
    - Patients who are not opioid tolerant
    - Acute pain management in the ED
- Adverse Reactions
    - Nervous: Confusion, depression, dizziness, drowsiness, fatigue, headache, insomnia
    - CV: Peripheral edema
    - Resp: Dyspnea, pneumonia
    - GI: Abdominal pain, anorexia, constipation, diarrhea, nausea, vomiting
    - Heme: Anemia
    - Metabolic: Hypokalemia, Dehydration, Hyperhydrosis
- Monitoring
    - Pain relief
    - Mental status/alertness, BP, heart rate
    - Signs of misuse, abuse, addiction
- Dosing
    - Acute pain
        - IV
            - 25-100 mcg every 2-5 minutes depending on severity of pain
        - IM
            - 50-100 mcg every 1-2 hours as needed
        - Transdermal
            - 1 patch is 40 mcg per activation, delivered over 10 minutes. Max 6 doses per hour.
