Quest Diagnostics

Report Status: Final

EPSTEIN, JEFFREY

Patient Information	Specimen Information	Client Information
EPSTEIN, JEFFREY **DOB:** [redacted] **AGE: 65** Gender: M Phone: [redacted] Patient ID: [redacted] Health ID: [redacted]	Specimen: MR047987L Requisition: 0006029 Collected: 08/14/2018 Received: 08/14/2018 / 21:21 EDT Reported: 08/15/2018 / 13:55 EDT	Client #: [redacted] 56W5265 MOSKOWITZ, BRUCE W BRUCE MOSKOWITZ, MD Attn: NATIONWIDE ACCOUNT 1411 N FLAGLER DR STE 7100 WEST PALM BEACH, FL 33401-3418

Test Name	In Range	Out Of Range	Reference Range	Lab
PTH, INTACT AND CALCIUM				
PTH, INTACT				MI
PARATHYROID HORMONE, INTACT		**94 H**	14-64 pg/mL	

Interpretive Guide	Intact PTH	Calcium
Normal Parathyroid	Normal	Normal
Hypoparathyroidism	Low or Low Normal	Low
Hyperparathyroidism		
Primary	Normal or High	High
Secondary	High	Normal or Low
Tertiary	High	High
Non-Parathyroid		
Hypercalcemia	Low or Low Normal	High

CALCIUM	9.8		8.6-10.3 mg/dL	MI

PERFORMING SITE:

MI QUEST DIAGNOSTICS-MIAMI, 10200 COMMERCE PARKWAY, MIRAMAR, FL 33025-3938 Laboratory Director: GLEN L. HORTIN MD PHD. CLIA: 10D0277334

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Quest Diagnostics

Report Status: Partial

EPSTEIN, JEFFREY

Patient Information	Specimen Information	Client Information
EPSTEIN, JEFFREY **DOB:** [redacted] **AGE: 65** Gender: M Phone: [redacted] Patient ID: [redacted] Health ID: [redacted]	Specimen: MR047985L Requisition: 0006030 Collected: 08/14/2018 Received: 08/15/2018 / 15:11 EDT Reported: 08/16/2018 / 07:59 EDT	Client #: 78300020 56W5265 MOSKOWITZ, BRUCE W BRUCE MOSKOWITZ, MD Attn: NATIONWIDE ACCOUNT 1411 N FLAGLER DR STE 7100 WEST PALM BEACH, FL 33401-3418

Test Name	In Range	Out Of Range	Reference Range	Lab
LIPID PANEL, STANDARD				
CHOLESTEROL, TOTAL		233 H	<200 mg/dL	MI
HDL CHOLESTEROL		29 L	>40 mg/dL	MI
TRIGLYCERIDES		541 H	<150 mg/dL	MI
LDL-CHOLESTEROL			mg/dL (calc)	MI

LDL cholesterol not calculated. Triglyceride levels greater than 400 mg/dL invalidate calculated LDL results.

Reference range: <100

Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
([redacted])

CHOL/HDLC RATIO		8.0 H	<5.0 (calc)	MI
NON HDL CHOLESTEROL		204 H	<130 mg/dL (calc)	MI

For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.

HS CRP	1.3		mg/L	TP

Average relative cardiovascular risk according to AHA/CDC guidelines.

For ages >17 Years:

hs-CRP mg/L	Risk According to AHA/CDC Guidelines
<1.0	Lower relative cardiovascular risk.
1.0-3.0	Average relative cardiovascular risk.
3.1-10.0	Higher relative cardiovascular risk. Consider retesting in 1 to 2 weeks to exclude a benign transient elevation in the baseline CRP value secondary to infection or inflammation.
>10.0	Persistent elevation, upon retesting, may be associated with infection and inflammation.

HOMOCYSTEINE		20.5 H	<11.4 umol/L	MI

Homocysteine is increased by functional deficiency of folate or vitamin B12. Testing for methylmalonic acid differentiates between these deficiencies. Other causes of increased homocysteine include renal failure, folate antagonists such as methotrexate and phenytoin, and exposure to nitrous oxide.

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Patient Information	Specimen Information	Client Information
EPSTEIN, JEFFREY **DOB:** [redacted] **AGE: 65** Gender: M Patient ID: [redacted] Health ID: [redacted]	Specimen: MR047985L Collected: 08/14/2018 Received: 08/15/2018 / 15:11 EDT Reported: 08/16/2018 / 07:59 EDT	Client #: [redacted] MOSKOWITZ, BRUCE W

Test Name	In Range	Out Of Range	Reference Range	Lab
COMPREHENSIVE METABOLIC PANEL				MI
GLUCOSE	95		65-99 mg/dL Fasting reference interval	
UREA NITROGEN (BUN)	21		7-25 mg/dL	
CREATININE	1.16		0.70-1.25 mg/dL	
For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.				
eGFR NON-AFR. AMERICAN	66		> OR = 60 mL/min/1.73m2	
eGFR AFRICAN AMERICAN	76		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	139		135-146 mmol/L	
POTASSIUM	4.4		3.5-5.3 mmol/L	
CHLORIDE	105		98-110 mmol/L	
CARBON DIOXIDE	23		20-32 mmol/L	
CALCIUM	9.8		8.6-10.3 mg/dL	
PROTEIN, TOTAL	7.0		6.1-8.1 g/dL	
ALBUMIN	4.2		3.6-5.1 g/dL	
GLOBULIN	2.8		1.9-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO	1.5		1.0-2.5 (calc)	
BILIRUBIN, TOTAL	0.8		0.2-1.2 mg/dL	
ALKALINE PHOSPHATASE	55		40-115 U/L	
AST	23		10-35 U/L	
ALT	35		9-46 U/L	
HEMOGLOBIN A1c		5.7 H	<5.7 % of total Hgb	MI
For someone without known diabetes, a hemoglobin A1c value between 5.7% and 6.4% is consistent with prediabetes and should be confirmed with a follow-up test. For someone with known diabetes, a value <7% indicates that their diabetes is well controlled. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations. This assay result is consistent with an increased risk of diabetes. Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.				
URIC ACID		8.3 H	4.0-8.0 mg/dL	MI
Therapeutic target for gout patients: <6.0 mg/dL				
TSH	2.31		0.40-4.50 mIU/L	MI
T4 (THYROXINE), TOTAL	7.9		4.9-10.5 mcg/dL	MI
FREE T4 INDEX (T7)	2.4		1.4-3.8	
T3 UPTAKE	30		22-35 %	MI
SED RATE BY MODIFIED				MI

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EFTA00314227

Patient Information	Specimen Information	Client Information
EPSTEIN, JEFFREY **DOB:** [redacted] **AGE: 65** Gender: M Patient ID: [redacted] Health ID: [redacted]	Specimen: MR047985L Collected: 08/14/2018 Received: 08/15/2018 / 15:11 EDT Reported: 08/16/2018 / 07:59 EDT	Client #: [redacted] MOSKOWITZ, BRUCE W

Test Name	In Range	Out Of Range	Reference Range	Lab
WESTERGREN	9		< OR = 20 mm/h	
CBC (INCLUDES DIFF/PLT)				MI
WHITE BLOOD CELL COUNT	5.9		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.12		4.20-5.80 Million/uL	
HEMOGLOBIN	15.1		13.2-17.1 g/dL	
HEMATOCRIT	44.5		38.5-50.0 %	
MCV	86.9		80.0-100.0 fL	
MCH	29.5		27.0-33.0 pg	
MCHC	33.9		32.0-36.0 g/dL	
RDW	13.8		11.0-15.0 %	
PLATELET COUNT	248		140-400 Thousand/uL	
MPV	9.7		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	2879		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	2018		850-3900 cells/uL	
ABSOLUTE MONOCYTES	502		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	443		15-500 cells/uL	
ABSOLUTE BASOPHILS	59		0-200 cells/uL	
NEUTROPHILS	48.8		%	
LYMPHOCYTES	34.2		%	
MONOCYTES	8.5		%	
EOSINOPHILS	7.5		%	
BASOPHILS	1.0		%	
URINALYSIS, COMPLETE				MI
See Endnote 1				
VITAMIN B12	373		200-1100 pg/mL	MI
Please Note: Although the reference range for vitamin B12 is 200-1100 pg/mL, it has been reported that between 5 and 10% of patients with values between 200 and 400 pg/mL may experience neuropsychiatric and hematologic abnormalities due to occult B12 deficiency; less than 1% of patients with values above 400 pg/mL will have symptoms.				
C-REACTIVE PROTEIN	1.6		<8.0 mg/L	MI
EXTRA BLUE-TOP TUBE				MI
AN EXTRA SPECIMEN WAS RECEIVED WITH NO TEST REQUESTED. THE SPECIMEN WILL BE MAINTAINED IN STORAGE IN CASE ADDITIONAL TESTING IS NEEDED. PLEASE CALL THE CLIENT SERVICE DEPARTMENT FOR FURTHER ASSISTANCE.				
PROLACTIN	3.9		2.0-18.0 ng/mL	MI
TESTOSTERONE, TOTAL				MI
MALES (ADULT), IA				
TESTOSTERONE, TOTAL, MALES (ADULT), IA		**150 L**	250-827 ng/dL	
In hypogonadal males, Testosterone, Total, LC/MS/MS, is the recommended assay due to the diminished accuracy of immunoassay at levels below 250 ng/dL. This test code (15983) must be collected in a red-top tube with no gel.				

Endnote 1

```
**********************************
* Test not performed.            *
* No specimen received.          *
**********************************
```


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Patient Information	Specimen Information	Client Information
EPSTEIN, JEFFREY **DOB:** [redacted] **AGE: 65** Gender: M Patient ID: [redacted] Health ID: [redacted]	Specimen: MR047985L Collected: 08/14/2018 Received: 08/15/2018 / 15:11 EDT Reported: 08/16/2018 / 07:59 EDT	Client #: [redacted] MOSKOWITZ, BRUCE W

Endocrinology

Test Name	Result	Reference Range	Lab
VITAMIN D,25-OH,TOTAL,IA	32	30-100 ng/mL	MI

Vitamin D Status — 25-OH Vitamin D:

Deficiency:	<20 ng/mL
Insufficiency:	20 - 29 ng/mL
Optimal:	> or = 30 ng/mL

For 25-OH Vitamin D testing on patients on D2-supplementation and patients for whom quantitation of D2 and D3 fractions is required, the QuestAssureD(TM) 25-OH VIT D, (D2,D3), LC/MS/MS is recommended: order code 92888 (patients >2yrs).

For more information on this test, go to: [redacted] (This link is being provided for informational/ educational purposes only.)

Physician Comments

PENDING TESTS:

MERCURY, BLOOD

PERFORMING SITE:

MI QUEST DIAGNOSTICS-MIAMI, 10200 COMMERCE PARKWAY, [redacted], FL 33025-3938 Laboratory Director: GLEN L HORTIN MD PHD CLIA: 10D0217314

TF QUEST DIAGNOSTICS-TAMPA, 4225 E FOWLER AVE, TAMPA, FL 33617-2026 Laboratory Director: GLEN L HORTIN,MD,PHD CLIA: 10D0276120

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Carnegie Hill Radiology
170 East 77th St
New York, NY 10075-1912

Phone [redacted]

Fax [redacted]

Steven D. Wolff, M.D., [redacted]
Director

CARDIAC AND CHEST CTA

PATIENT: Epstein, Jeffrey
AGE: 65 SEX: M ID#: [redacted]

DATE: July 29, 2018
REFERRING: Dr. Bernard Kruger

HISTORY
Abdominal pain.

COMPARISON
To 2/8/2006.

TECHNIQUE
A low-dose gated cardiac and chest CTA were performed before and after the intravenous administration of 94 mL of Isovue-370. The images were reviewed and reconstructed on a 3-D workstation.

FINDINGS
The coronary arteries originate normally from the aortic root and have a normal epicardial course. The left main is widely patent and free of plaque. In the proximal LAD there are focal calcified and soft plaque causing 30% to 49% stenosis. In the mid LAD there are focal calcifications causing 30% to 49% stenosis. The distal LAD is diffusely small in size with a small bulky calcification. The diagonal arteries are small in caliber. The circumflex is widely patent. The obtuse marginal arteries are small in caliber. The RCA is dominant. The proximal and mid RCA is widely patent. The distal RCA and PDA are small in caliber.

There is posterior right pleural thickening. No pleural or pericardial effusion is noted. There is no evidence for significant lymphadenopathy. There is diffuse thickening of the esophagus with fluid noted in the posterior mediastinum adjacent to the esophagus, which may be related to an inflammatory process. This was not seen previously. There is heterogeneity of the liver parenchyma, likely fatty liver. The ascending aorta measures 4.0 cm at the level of the sinuses of Valsalva. In the lateral left 6th rib there is a bone island noted. In the right lateral 8th rib there is a bone island noted. There are degenerative changes of the osseous structures.

IMPRESSION
1. The coronary calcium score is 84, placing the patient in the 25th to 50th percentile. It previously measured 41.
2. Nonobstructive atherosclerosis is noted in the LAD as described above. No definite obstructive coronary artery disease is noted.
3. There is nonspecific fluid noted in the posterior mediastinum adjacent to a diffusely thickened esophagus, which is indeterminate. This may represent an inflammatory or

(continued)

EFTA00314230

infectious process. Advise correlation with endoscopy. A short-term followup chest CT with contrast is recommended in 2 months to confirm resolution of these findings.

4. Hepatic steatosis.
5. There is thickening of the right posterior pleura, which may be due to infection and/or inflammation.

M. Robert Peters, MD

EFTA00314231

Richard J. Katz, M.D.
Steven A. Albert, M.D.
Stephen D. Greenberg, M.D
Douglas R. DeCorato, M.D.
Gavin L. Duke, M.D.
Paul S. Choi, M.D.
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BRUCE W MOSKOWITZ, M.D.
1411 NORTH FLAGLER DRIVE
SUITE 7100
WEST PALM BEACH, FL 33401

Patient: EPSTEIN, JEFFREY
Exam Date: 1/30/18 **Acc No:** [redacted] **MRN:** 0315192

Dear Dr. Moskowitz,

CT NECK

Clinical History:

65 y/o male with elevated PTH, concern for parathyroid adenoma.

Technique:

Multidetector helical CT scans of the neck were performed utilizing 4D parathyroid technique, from the superior orbital rim to the thoracic inlet using 2.5 mm slices, prior to and during the constant infusion of nonionic intravenous contrast. Multiphase postcontrast dynamic imaging was employed. Images were reconstructed at 1.25mm slice thicknesses at 1.25mm slice intervals with coronal and sagittal reformats.

Comparison:

Neck MRI performed 11/30/2016

Findings:

The visualized brain parenchyma is normal.

The orbital contents are partially excluded from the field of view but are grossly normal in appearance.

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The masticator spaces are normal.

The mastoid air cells and tympanic cavities are clear.

Mild scattered paranasal sinus mucosal thickening is seen with areas appearing polypoid in nature. Findings are worse along the left frontal drainage pathway which is occluded.

A few of the maxillary and mandibular teeth have been endodontically treated. There is a left 2nd mandibular molar dental implant. Small bilateral mandibular tori are present.

The nasopharynx is normal. Prominence of the bilateral palatine tonsils are seen without deep extension, likely reactive in nature. Punctate calcifications involve both palatine tonsils, likely reflecting remote inflammation. Minimal prominence of the bilateral lingual tonsils is seen without deep extension, likely reactive in nature. There is a tiny air-filled right internal laryngocele. The hypopharynx and larynx are otherwise normal. The true cords are adducted.

The major salivary glands including the parotid, submandibular and sublingual glands are normal.

The thyroid is mildly heterogeneous. There is a 0.5 cm enhancing nodule within the posterior right midpole of the thyroid.

There are no early enhancing parathyroid nodules. No discrete parathyroid mass is present. There is no evidence for a parathyroid adenoma.

There is no suspicious or pathologically enlarged cervical chain lymphadenopathy.

There is a partially imaged lipoma within the left supraclavicular fossa measuring 4.7 cm in greatest craniocaudad dimension and 2.5 cm in greatest AP dimension. This is unchanged.

There is a bovine configuration of the great vessels arising from the aortic arch, a normal anatomic variant. There is patency of the major vessels of the neck.

The pericervical musculature, scalene musculature and sternocleidomastoid muscles are normal asymmetric atrophy.

The lung apices are clear. There is no suspicious mediastinal mass or evidence of ectopic parathyroid adenoma within the mediastinum on the images provided.

Multilevel cervical spondylosis is seen with disc herniations and superimposed disc osteophyte complexes resulting in multilevel ventral cord impingement as well as foraminal narrowing with suspected cervical nerve root impingement.

IMPRESSION

No evidence for parathyroid adenoma.

EPSTEIN, JEFFREY ACC: [redacted] Exam Date: 1/30/18 DOB: [redacted]

Mild scattered polypoid paranasal sinus mucosal thickening with an occluded left frontal drainage pathway.

A 0.5 cm right midpole thyroid nodule.

Left supraclavicular lipoma, unchanged.

Multilevel cervical spondylosis.

Very truly yours,

ADAM WILNER, M.D.

Electronically Signed By: ADAM WILNER, M.D.
Date/Time Transcribed: 1/30/18 9:02 am

Contrast: Omnipaque Contrast 350mg 100cc
Creatinine 1.2mg/dl

REPORT

CC: CC PATIENT

EPSTEIN, JEFFREY ACC: [redacted] Exam Date: 1/30/18 DOB: [redacted]

Mount Sinai

Nuclear Medicine Associates
Nuclear & PET Imaging
1 Gustave Levy Place #1141
New York, NY 10029
(212) 241-6969
(212) 831-2851 (fax)

Rony Shimony, MD
486 Madison Ave
17th Floor
New York, NY 10022

Patient: EPSTEIN, JEFFREY
Sinai MR#: [redacted]
DOB:
Accession #:
Date of Exam: 12/13/2017
Examination: NM PARATHYROID SCAN
123 DOSING

Dear Dr. Shimony:

STUDY: Dual Isotope Parathyroid scan

INDICATION: The patient presents with hypercalcemia, evaluate for parathyroid adenoma.

METHOD: The patient received 0.2 mCi of I-123 orally. Anterior pinhole views of the neck were then obtained. Then the patient received 20 mCi of Tc-99m Sestamibi intravenously. Anterior pinhole views of the neck are obtained immediately followed by SPECT-CT images of the neck and chest. Again, pinhole views of the neck at 2 hours are obtained. The low- dose nondiagnostic CT scan images were obtained solely for the purpose of anatomic co-registration with the SPECT images.

FINDINGS: There is no prior study for comparison.

The I-123 thyroid image shows homogeneous radiotracer distribution in both lobes of the thyroid gland.

The early Sestamibi image shows homogeneous radiotracer distribution in both lobes of the thyroid gland.

The delayed Sestamibi image shows equal radiotracer washout from both lobes of the thyroid gland.

SPECT-CT images show no abnormal focal uptake in the neck or chest.

IMPRESSION:

THERE IS NO ABNORMAL FOCAL UPTAKE IN THE NECK OR CHEST TO SUGGEST PARATHYROID ADENOMA.

Thank you for the courtesy of this referral.

Sincerely,

Sherif I Heiba, MD

(Electronically Signed)
Contributing Provider(s): 1) Heiba, Sherif I 2) KESTENBAUM, DAVID

* Final Report *

Referring Physician
Dr. Bruce Moskowitz

Endocrinologist
None

Chief Complaint
Primary Hyperparathyroidism

History of Present Illness
Mr. Epstein, Jeffrey is a 65-year-old male who presents for surgical evaluation and treatment, referred by Dr. Bruce Moskowitz. The patient presents with the diagnosis of Primary Hyperparathyroidism and Hypercalcemia. The patient became aware of the problem for about 10 years. He was previously evaluated by myself at Yale. At that time, surgery was differed.

The patient does have a history of nephrolithiasis (2 episodes 6 years ago). The patient does not take any thiazide diuretics or lithium.

His symptoms include constipation, trouble concentrating, and exacerbated fatigue. He experiences these symptoms sporadically and they correlate with elevated PTH and calcium levels. The patient has no complaints of hoarseness, dysphagia, or difficulty breathing. The patient has no history of radiation treatment to head or neck. Laboratory and imaging are listed below. ***I have reviewed all laboratory results and images in detail.***

Laboratory Studies, August 16th, 2018 (Quest Diagnostics)
BUN: 21 [7-25]
Creatinine: 1.16 [0.70-1.25]
eGFR: 66 [>60]
Calcium: 9.8 [8.6-10.3] it was 10.7 last week
PTH, Intact: 94 [14-64]
Vitamin D, 25-OH: 32 [30-100]
TSH: 2.31 [0.40-4.50]
Free T4: 2.4 [1.4-3.8]
T 150 (250-800) according to the patient his LH and FSH are both normal
as per patient had a 24 hour urine for calcium which was normal.

Diagnostic Imaging and Procedures
Parathyroid Scan, December 2017 (Mount Sinai, New York):
IMPRESSION: There is no abnormal focal uptake in the neck or chest to suggest parathyroid adenoma.

Past Medical History
Ongoing
Primary hyperparathyroidism

Past Surgical History
None

Allergies
No active allergies

Family History
Mother: Deceased; Kidney disease
Father: Deceased; Heart disease
Brother (1): Alive and healthy
Sister: None
Children: None
No family history of endocrine disorders.

Social History
Smoking: None
Alcohol: None
Drugs: None
Occupation: Banker

Home Medications
None

Result type:	Surgery Office Clinic Note
Result date:	August 20, 2018 13:40 EDT
Result status:	Auth (Verified)
Result title:	Endocrine Surgery Consultation
Performed by:	Alonso, Rafael ARNP on August 20, 2018 13:42 EDT
Verified by:	Udelsman, Robert MD on August 20, 2018 14:49 EDT
Encounter info:	903306115, MCI, Clinic, 08/20/2018 -

EFTA00314236

Neck CT (4D Parathyroid Technique), January 2018 (East River Medical Imaging, New York):
IMPRESSION:
No evidence for parathyroid adenoma.
Mild scattered polypoid paranasal sinus mucosal thickening with an occluded left frontal drainage pathway.
A 0.5 cm right mid pole thyroid nodule.
Left supraclavicular lipoma, unchanged.
Multilevel cervical spondylolysis.

Para Ultrasound
Negative

Bone density: as per patient was normal

Review of Systems
CONSTITUTIONAL: No fever, weight loss, or night sweats.
EYES: No visual changes or eye pain.
ENT: No sore throat, sinus pain, or ear pain.
CARDIOVASCULAR: No chest pain or palpitations.
RESPIRATORY: No cough, wheeze, or shortness of breath.
GASTROINTESTINAL: No abdominal pain, nausea, or vomiting, **+ constipation**
ENDOCRINE: As above only.
MUSCULOSKELETAL: No musculoskeletal pain or joint swelling.
NEUROLOGICAL: No changes in special senses, no headaches.
IMMUNOLOGY: No swollen lymph nodes
HEMATOLOGY: No easy bruising or history of excessive bleeding.
INTEGUMENTARY: No rashes or skin lesions.
ALL OTHER: Negative

Physical Exam

Vitals & Measurements
T: 37.2 °C (Oral) **HR:** 77 (Peripheral) **RR:** 16 **BP:** 123/74 **SpO2:** 96%
WT: 88.5 kg (Measured) **BMI:** 27.01

Physical exam reveals a well-developed male
GENERAL: No resting tremors
EYES: Conjunctivae are not injected. No scleral icterus. No exophthalmos.
CARDIOVASCULAR: Regular rate and rhythm without murmurs, rubs, or gallops. No carotid bruits.
RESPIRATORY: Lungs are clear to percussion and auscultation.
MUSCULOSKELETAL: No muscular atrophy. Gait normal.
SKIN: Normal skin turgor, no obvious bruising.
NEUROLOGIC: Oriented X3. Motor and sensory grossly intact.
THYROID: Examination of the neck reveals a normal thyroid gland.
VOCAL CORDS: I was unable to visualize his cords by mirror exam.
HEMATOLOGY/LYMPHATICS: There is no cervical or supraclavicular lymphadenopathy.

Result type:	Surgery Office Clinic Note
Result date:	August 20, 2018 13:40 EDT
Result status:	Auth (Verified)
Result title:	Endocrine Surgery Consultation
Performed by:	Alonso, Rafael ARNP on August 20, 2018 13:42 EDT
Verified by:	Udelsman, Robert MD on August 20, 2018 14:49 EDT
Encounter info:	903306115, MCI, Clinic, 08/20/2018 -

EFTA00314237

Assessment/Plan

1. Primary hyperparathyroidism E21.0
--laboratory: 24 hour urine for calcium and creatinine
-- Educational session and booklet provided to the patient

This patient almost certainly has minor primary HPTH with a history of nephrolithiasis and neurocognitive symptoms. His imaging is negative making him at higher risk for multi-gland disease. I do believe he would be best served by parathyroid surgery and I explained this in detail. He will obtain his 24 hr urine collection in West Palm Beach and we will chat after this study.

-- I had a detailed conversation with the patient about his options. Based on the most current laboratory values, imaging studies, and physical examination, I have recommended: ***[Parathyroid exploration with the intact PTH assay]***. I explained the procedure as well as the risks, benefits, and potential complications to the patient. Risks include, but are not limited to, bleeding, infection, hypocalcemia, reaction to anesthesia, and injury to the nerves near the vocal cords. The patient verbalized understanding and has no further questions. We will proceed to surgery at a time convenient for the patient.

I, Dr. Robert Udelsman had a face-to-face encounter with this patient, examined the patient and reviewed the APP notes. I have formulated the assessment and plan for this patient and reviewed them with the patient.

A total of 40 minutes were spent face-to-face with the patient during this encounter and over half of the time was spent counseling and coordination of care. Discussed the operation, potential complications, post-operative recovery and management, past medical records including laboratory data and diagnostic imaging available at the time of the consult.

Dr. Bruce Moskowitz is thanked for involving me in the care of this interesting patient.

Robert Udelsman, MD, MBA, FACS, FACE
Endocrine Neoplasia Institute
Miami Cancer Institute
Baptist Health South Florida

Signature Line
Electronically Signed on 08/21/2018 07:33

_____

Alonso, Rafael ARNP

Result type:	Surgery Office Clinic Note
Result date:	August 20, 2018 13:40 EDT
Result status:	Auth (Verified)
Result title:	Endocrine Surgery Consultation
Performed by:	Alonso, Rafael ARNP on August 20, 2018 13:42 EDT
Verified by:	Udelsman, Robert MD on August 20, 2018 14:49 EDT
Encounter info:	903306115, MCI, Clinic, 08/20/2018 -

Electronically Signed on 08/20/2018 14:49

Udelsman, Robert MD

Completed Action List:
* Perform by Alonso, Rafael ARNP on August 20, 2018 13:42 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 13:51 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 13:51 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 13:53 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 13:53 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 13:53 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 14:12 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 14:16 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 14:17 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 14:19 EDT
* Modify by Alonso, Rafael ARNP on August 20, 2018 14:20 EDT
* Modify by Udelsman, Robert MD on August 20, 2018 14:49 EDT
* Sign by Udelsman, Robert MD on August 20, 2018 14:49 EDT Requested by Alonso, Rafael ARNP on August 20, 2018 14:40 EDT
* VERIFY by Udelsman, Robert MD on August 20, 2018 14:49 EDT
* Sign by Alonso, Rafael ARNP on August 21, 2018 07:33 EDT Requested by Alonso, Rafael ARNP on August 20, 2018 13:42 EDT

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