

ORIGINAL

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Appellate Panel
T. Scott Beck, Commissioner

WCC File No. 1103604

Appellate Case No. 2013-001515

RECEIVED

JUN 04 2014

SC Court of Appeals

Michael Philip Worthen, Employee, Claimant Appellant,

v.

Laurens County, Employer, and
SC Association of Counties SIF, Carrier, Defendants Respondents.

RECORD ON APPEAL

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**Decision and Order
of Commission Gene McCaskill,
dated November 7, 2012**

WCC FILE No. 1103604

DECISION AND ORDER

FILED: November 7, 2012

STIPULATIONS

The parties stipulated at the hearing to the following:

1. Notice of the hearing was timely and properly served upon all parties of interest.
2. The South Carolina Workers' Compensation Commission has jurisdiction over this claim.
3. Venue in Anderson County is proper.
4. The Commission file is made part of the record with the exceptions of self-serving declarations and unstipulated medical records.
5. The APA submissions of both parties are admitted without objection.
6. Claimant's average weekly wage is \$520.19 with a corresponding compensation rate of \$346.81.
7. That Claimant had a myocardial infarction on February 26, 2011.

A.P.A. SUBMISSIONS

Pursuant to the South Carolina Administrative Procedures Act and Regulations of the South Carolina Workers' Compensation Commission, the following records and documents were submitted into evidence.

APA's Submitted by the Claimant:

1. EKG completed at 10:15 p.m. when the injury occurred, 2/26/11, pages 1-6.
2. Greenville Memorial Hospital, 2/27/11 – 3/14/11, pages 7 – 144.
3. Upstate Cardiology, Dr. John Bittrick, 2/27/11 – 04/26/12, pages 145-184.
4. Questionnaire completed by Dr. John M. Bittrick, 7/19/12, pages 185-186.

5. Questionnaire completed by Dr. Guiaro, 07/19/12, page 187.
6. Monthly prescription costs, 04/29/10, pages 188-191.

APA's Submitted by Defendant:

7. Dr. W. Travis Ellison, 08/08/11, page 192.
8. Greenville Hospital System, 02/26/11 – 03/14/11, pages 193-256.
9. Dr. Catherine Chang, 04/27/11 – 06/23/11, pages 257-267.
10. Hillcrest Memorial Hospital, 02/18/11, pages 268-275.
11. Internal Medicine Associates of Greenville, 04/28/10 -02/17/11, pages 276-314.
12. NHC Healthcare, 2/02/11, page 315.
13. Stryker Power Pro XT, pages 316-317.
14. Laurens County Emergency Medical Services, 02/26/11, pages 318-319.

Exhibits

1. Deposition transcript of Dr. Jon M. Bittrick.
2. Deposition transcript of Dr. W. Travis Ellison

STATEMENT OF THE CASE

Claimant alleges he suffered a heart attack that was a work-related compensable injury arising out of and in the course of his employment with Defendant Laurens County on February 26, 2011. Defendants deny Claimant suffered a compensable injury by accident arising out of and in the course of employment and further deny Claimant's heart attack was induced by an unexpected strain or overexertion of the performance of his duties of employment or by an unusual or extraordinary condition in his employment.

The primary question in this case is whether the event of February 26, 2011 triggered Claimant's heart attack.

EVIDENCE OF THE CASE

Claimant is 54 years old and is an EMT with Laurens County EMS. On February 26, 2011, while on duty, he and a fellow co-worker, Mike Lundis ("Lundis"), were called to National Health Care of Clinton to attend to a patient who was in respiratory distress. (T.R., pp. 17-18, 20, 32). Claimant described the patient as a "very large individual" estimated to be over 6-and-a-half feet tall because his body extended beyond the end of the stretcher which is 76.5 inches long, according to the manufacturer's measurements. (See APA #13, p. 316) (T.R., pp. 33-34). Claimant estimated the patient weighed between 400 and 500 pounds, but conceded he had no ability to determine the actual weight on the subject date. (T.R., p. 69). Lundis agreed the patient was "larger than [the] average sized patient" and estimated the patient weighed approximately 350 pounds, if not more. (T.R., p. 85, 87-88) (APA #14, p. 318). Both Claimant and Lundis believe the patient was larger than their 325-pound, 6-foot-1-inch, co-worker Magistrate Earnest Michael O'Brien, Sr. ("O'Brien"). (T.R., p. 33, 88, 114).

Claimant testified, upon arrival, the patient was gasping and in severe respiratory distress. (T.R., p. 32). Lundis confirmed the patient was in respiratory distress with swelling in his legs and fluid in his lungs. (T.R., p. 89). In a typical case involving the transport of an obese or otherwise large, heavy individual, the EMTs would request assistance from local Fire Department personnel. (T.R., pp. 39-40, 86-87). In this instance, however, Claimant and Lundis had to lift the patient without assistance, moving him from the bed onto the stretcher due to his dire condition. (T.R., pp. 32, 40, 90).

Claimant testified when he first lifted the patient he felt a sharp pain behind his shoulder blade, as well as “heaviness” in his chest he described as “like something sitting on [his] chest.” (T.R., pp. 32, 40-41). Although Claimant and Lundis had a battery-operated stretcher (APA #13, p. 316), they had to manually lift the patient up and onto the stretcher from the bed. (T.R., p. 30). Claimant testified “really strain[ed]” to lift the patient. (T.R., p. 9). All of the witnesses testified that the patient was so large the side rails on the stretcher could not be raised, nor would the standard strap on the stretcher reach around his chest. (T.R., pp. 34-35, 85-87). Instead, a reserve 9-foot strap had to be used to secure the patient, which Claimant testified was highly unusual – having to use it approximately only 10 times out of thousands of emergency call runs in his career. (T.R., pp. 35-36). Lundis also testified it was unusual to have to use the 9-foot strap. (T.R., p. 104). Claimant estimated he had only encountered a patient of this size 2 or 3 times in his career with Laurens County. (T.R., p. 39). In those other instances, however, there was time to wait for additional assistance to help lift the patient. (T.R., p. 39).

Claimant testified he continued to experience “heaviness [in his chest] and difficulty breathing” when moving the patient on the stretcher over the carpeted floors from the nursing home to the truck and, again, when lifting the patient into and out of the truck. (T.R., p. 41). When they arrived at the hospital and while transferring the patient from stretcher to bed, Claimant was sweating profusely and was still experiencing pain behind his shoulder blade and “heaviness” in his chest. (T.R., p. 41). Once the transport was completed, Claimant informed Lundis he felt like he was having flu-like symptoms. (T.R., p. 46). Lundis testified he noticed Claimant was having an unusual amount of difficulty and was exhibiting some distress at that point in time. (T.R., p. 91).

After returning to the station, Lundis monitored Claimant and measured the rate and regularity of his heartbeats with an EKG machine because Claimant was still complaining of “heaviness” in his chest and was severely sweating. (T.R., p. 46, 91-92). Lundis is an EMT paramedic who is, amongst other things, qualified to perform cardiac monitoring, including, but not limited to, reading EKG strips. (T.R., p. 80-81). Lundis testified the results of the EKG, while not conclusive, indicated some problem with the heart that is usually indicative of a myocardial infarction or heart attack. (T.R., p. 94) (See Claimant’s Exh. 1). Lundis testified Claimant told him that day he was experiencing tightness in his chest. (T.R., p. 92). Indeed, Lundis filled out a report based upon Claimant’s complaints and his own observations listing Claimant’s symptoms as “cardiac chest pain, pressure, tightness, respiratory dysthymia.” (T.R., p. 93) (APA #1, pp. 4-6).

Lundis and O’Brien advised Claimant to go to the hospital. (T.R., p. 46, 92). Claimant understood there was something wrong with the EKG strip and with his heart. (T.R., pp. 46-47); (See APA #1, p. 2). Lundis and O’Brien then transported Claimant to Greenville Memorial Hospital. (T.R., pp. 48-49). It is undisputed Claimant suffered a myocardial infarction on February 26, 2011. Claimant’s supervisor on duty, Doug Maynard, was informed by Lundis and O’Brien that Claimant had suffered a heart attack. (T.R., p. 57). Claimant contends his heart attack was caused by the aforementioned events that included overexertion and unusual strain.

Prior to the date of accident, Claimant was treated for diabetes, which his employer was aware. (T.R., pp. 20-21, 58). Approximately eight months prior to the accident, Claimant was hospitalized briefly due to a foot injury. (T.R., p. 21). During this

hospitalization, Claimant testified he had blood work done and an EKG, but was not found to be at risk for the surgery he underwent. (T.R., p. 21).

Claimant contends his heart attack is a compensable accident because it was induced by an unexpected strain or overexertion in the performance of his duties or employment, or by unusual ordinary conditions of the employment. See Walker v. City of Columbia, 247 S.C. 241, 246, 146 S.E.2d 856 (1966) (“[T]he right to compensation in [a heart attack] case is not affected by the fact that a pre-existing pathology may have been a contributing factor, or by the fact that the unusual or excessive strain that precipitated the heart attack occurred while the employee was performing work of the same general type as that in which he was regularly involved.”).

As a result of his heart attack, Claimant is now prescribed four medications he was not taking before the accident, including Coumadin. (T.R., p. 52). He also had an implantable cardioverter defibrillator (ICD) implanted. (T.R., p. 52). Claimant was out of work due to this accident from February 26, 2011, until he returned July 2, 2011, during which time he received no workers’ compensation benefits. (T.R., pp. 53-54). He is still treating with Dr. Bittrick who sees Claimant once a month to check his medication and every three months to get his pacemaker and defibrillator analyzed. (T.R., p. 54).

Claimant requests back TTD which he is owed from February 26, 2011 to July 1, 2011, at which time he returned to work. He has scars on both of his legs and has a defibrillator. Claimant seeks compensation from Defendants for medical expenses, cost for any future medical treatment and medication, and scarring, along with any other compensation he is due as a result of this work-related injury.

FINDINGS OF FACT

IT IS FOUND AS FACT:

1. That the parties to this proceeding are subject to and bound by the provisions of the South Carolina Workers' Compensation Act, as amended, with Laurens County as the employer, South Carolina Association of Counties as the carrier, and the Claimant as the employee.

2. The South Carolina Workers' Compensation Commission has jurisdiction to hear the Claimant's claim for benefits.

3. Venue is proper in Anderson County.

4. Notice of the hearing was timely and properly served upon all parties of interest.

5. Claimant was employed by Laurens County as an EMT.

6. Claimant's stipulated average weekly wage is \$520.19 with a corresponding compensation rate of \$346.81.

7. Claimant and his partner answered a call on February 26, 2011 that required the two of them to lift and transport a very large man. (The exact size of the patient is in dispute. He weighed somewhere between 262 – 500 pounds. Based upon the testimony it is reasonable to conclude his exact weight was closer to the lower end of the foregoing range.)

8. After lifting and transporting the subject patient, Claimant presented with symptoms, including, but not limited to, cardiac chest pain, pressure, tightness, and respiratory dysthymia, that led him and other EMTs to conclude he was having a cardiac

episode and he was therefore taken to the hospital. (Claimant's Exh. 1) (APA #1, pp. 4-6).

9. Upon examination and treatment, it was determined Claimant had suffered a cardiac infarction / heart attack.

10. The event also led to the discovery Claimant suffered from pre-existing coronary artery disease.

11. Defendant Employer received timely notice under the Act of Claimant's claim.

12. Defendant Employer denied the claim and therefore Claimant has not received any workers' compensation benefits from Defendants.

13. The deposition testimony of Dr. W. Travis Ellison and Dr. John M. Bittrick are essential in determining whether or not this event triggered Claimant's heart attack.

14. While both doctors spend a great deal of time speaking in the abstract regarding events, such as the one Claimant experienced, they both reach the same conclusion – the event was a trigger in Claimant's infarction.

15. When asked to speak to a reasonable degree of medical certainty, Dr. Bittrick states, "... it is assumption at the time is that – at this current time, is that that [i.e., the overexertion in lifting and transporting a very large patient] was the precipitating factor." (The undersigned Commissioner notes defense counsel objected to the question eliciting this response on the ground the question referenced the patient's weight to be approximately 400 to 500 pounds. When Dr. Bittrick's deposition testimony is read in its

entirety, however, the exact weight of the patient is always in flux, but it is clear Dr. Bittrick understands the subject patient is a very large man.

16. Dr. Ellison's testimony is even more direct. Dr. Ellison testified as follows:

Q. But as it pertains to this particular triggering event, do you still hold your initial opinion that you gave me that this strenuous event of transferring the patient triggered his heart attack?

A. Yes, I think that's correct. It was a triggering event.

Q. And you maintain that?

A. Yes.

Q. So regardless of what he had, hyperlipidemia, diabetes, the triggering event was this particular strenuous event; wouldn't you say?

A. Yes.

(The undersigned Commissioner notes Dr. Ellison's sworn deposition testimony contradicts the conclusions – that Claimant's cardiac event could have occurred at any time – which he conveyed in a letter to defense counsel dated August 8, 2011. Dr. Ellison's sworn testimony was taken by deposition, however, on August 22, 2012, and that deposition testimony is given greater weight.)

17. The greater weight of the evidence supports the conclusion Claimant suffered a heart attack within the course and scope of his employment and that his duties were the triggering factor in the heart attack.

18. The right to compensation in a case such as this one is not affected by the fact that a pre-existing pathology may have been a contributing factor, or by the fact that the unusual or excessive strain that precipitated the heart attack occurred while the

employee was performing work of the same general type as that in which he was regularly involved. See Walker v. City of Columbia, 247 S.C. 241, 246, 146 S.E.2d 856 (1966).

19. Claimant's cardiac infarction/heart attack is a compensable injury under the Act because it was induced by an unexpected strain or overexertion in the performance of his duties or employment, or by unusual ordinary conditions of the employment.

20. Claimant is entitled to TTD for the time he was out of work from February 26, 2011 to July 2, 2011.

21. Claimant is also entitled to have all his medical expenses that are causally related covered under the Act.

22. Claimant is also entitled to reimbursement for any causally related out of pocket expenses and mileage.

23. Claimant is at MMI.

24. Claimant will continue to treat with Dr. Jon M. Bittrick.

25. All other issues are held in abeyance.

CONCLUSIONS OF LAW

Under Section 42-1-160, Defendants are subject to the provision of the South Carolina Workers Compensation Act.

1. Under Section 42-1-130, the Claimant was a covered employee.
2. Under Section 42-1-140, the employer was a covered employer.
3. Under Section 42-3-15, there was an employee/employer relationship.

4. Under Section 42-3-180, this Commission has jurisdiction over the parties to hear the issues herein.

5. Under Section 42-17-20, venue in Anderson, S.C. was proper and stipulated.

6. Under Regulation 67-607, notice of the hearing was properly served.

7. Under Section 42-1-160, Claimant suffered a compensable heart attack injury on February 26, 2011.

8. Under Section 42-1-40, Claimant's compensation rate is \$346.84 per week.

9. Under Section 42-1-60, Defendants are responsible for all causally related medical expenses allowable under the Act.

10. Under Section 42-15-60, Risinger v. Knight Textiles, 353 SC 69, 577 S.E.2d 222 (2002) and Clark v. Aiken County Gov't, 366 SC 102, 620 S.E.2d 99 (Ct. App. 2005), the Commission may order a change in the medical service.

11. Pursuant to Walker v. City of Columbia, it is a compensable accident if it is induced by an unexpected strain or overexertion in the performance of his duties or employment, or by unusual ordinary conditions of the employment. See Walker v. City of Columbia, 247 S.C. 241, 246, 146 S.E.2d 856 (1966) ("[T]he right to compensation in [a heart attack] case is not affected by the fact that a pre-existing pathology may have been a contributing factor, or by the fact that the unusual or excessive strain that precipitated the heart attack occurred while the employee was performing work of the same general type as that in which he was regularly involved.").

ORDER

NOW, THEREFORE, IT IS ORDERED that Claimant is entitled to, and Defendants are liable for, TTD for the time he was out of work from February 26, 2011 to July 2, 2011.

IT IS FURTHER ORDERED that Claimant is entitled to, and Defendants are liable for, have all his medical expenses that are causally related covered under the Act.

IT IS FURTHER ORDERED Claimant is entitled to, and Defendants are liable for, reimbursement for any causally related out of pocket expenses and mileage.

IT IS FURTHER ORDERED that Claimant is at MMI and will continue to treat with Dr. Jon M. Bittrick.

IT IS FURTHER ORDERED all other issues are held in abeyance.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Gene McCaskill

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.
November 7, 2012

By: Kellie Lindler, Administrative Assistant to Commissioner McCaskill

**Appellate Panel Decision and Order,
dated June 14, 2014**

**APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1103604**

MICHAEL PHILIP WORTHEN, EMPLOYEE,

CLAIMANT-RESPONDENT.

-VS-

LAURENS COUNTY, EMPLOYER,
AND SC ASSOCIATION OF COUNTIES SIF, CARRIER,

DEFENDANTS-APPELLANTS.

Appellate Panel Review held in
Columbia, South Carolina on April 16,
2013, per notices timely and properly
served upon all parties of interest.

Appellate Panel Decision & Order, filed
6/14, 2013.

APPEARANCES: Claimant-Respondent represented by
Monty Desai, Esquire of Greenville,
South Carolina.

Defendants-Appellants represented by
Richard B. Kale, Esquire of Willson
Jones Carter & Baxley, P.A., of
Greenville, South Carolina.

The parties were heard by Commissioner Gene McCaskill on August 14, 2012, in Anderson, South Carolina. On November 7, 2012, Commissioner McCaskill issued his Decision and Order, which contained the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

IT IS FOUND AS FACT:

1. That the parties to this proceeding are subject to and bound by the provisions of the South Carolina Workers' Compensation Act, as amended, with Laurens County as the employer, South Carolina Association of Counties as the carrier, and the Claimant as the employee.
2. The South Carolina Workers' Compensation Commission has jurisdiction to hear the Claimant's claim for benefits.
3. Venue is proper in Anderson County.
4. Notice of the hearing was timely and properly served upon all parties of interest.
5. Claimant was employed by Laurens County as an EMT.
6. Claimant's stipulated average weekly wage is \$520.19 with a corresponding compensation rate of \$346.81.
7. Claimant and his partner answered a call on February 26, 2011 that required the two of them to lift and transport a very large man. (The exact size of the patient is in dispute. He weighed somewhere between 262 – 500 pounds. Based upon the testimony it is reasonable to conclude his exact weight was closer to the lower end of the foregoing range.)
8. After lifting and transporting the subject patient, Claimant presented with symptoms, including, but not limited to, cardiac chest pain, pressure, tightness, and respiratory dysthymia, that led him and other EMTs to conclude he was having a cardiac episode and he was therefore taken to the hospital. (Claimant's Exh. 1) (APA #1, pp. 4-6).
9. Upon examination and treatment, it was determined Claimant had suffered a cardiac infarction / heart attack.
10. The event also led to the discovery Claimant suffered from pre-existing coronary artery disease.
11. Defendant Employer received timely notice under the Act of Claimant's claim.
12. Defendant Employer denied the claim and therefore Claimant has not received any workers' compensation benefits from Defendants.

13. The deposition testimony of Dr. W. Travis Ellison and Dr. John M. Bittrick are essential in determining whether or not this event triggered Claimant's heart attack.
14. While both doctors spend a great deal of time speaking in the abstract regarding events, such as the one Claimant experienced, they both reach the same conclusion – the event was a trigger in Claimant's infarction.
15. When asked to speak to a reasonable degree of medical certainty, Dr. Bittrick states, “. . . it is assumption at the time is that – at this current time, is that that [i.e., the overexertion in lifting and transporting a very large patient] was the precipitating factor.” (The undersigned Commissioner notes defense counsel objected to the question eliciting this response on the ground the question referenced the patient's weight to be approximately 400 to 500 pounds. When Dr. Bittrick's deposition testimony is read in its entirety, however, the exact weight of the patient is always in flux, but it is clear Dr. Bittrick understands the subject patient is a very large man.
16. Dr. Ellison's testimony is even more direct. Dr. Ellison testified as follows:
 - Q. But as it pertains to this particular triggering event, do you still hold your initial opinion that you gave me that this strenuous event of transferring the patient triggered his heart attack?
 - A. Yes, I think that's correct. It was a triggering event.
 - Q. And you maintain that?
 - A. Yes.
 - Q. So regardless of what he had, hyperlipidemia, diabetes, the triggering event was this particular strenuous event; wouldn't you say?
 - A. Yes.

(The undersigned Commissioner notes Dr. Ellison's sworn deposition testimony contradicts the conclusions – that Claimant's cardiac event could have occurred at any time – which he conveyed in a letter to defense counsel dated August 8, 2011. Dr. Ellison's sworn testimony was taken by deposition, however, on August 22, 2012, and that deposition testimony is given greater weight.)

17. The greater weight of the evidence supports the conclusion Claimant suffered a heart attack within the course and scope of his employment and that his duties were the triggering factor in the heart attack.
18. The right to compensation in a case such as this one is not affected by the fact that a pre-existing pathology may have been a contributing factor, or by the fact that the unusual or excessive strain

that precipitated the heart attack occurred while the employee was performing work of the same general type as that in which he was regularly involved. See Walker v. City of Columbia, 247 S.C. 241, 246, 146 S.E.2d 856 (1966).

19. Claimant's cardiac infarction/heart attack is a compensable injury under the Act because it was induced by an unexpected strain or overexertion in the performance of his duties or employment, or by unusual ordinary conditions of the employment.
20. Claimant is entitled to TTD for the time he was out of work from February 26, 2011 to July 2, 2011.
21. Claimant is also entitled to have all his medical expenses that are causally related covered under the Act.
22. Claimant is also entitled to reimbursement for any causally related out of pocket expenses and mileage.
23. Claimant is at MMI.
24. Claimant will continue to treat with Dr. Jon M. Bittrick.
25. All other issues are held in abeyance.

CONCLUSIONS OF LAW

Under Section 42-1-160, Defendants are subject to the provision of the South Carolina Workers Compensation Act.

1. Under Section 42-1-130, the Claimant was a covered employee.
2. Under Section 42-1-140, the employer was a covered employer.
3. Under Section 42-3-15, there was an employee/employer relationship.
4. Under Section 42-3-180, this Commission has jurisdiction over the parties to hear the issues herein.
5. Under Section 42-17-20, venue in Anderson, S.C. was proper and stipulated.
6. Under Regulation 67-607, notice of the hearing was properly served.
7. Under Section 42-1-160, Claimant suffered a compensable heart attack injury on February 26, 2011.
8. Under Section 42-1-40, Claimant's compensation rate is \$346.84 per week.
9. Under Section 42-1-60, Defendants are responsible for all causally related medical expenses allowable under the Act.
10. Under Section 42-15-60, Risinger v. Knight Textiles, 353 SC 69, 577 S.E.2d 222 (2002) and Clark v. Aiken County Gov't, 366 SC 102, 620 S.E.2d 99 (Ct. App. 2005), the Commission may order a change in the medical service.

11. Pursuant to Walker v. City of Columbia, it is a compensable accident if it is induced by an unexpected strain or overexertion in the performance of his duties or employment, or by unusual ordinary conditions of the employment. See Walker v. City of Columbia, 247 S.C. 241, 246, 146 S.E.2d 856 (1966) ("[T]he right to compensation in [a heart attack] case is not affected by the fact that a pre-existing pathology may have been a contributing factor, or by the fact that the unusual or excessive strain that precipitated the heart attack occurred while the employee was performing work of the same general type as that in which he was regularly involved.").

ORDER

NOW, THEREFORE, IT IS ORDERED that Claimant is entitled to, and Defendants are liable for, TTD for the time he was out of work from February 26, 2011 to July 2, 2011.

IT IS FURTHER ORDERED that Claimant is entitled to, and Defendants are liable for, have all his medical expenses that are causally related covered under the Act.

IT IS FURTHER ORDERED Claimant is entitled to, and Defendants are liable for, reimbursement for any causally related out of pocket expenses and mileage.

IT IS FURTHER ORDERED that Claimant is at MMI and will continue to treat with Dr. Jon M. Bittrick.

IT IS FURTHER ORDERED all other issues are held in abeyance.

IT IS SO ORDERED.

Within the statutory period, Counsel for Defendants filed an application for review in the case setting forth Defendants' grounds for review, copies of which were furnished to all interested parties prior to oral argument presented before the Appellate Panel on April 16, 2013.

By appeal, Defendants submitted the following grounds for review:

1. That the Hearing Commissioner erred in finding and concluding that Claimant suffered a myocardial infarction/heart attack within the course and scope of his employment, that error being that such finding was not supported by the greater weight of the evidence.
2. That the Hearing Commissioner erred in finding and concluding that Claimant's myocardial infarction/heart attack was induced by an "unexpected strain or overexertion" in the performance of his duties of employment, that error being that such finding and conclusion was not supported by the greater weight of the evidence.
3. That the Hearing Commissioner erred in finding and concluding that Claimant's myocardial infarction/heart attack was induced by an

unusual or extraordinary condition of employment, that error being that such finding and conclusion was not supported by the greater weight of the evidence.

4. That the Hearing Commissioner erred in failing to find that the patient's weight was 262 pounds, that error being that such finding was supported by the greater weight of the evidence.
5. That the Hearing Commissioner erred in failing to make a specific finding as to the patient's weight, that error being that such finding was necessary in determining whether Claimant's heart attack was due to an unexpected strain or overexertion.
6. That the Hearing Commissioner erred in finding and concluding that lifting a patient weighing 262 pounds was an unexpected strain or overexertion, that error being that such finding was not supported by the greater weight of the evidence.
7. That the Hearing Commissioner erred in finding that lifting a patient that weighed 262 pounds was an unusual or extraordinary condition of employment, that error being that such finding was not supported by the greater weight of the evidence.
8. That the Hearing Commissioner erred in finding that Claimant was entitled to have all of his medical expenses paid under the Workers' Compensation Act, that error being that Claimant's coronary artery bypass surgery performed on March 2, 2011 was the result of the Claimant's preexisting severe coronary artery disease and not the result of his myocardial infarction/heart attack on February 27, 2011.
9. That the Hearing Commissioner erred in failing to find that the Claimant's coronary artery bypass surgery was the result of his preexisting severe coronary artery disease and not his myocardial infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.
10. That the Hearing Commissioner erred in failing to find that Claimant's bypass surgery was not a result of his myocardial infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.
11. That the Hearing Commissioner erred in failing to find that the Claimant's need for bypass surgery was the result of his preexisting coronary artery disease, that error being that such finding was supported by the greater weight of the evidence.
12. That the Hearing Commissioner erred in not finding that Claimant's coronary artery bypass surgery would have been required even if Claimant had not had his myocardial infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.

13. That the Hearing Commissioner erred in failing to find that Claimant's need for an implantable cardiac defibrillator was the result of his having undergone coronary artery bypass surgery, that error being that such finding was supported by the greater weight of the evidence.
14. That the Hearing Commissioner erred in finding that Claimant was entitled to temporary total disability compensation from February 26, 2011 to July 2, 2011, that error being that Claimant's absence from work from March 2, 2011 to July 2, 2011 was the result of having undergone a coronary artery bypass surgery, not his myocardial infarction/heart attack.
15. That the Hearing Commissioner erred in finding that Claimant was entitled to reimbursement for any causally related out-of-pocket expenses and mileage, that error being that the greater weight of the evidence established that Claimant's out-of-pocket medical expenses and mileage were the result of his coronary artery bypass surgery and not an injury by accident as a result of any work related injury.
16. That the Hearing Commissioner erred in concluding as a matter of law that Claimant's heart attack was compensable under Section 42-1-160, S.C. Code Ann. (1976), that error being that the greater weight of the evidence did not establish that Claimant's heart attack was the result of an unusual strain or overexertion or an unusual or extraordinary condition of employment.
17. That the Hearing Commissioner erred in concluding as a matter of law that Defendants were responsible for all causally related medical expenses under Section 42-1-160, S.C. Code Ann. (1976), that error being that Claimant's medical expenses were not the result of a myocardial infarction but the result of preexisting severe coronary artery disease.
18. That the Hearing Commissioner erred in ordering Defendants to pay Claimant temporary total disability compensation from February 26, 2011 to July 2, 2011, that error being that Claimant's missed time from work was not the result of an injury by accident arising out of and in the course of his employment.
19. That the Hearing Commissioner erred in ordering Defendants to pay Claimant's causally related medical expenses, that error being that Claimant's medical expenses were not the result of an injury by accident arising out of and in the course of employment.
20. That the Hearing Commissioner erred in ordering Defendants to reimburse the Claimant for causally related out-of-pocket expenses and mileage, that error being that Claimant's out-of-pocket expenses and mileage were not the result of an injury by accident arising out of and in the course of employment.

All proffered testimony has been taken. Such, together with all documentary evidence, was delivered by oral argument to the individual members of the Appellate Panel on April 16, 2013 and has since been under study and consideration.

In an appellate review, the Appellate Panel shall, pursuant to S.C. Code Ann. Section 42-17-50 (1985), review the Award, weigh the evidence as presented at the initial hearing, and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner. After careful review in the instant case, the Appellate Panel, by unanimous vote, has determined that the Decision and Order of the Hearing Commissioner was based on error, and thus, shall be REVERSED in its entirety. Accordingly, the Appellate Panel makes the following Findings of Fact, Conclusions of Law, and Order, which shall become, and hereby are, the law of the case.

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Laurens County as the employer and S.C. Association of Counties SIF, as the carrier.
2. That Claimant's average weekly wage was \$520.19, making the compensation rate of \$346.81 applicable in this case.
3. That Claimant was hired by Laurens County as an Emergency Medical Technician ("EMT") in September of 2007, and was working as an EMT for Laurens County at the time of his alleged accident on February 26, 2011.
4. That Claimant specifically alleges that he sustained a heart attack arising out of and in the course of his employment on February 26, 2011 as a result of an unusual or excessive strain and/or an unusual and extraordinary condition in his employment.

5. That prior to February 26, 2011, Claimant suffered from Type II diabetes mellitus, hyperlipidemia, hypothyroidism, hypertension, and obesity. Claimant also had a history of tobacco abuse, smoking approximately a pack and a half per day for twelve years before quitting in the 1970s. This finding is supported by the medical records of Internal Medicine Associates of Greenville.

6. That Claimant's father suffered from coronary artery disease, had a myocardial infarction in his 40s, and died at age 54 as a result of a myocardial infarction. This finding is based on the medical records from Greenville Memorial Hospital.

7. That at the time of his alleged accident on February 26, 2011, Claimant was 54 years old, weighed 275 pounds, and was 6'2" tall. This finding is supported by the medical records from Greenville Memorial Hospital.

8. That Claimant was required as a part of his job as an EMT for Laurens County to respond to medical calls, to provide patients with treatment, and to transport patients to the hospital for further treatment. Claimant's job duties also required him to lift patients when transferring them onto a stretcher and to lift patients that are secured on stretchers when putting them in and taking them out of an ambulance. This finding is supported by Claimant's testimony.

9. That at approximately 10:00 p.m. on February 26, 2011, Claimant and his partner, Mike Lundis, responded to a call from National Health Care of Clinton ("NHC") to attend to a patient in respiratory distress, and upon arrival, Claimant and his partner determined that the patient needed to be transported to the hospital for further treatment. This finding is based on the Claimant's testimony.

10. That in order to transfer the patient to the stretcher, Claimant reached under the patient's arms, grabbed the patient's wrists, and lifted, while his partner simultaneously grabbed the patient's lower extremities and lifted. After placing the patient on the stretcher, Claimant and

his partner wheeled the patient to the ambulance, placed the stretcher in the ambulance, and transported him to the hospital. When they arrived at the hospital, Claimant and his partner removed the stretcher from the ambulance, wheeled the patient into the hospital, and transferred the patient onto a hospital bed. This finding is based on Claimant's testimony and Mr. Lundis's testimony.

11. That Claimant testified he felt a sharp pain behind his shoulder blade and "heaviness" in his chest when he initially lifted the patient and that he continued experiencing these symptoms when he arrived at the hospital and transferred the patient onto a hospital bed. This finding is based on Claimant's testimony.

12. That it was Claimant's "guesstimation" that the patient he and his partner were tending to on February 26, 2011 weighed between 400 and 500 pounds. This finding is based on Claimant's testimony.

13. That Mr. Lundis "guessed" that the patient in question weighed 350 pounds or more. This finding is based on Mr. Lundis's testimony.

14. That the patient that Claimant and his partner were tending was 6'2" tall and weighed approximately 262 pounds. While there were several guesses and estimates in the record as to the patient's weight (ranging from 350 pounds to 500 pounds), the patient was never actually weighed on February 26, 2011. Thus, we find that the most reliable and probative evidence of the patient's weight on February 26, 2011, was the patient's chart from NHC, dated February 2, 2011, which specifically indicated that the patient was 74 inches tall and weighed 262 pounds based "on [the] most recent measure in last 30 days." (See Defendants' APA #12, p. 315). The patient's chart from NHC, dated February 2, 2011, *less than one month before Claimant's alleged accident*, was the only objective measurement of the patient's weight in the record, and we give great weight to this evidence. This finding is based on the evidence in the record as a whole.

15. That after transporting the patient to the hospital, Claimant complained of pain, pressure, and tightness in his chest, and he was subsequently taken to Greenville Memorial Hospital. This finding is based on Claimant's testimony, Mr. Lundis's testimony, and the medical records of Greenville Memorial Hospital.

16. That upon arrival at Greenville Memorial Hospital, Claimant underwent several tests, including an EKG, which revealed "severe global hypokinesis of the left ventricle" with an estimated injection fraction of 30-35%, and it was subsequently determined that Claimant had suffered an acute myocardial infarction/heart attack. This finding is supported by the medical records from Greenville Memorial Hospital.

17. That on February 27, 2011, Dr. Charles Ross performed a cardiac catheterization on Claimant, opined that Claimant "had extreme coronary disease" with three vessel total occlusion, and recommended a surgical consultation. (See Defendants' APA #8, pp. 246-247).

18. That Claimant was seen by Dr. Barry R. Davis for a surgical consultation on February 28, 2011, and following his examination, Dr. Davis diagnosed Claimant with "significant multi-vessel coronary artery disease with decreased left ventricular function" and recommended and scheduled Claimant for "coronary artery bypass grafting with possible left ventricular aneurysmorrhaphy." (See Claimant's APA #2, pp.32-34).

19. That on March 2, 2011, Claimant underwent quadruple bypass surgery. (See Claimant's APA #2, pp.37-39).

20. That Claimant had several risk factors for developing coronary artery disease, including diabetes mellitus, hyperlipidemia/high cholesterol, history of smoking, and a family history of coronary artery disease. This finding is supported by the deposition testimony of Dr. Jon M. Bittrick, Claimant's treating cardiologist.

21. That Claimant suffered from severe coronary artery disease prior to his heart attack on February 26, 2011. This finding is based on the evidence in the record as a whole, including but not limited to, the deposition testimony of Dr. Bittrick, the deposition testimony of Dr. Travis W. Ellison, and the medical records from Greenville Memorial Hospital.

22. That Claimant's need for quadruple bypass surgery on March 2, 2011 was due to his severe, preexisting coronary artery disease, and not due to his heart attack on February 26, 2011. Dr. Bittrick testified that the reason for Claimant's quadruple bypass surgery was to treat Claimant's preexisting coronary artery disease. Dr. Bittrick specifically testified that the purpose of the quadruple bypass surgery was to correct the blood flow problem that Claimant had from the coronary artery disease and that Claimant would have needed the quadruple bypass surgery even if he had not had the myocardial infarction/heart attack on February 26, 2011. Additionally, Dr. Ellison also testified that Claimant's quadruple bypass surgery was to treat his preexisting coronary artery disease and that Claimant would have needed the surgery even if he had not had a heart attack on February 26, 2011. This finding is based on the evidence in the record as a whole.

23. That as a result of his quadruple bypass surgery, Claimant was out of work from February 27, 2011 through July 1, 2011. Claimant returned to work without restrictions as an EMT for Laurens County on July 2, 2011. That Claimant's lost time was a direct result of his quadruple bypass surgery, and not due to his heart attack. This finding is based on the evidence in the record as a whole.

24. That Claimant has responded to thousands of calls as an EMT for Laurens County, and he would "frequently" treat and transport patients that weighed 250-260 pounds. This finding is based on Claimant's testimony.

25. That the act of lifting and transporting a patient weighing approximately 262 pounds, with his partner, was not an unexpected strain or overexertion in the performance of the

duties of Claimant's employment as an EMT for Laurens County. This finding is based on the evidence in the record as a whole.

26. That the act of lifting and transporting a patient weighing approximately 262 pounds, with his partner, was not an unusual or extraordinary condition of Claimant's employment as an EMT for Laurens County. This finding is based on the evidence in the record as a whole.

27. That Claimant has failed to prove by a preponderance of the credible, reliable, and probative evidence that his heart attack on February 26, 2011 was either (1) the result of an unusual strain or overexertion in the performance of his duties as an EMT for Laurens County or (2) the result of an unusual or extraordinary condition of his employment as an EMT for Laurens County. This finding is based on the evidence in the record as a whole.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under Section 42-1-130, S.C. Code Ann. (1976), Michael Phillip Worthen was a covered employee at the time in question, and under Section 42-1-140, S.C. Code Ann. (1976), Laurens County was a covered employer.

2. Under Section 42-1-160, S.C. Code Ann. (1976), Claimant did not sustain an injury by accident arising out of and in the course of his employment with Laurens County.

ORDER

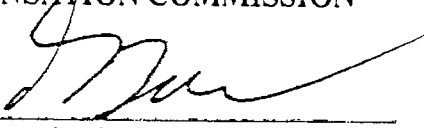
IT IS, THEREFORE, ORDERED that the Order of the Single Commissioner filed in the above-captioned matter on November 7, 2012, is hereby REVERSED by the Appellate Panel.

IT IS FURTHER ORDERED that Claimant's claim for benefits under the South Carolina Workers' Compensation Act be, and hereby is, denied.

No hearing costs are assessed in this instance.

IT IS SO ORDERED.

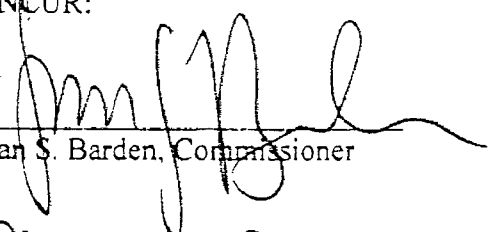
**SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION**

BY: 

T. Scott Beck, Commissioner

REVERSED

CONCUR:


Susan S. Barden, Commissioner


Melody L. James, Commissioner

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Valerie Deller on June 14, 2013

**Appellant's Form 50,
dated June 22, 2012**



AMENDED

Claimant's Name: Mike Worthen SSN: _____ Employer's Name: Laurens County
Address: _____ Address: P.O. Box 445
☐ _____
City: Simpsonville State: SC Zip: 29680 City: Laurens State: SC Zip: 29360
Home Phone: _____ Work Phone: () Insurance Carrier: SC Association of Counties SIF
Preparer's Name: Monty Desai Law Firm: The Carolina Law Group Preparer's Phone #: _____

Complete each information blank. To request a hearing, check Box 13b., indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

- 1a. The claimant sustained an accidental injury to Heart Attack, both lower extremities from surgery (Part of Body Hurt) on 02/26/2011 (m/d/yyyy) in
1b. Laurens County, State of South Carolina.
Briefly describe how the accident occurred. Claimant was helping lift a 400 to 450 pound patient several times and felt pain in chest and could not catch his breath.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on 02/26/11 (Month Day Year) in the following manner:
Verbally to Doug Maynard

- ☒ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for: _____
☒ (b) additional medical examination and treatment for: Heart Attack, both lower extremities from surgery
- ☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
TBD
- ☒ 8. Due to the injury, the claimant has permanent disability of the following nature and extent (check one):
☐ (1) General Disability: ☐ Total ☒ (2) Specific Disability: ☐ Total ☒ Partial
Body part(s) affected are: Heart Attack, both lower extremities from surgery
- ☒ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of
TBD
- 10a. At the time of the injury, the claimant was paid weekly wages of \$500.00, and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident:
none
- 11a. Further grounds of claim: TBD
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident:
See attachment
- 11c. To the best of your knowledge, did you have any prior permanent disability? No
If yes, describe: _____
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☐ 13a. I am filing a claim. I am not requesting a hearing at this time.
- ☒ 13b. I am requesting a hearing. A \$25 fee is required.

Signature of Claimant/Representative

June 22, 2012
Date (m/d/yyyy)

Refer to R.67-205 and R.67-206 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.

Greenville Memorial Hospital
701 Grove Road
Greenville, SC 29605
864-455-7000

Carolina Cardiology
877 W Faris Rd # B
Greenville, SC 29605-4296
(864) 455-6900

Dr. Barry R. Davis
890 W Faris Road # 550
Greenville, SC 29605-4286
(864) 455-6800

Internal Medicine Associates
1025 Verdae Boulevard
Greenville, SC 29607
tele: 864.242.4683
fax: 864.240.8104

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1103604

Hier File # 58-232221

Carrier Code #

Employer FEIN 576000372

Michael Worthen

Claimant's Name

SSN

Laurens County

Employer's Name

Address

City

State

Zip

Address

City

State

Zip

Home Phone

Work Phone

S.C. Association Of Counties SIF

Insurance Carrier

Richard B. Kale, Jr.

Preparer's Name

Phone #

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.

The employer-insurance carrier in answer to the claim, respectfully shows:

1. It is (denied) that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: Deny that Claimant's heart attack was the result of an injury by accident arising out of and in the course of his employment; See #11
2. It is (admitted) that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: But see #1
3. It is (admitted) that the relationship of employer and employee existed at the time in question. The reasons for denial are: But see #1
4. It is (denied) that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: See #1 and #11
5. It is (denied) that notice of injury was given the employer. The reasons for denial are: See #1 and #11
6. It is (denied) that the employee needs or is entitled to additional medical care as a result of injury. The reasons for denial are: See #1 and #11; No medical evidence.
7. It is (denied) that the employee is entitled to temporary total disability for the period(s) of: _____
8. It is (denied) that the employee is permanently disabled. The reasons for denial are: See #1 and #11; No medical evidence.
9. It is (denied) that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of \$ 520.19 applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: Cooper v. McDevitt & Street, if applicable. Defendants reserve the right to amend.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Monty Desai, Esquire,

Name

PO Box 5192, Greenville, SC 29606 and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202

Address

on the 27th day of June, 2012 by ☒ first class mail; ☐ personal service; ☐ certified mail.

I verify the contents of this form are accurate and true to the best of my knowledge.

Richard B. Kale, Jr.
Preparer's Signature, Attorney for Defendants

Richard B. Kale, Jr.

Willson Jones Carter & Baxley, P.A.

872 S. Pleasantburg Drive

Greenville, SC 29607

Jane C. Watkins
Jane C. Watkins, Certifier

June 27, 2012

Date

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

**Respondents' Form 51,
dated June 27, 2012**

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1103604
Carrier File # 58-232221
Carrier Code #
Employer FEIN 576000372

Michael Philip Worthen				Laurens County					
Claimant's Name				Employer's Name					
SSN									
Address		City	State	Zip	Address		City	State	Zip
Home Phone		Work Phone			South Carolina Association of Counties SIF		Insurance Carrier		
		Richard B. Kale, Jr.					Phone #		
		Preparer's Name					Phone #		

Request for Commission Review by ☐ claimant ☒ employer (check one) Date of injury: 2/27/2011

The undersigned makes application for review of the findings of the Commissioner in the above captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages, if necessary).

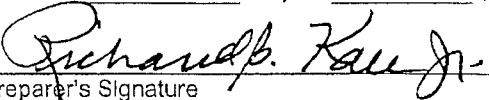
SEE ATTACHED

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that X I have served this document pursuant to R.67-211 by delivering a copy to Monty Desai, Esquire
Name

P.O. Box 5192, Greenville, SC 29606; and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202-1715
Address

on the 13th day of November, 2012 by ☒ first class mail; ☐ personal service; ☐ certified mail.


Preparer's Signature

Attorney for Defendants
Title

November 13, 2012
Date

Richard B. Kale, Jr.
Willson Jones Carter & Baxley, P.A.
872 S. Pleasantburg Drive
Greenville, SC 29607

Check this box if you are not represented by an attorney. ☐

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701 B. Otherwise, file the original and 4 copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

**Respondents' Form 30,
dated November 13, 2012**

GROUND FOR REVIEW

1. That the Hearing Commissioner erred in finding and concluding that Claimant suffered a myocardial infarction/heart attack within the course and scope of his employment, that error being that such finding was not supported by the greater weight of the evidence.
2. That the Hearing Commissioner erred in finding and concluding that Claimant's myocardial infarction/heart attack was induced by an "unexpected strain or overexertion" in the performance of his duties of employment, that error being that such finding and conclusion was not supported by the greater weight of the evidence.
3. That the Hearing Commissioner erred in finding and concluding that Claimant's myocardial infarction/heart attack was induced by an unusual or extraordinary condition of employment, that error being that such finding and conclusion was not supported by the greater weight of the evidence.
4. That the Hearing Commissioner erred in failing to find that the patient's weight was 262 pounds, that error being that such finding was supported by the greater weight of the evidence.
5. That the Hearing Commissioner erred in failing to make a specific finding as to the patient's weight, that error being that such finding was necessary in determining whether Claimant's heart attack was due to an unexpected strain or overexertion.
6. That the Hearing Commissioner erred in finding and concluding that lifting a patient weighing 262 pounds was an unexpected strain or overexertion, that error being that such finding was not supported by the greater weight of the evidence.
7. That the Hearing Commissioner erred in finding that lifting a patient that weighed 262 pounds was an unusual or extraordinary condition of employment, that error being that such finding was not supported by the greater weight of the evidence.
8. That the Hearing Commissioner erred in finding that Claimant was entitled to have all of his medical expenses paid under the Workers' Compensation Act, that error being that Claimant's coronary artery bypass surgery performed on March 2, 2011 was the result of the Claimant's preexisting severe coronary artery disease and not the result of his myocardial infarction/heart attack on February 27, 2011.
9. That the Hearing Commissioner erred in failing to find that the Claimant's coronary artery bypass surgery was the result of his preexisting severe coronary artery disease and not his myocardial infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.
10. That the Hearing Commissioner erred in failing to find that Claimant's bypass surgery was not a result of his myocardial infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.
11. That the Hearing Commissioner erred in failing to find that the Claimant's need for bypass surgery was the result of his preexisting coronary artery disease, that error being that such finding was supported by the greater weight of the evidence.
12. That the Hearing Commissioner erred in not finding that Claimant's coronary artery bypass surgery would have been required even if Claimant had not had his myocardial

infarction/heart attack, that error being that such finding was supported by the greater weight of the evidence.

13. That the Hearing Commissioner erred in failing to find that Claimant's need for an implantable cardiac defibrillator was the result of his having undergone coronary artery bypass surgery, that error being that such finding was supported by the greater weight of the evidence.
14. That the Hearing Commissioner erred in finding that Claimant was entitled to temporary total disability compensation from February 26, 2011 to July 2, 2011, that error being that Claimant's absence from work from March 2, 2011 to July 2, 2011 was the result of having undergone a coronary artery bypass surgery, not his myocardial infarction/heart attack.
15. That the Hearing Commissioner erred in finding that Claimant was entitled to reimbursement for any causally related out-of-pocket expenses and mileage, that error being that the greater weight of the evidence established that Claimant's out-of-pocket medical expenses and mileage were the result of his coronary artery bypass surgery and not an injury by accident as a result of any work related injury.
16. That the Hearing Commissioner erred in concluding as a matter of law that Claimant's heart attack was compensable under Section 42-1-160, S.C. Code Ann. (1976), that error being that the greater weight of the evidence did not establish that Claimant's heart attack was the result of an unusual strain or overexertion or an unusual or extraordinary condition of employment.
17. That the Hearing Commissioner erred in concluding as a matter of law that Defendants were responsible for all causally related medical expenses under Section 42-1-160, S.C. Code Ann. (1976), that error being that Claimant's medical expenses were not the result of a myocardial infarction but the result of preexisting severe coronary artery disease.
18. That the Hearing Commissioner erred in ordering Defendants to pay Claimant temporary total disability compensation from February 26, 2011 to July 2, 2011, that error being that Claimant's missed time from work was not the result of an injury by accident arising out of and in the course of his employment.
19. That the Hearing Commissioner erred in ordering Defendants to pay Claimant's causally related medical expenses, that error being that Claimant's medical expenses were not the result of an injury by accident arising out of and in the course of employment.
20. That the Hearing Commissioner erred in ordering Defendants to reimburse the Claimant for causally related out-of-pocket expenses and mileage, that error being that Claimant's out-of-pocket expenses and mileage were not the result of an injury by accident arising out of and in the course of employment.

**Appellant's Notice of Appeal,
dated July 10, 2013**

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Appellate Panel
T. Scott Beck, Commissioner

WCC File No. 1103604

Michael Philip Worthen,
Employee,

Appellant,

v.

Laurens County, Employer,
And SC Association of
Counties SIF, Carrier,

Respondents.

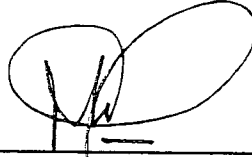
NOTICE OF APPEAL

Michael Philip Worthen appeals the decision and order of the Honorable T. Scott Beck and the South Carolina Workers' Compensation Commission Appellate Panel (hereinafter, "The Commission"), dated June 14, 2013. Appellant received a copy of this decision on June 14, 2013, which is being appealed on the following grounds and alleged errors of law:

- I. The Commission erred in finding and concluding Appellant did not sustain an injury by accident arising out of and in the course of his employment with Respondent Employer on February 26, 2011.

- II. Substantial rights of Appellant have been prejudiced because the Commission's findings, inferences, conclusions, and decision were clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.
- III. Substantial rights of Appellant have been prejudiced because the Commission's findings, inferences, conclusions, and decision were arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.
- IV. The Commission's decision and order is unsupported by substantial evidence.
- V. The Commission erred in failing to find Appellant's myocardial infarction/heart attack was induced by unexpected strain or overexertion in the performance of the duties of his employment and/or by unusual and extraordinary conditions of employment.
- VI. The Commission erred in failing to find Appellant's defibrillator implantation and coronary artery bypass surgery were causally related to the heart attack Appellant sustained on February 26, 2011.
- VII. The Commission erred in failing to find Appellant's lost time from work was a result of his heart attack.

July 10, 2013



Monty D. Desai (S.C. Bar No. 73967)
monty@thecarolinallawgroup.com
J. Matthew Whitehead (S.C. Bar No. 73803)
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Other Counsel of Record:

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WILSON JONES CARTER & BAXLEY, P.A.
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Greenville, South Carolina 29607
(864) 527-3280
(864) 235-6015 (fax)

Attorney for Respondents

**Transcript of Single
Commissioner Hearing
held on August 14, 2012**

Mike Worthen,
Claimant,
vs.
Laurens County, Employer,
and
South Carolina Association of
Counties, Carrier,
Defendants.

This hearing was held before Commissioner Gene McCaskill, reported by Kimberly T. Power, Court Reporter and Notary Public in and for the State of South Carolina; said proceedings were held at the South Carolina Workers' Compensation Commission, 100 North Main Street, Anderson County Court House, Anderson, South Carolina, on Tuesday, August 14, 2012.

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1 THE COURT: Today's date is August 14, 2012.
2 This is the case of Mike Worthen vs. Laurens County. The
3 Workers' Compensation Commission File Number is 1103604.
4 The claimant is represented by Monty Desai. The
5 carrier/employer is represented by Richard B. Kale, Jr.
6 The carrier is South Carolina Association of Counties.
7 They are self-insured.

8 All right. The claimant's average weekly
9 wage, we did not talk about that. Is that in dispute?

10 MR. KALE: I have \$520.19 as the average
11 weekly wage with a comp rate of \$346.81.

12 MR. DESAI: We do not dispute that, Your
13 Honor.

14 THE COURT: All right. The record will so
15 reflect. The date of the accident is February 26, 2011.
16 This is a denied case. Are there any objections to
17 jurisdiction, venue, or any APA submissions?

18 MR. DESAI: None from the claimant, Your
19 Honor.

20 MR. KALE: None from defense.

21 THE COURT: All right. The Commission file
22 becomes a part of the record with the exception of
23 self-serving declarations and unstipulated medical
24 reports.

25 In our pre-hearing conference, I made the

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1 decision to keep the record open for a period of 30 days
2 for the deposition of Dr. Ellison. If somebody could
3 give me his entire name.

4 MR. KALE: Travis Ellison.

5 THE COURT: Dr. Travis Ellison. And the
6 record will be left open for that reason and that reason
7 only.

8 All right. Mr. Desai, can you state your
9 client's position for the record, please?

10 MR. DESAI: Yes, Your Honor. Our position,
11 Your Honor, is that this is a work-related injury that
12 should be compensable. We believe it's compensable based
13 on Dr. Bittrick's testimony under oath, a deposition
14 which we have submitted the official transcript, Your
15 Honor. It's also based on we believe the evidence will
16 come from that stand from the witnesses that we will
17 bring forward.

18 Your Honor, the law is quite clear on heart
19 attack. The law says that if it is a compensable
20 accident, if it is induced by, one, unexpected strain or
21 overexertion in the performance of the duties of his or
22 her employment, or by unusual ordinary conditions of the
23 employment. There's a case, Your Honor, that goes
24 further and it's been stated several times, Walker vs.
25 The City of Columbia, 247 S.C. 241, where it says -- goes

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1 on -- it goes on further and says, "The right to the
2 compensation in such cases is not affected by the fact
3 that a pre-existing pathology may have been a
4 contributing factor or by the fact that the unusual or
5 excessive strain that precipitated the heart attack
6 occurred while the employee was performing work of the
7 same general type as that in which he was regularly
8 involved."

9 I think that's the case here, Your Honor. My
10 client was an EMT. He was called to National Health Care
11 Center. He responded there along with a co-worker, Mike
12 Lundis, who will testify. When they got there, the
13 testimony will show, Your Honor, I believe, he sought a
14 large male, approximately six-eight, weight is in
15 dispute -- over 400 pounds, I'll say -- who was in a
16 respiratory distress.

17 My client will testify that in a normal case,
18 they would get the fire department to help them load
19 somebody like that. However, due to the fact that it
20 was -- that the gentleman was in respiratory distress, my
21 client and his co-worker had to lift him from the bed
22 onto the stretcher, take him from the room to the
23 ambulance, and then lift him back when they brought him
24 to the hospital. After that event, my client felt pain
25 in his left scapula twice, told his co-worker that I

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1 don't feel right. As the -- thank God that they were
2 EMTs. They put -- Mr. Lundis will testify they put him
3 on an EKG machine and got a strip immediately which
4 showed an irregular heartbeat. Dr. Bittrick, I think,
5 has looked at it and has talked about the fact that it
6 was irregular.

7 Based on that, Mr. O'Brien was called in to
8 relieve my client. My client was driven to the hospital
9 by Mr. O'Brien and Mr. Lundis. And our position, quite
10 simply, Your Honor, is that this lifting this -- this
11 obese patient caused an unusual -- or overexertion,
12 unusual strain. I think Mr. Lundis and Mr. O'Brien will
13 talk about the unusual nature of a patient that size. My
14 client will testify to that as well, Your Honor.

15 We just ask for back TTD which he is owed from
16 February 26, 2011 to July 1st of 2011 at which point my
17 client was returned back to work. He is currently
18 working, Your Honor. He will testify to that.

19 MR. KALE: What was that closing date?

20 MR. DESAI: 7/1/11. He's got scars on both of
21 his legs. He's got a pacemaker, Your Honor -- a
22 defibrillator. I'm sorry, Your Honor. And we believe
23 that the defense is responsible for any cost of medicals
24 and any future meds and scarring and any other
25 compensation that my client is due as a result of this

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1 work-related injury. That's all I have.

2 THE COURT: Mr. Kale.

3 MR. KALE: May it please Your Honor. The
4 defendants deny that Mr. Worthen suffered an injury by
5 accident arising out of and in the course of employment.
6 As you are well aware, there is a different standard for
7 heart attack cases than with a regular injury by
8 accident. We further deny that the heart attack was
9 induced by an unexpected strain or overexertion of the
10 performance of his duties of employment or by an unusual
11 or extraordinary condition in his employment. We deny
12 that what Mr. Worthen was doing on February 26, 2011
13 caused his heart attack.

14 And I think it's important for you to know
15 that both Dr. Bittrick and Dr. Ellison have testified
16 that Mr. Worthen had severe pre-existing coronary heart
17 disease. In fact, a catheterization that was done on
18 February 26th, the date he had his myocardial infarction,
19 showed that he had three vessel coronary disease with
20 three vessels being totally occluded and basically with
21 that he was running on a coronary artery system that had
22 set up.

23 As I said, both Dr. Bittrick and Dr. Ellison
24 classified the pre-existing coronary disease as severe
25 and advanced. Dr. Ellison said he could have had a heart

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1 attack at any time, and we would submit it was purely
2 coincidental that it happened at the time that he was
3 working on his shift that day.

4 We have submitted -- you're going to see all
5 different types of estimates as to his weight. In the
6 APA that was submitted by Mr. Desai, he has a
7 questionnaire from Dr. Bittrick, and apparently at that
8 time the claimant told Dr. Bittrick that the patient
9 weighed 500 pounds. Then you're going to have the
10 claimant's testimony, which I think is not going to be
11 that. I think it's going to be different. I think it's
12 going to be in the 400, 450 pound range. Then you have
13 the EMS run that was prepared by Mr. Lundis that gave his
14 weight as 350 pounds. All of those are estimates.

15 The one thing that really gives you exactly
16 what the weight was is the report from National Health
17 Care which is contained at Page 315 of my APAs as APA No.
18 12; Page 315. I believe Mr. Desai said that his height
19 was something like six -- I didn't write it down --
20 six-seven or six-nine. Well, in fact, it gives his
21 height at being 74 inches which is six feet two inches,
22 and it gives his weight as being 262 pounds. And it says
23 on that chart based weight on most recent measure in last
24 30 days. So that -- that is a weight, according to the
25 report that was done by actually weighing the man rather

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1 than guessing at, you know, what weight he is.

2 Mr. Worthen has suffered for a number of years
3 from a number of different medical conditions, including
4 diabetes melitis, hyperlipidemia, hypertension. And
5 according to Dr. Ellison, these are the conditions that
6 caused his coronary artery disease.

7 The treatment that he received -- and I might
8 add when this event occurred, when Mr. Worthen picked up
9 the patient at NHC, he didn't have the traditional chest
10 pain that most heart attacks have. He had some pain
11 behind his shoulder blade that went away within a few
12 seconds. Then he transported Mr. Coon to Laurens County
13 Hospital and they -- they then transferred him from the
14 stretcher to a bed, and he said he again felt that pain.
15 But he didn't have the traditional heart pain that you
16 see with heart attack.

17 He did feel bad during this period which he
18 thought may be the flu. But what really showed that he
19 had -- was having a heart attack was they did an EKG
20 which showed that he was in the midst of having a heart
21 attack.

22 The treatment that was done was not treatment
23 for his heart attack, but to treat his coronary artery
24 disease that pre-existed. And Dr. Bittrick testified in
25 his deposition that that would have occurred regardless

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1 of whether he had had a heart attack or not. It was the
2 pure fact that he had three vessels that were totally
3 occluded. While he was at the hospital, he had an
4 incident where his heart stopped and they put a
5 defibrillator in to protect -- to prevent that from
6 happening again. That, again, is not a result of having
7 his heart attack. It's because of his pre-existing
8 disease.

9 During the period of time that Mr. Worthen was
10 out, he did receive some vacation time and sick leave.
11 So he was not without compensation all during that period
12 of time. But, again, this is basically a denied claim,
13 and we don't believe it meets the requirements of the law
14 for a heart attack to be compensable.

15 THE COURT: Mr. Desai, anything else?

16 MR. DESAI: Just briefly, Your Honor. Your
17 Honor, it's very important that Your Honor, as I am sure
18 you will, go through Dr. Bittrick's testimony.
19 Dr. Bittrick on two different occasions or at least two
20 different occasions says that there has to be a substrate
21 for this. He also says that you could have had
22 perfectly -- you could have no coronary heart disease and
23 still have a heart attack. And I'll just go to Page 25,
24 Lines 16 through 21. It says, "Are there any" -- my
25 question was, "Are there any triggering events that would

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1 cause attacks such as stress on heart muscle tissues?"

2 "There are triggers that can precipitate this.
3 Physical stress, emotional stress, extreme activity could
4 all do it."

5 He's not talking about any -- he's not
6 committing to a weight, Your Honor. He says extreme
7 activity. Your Honor, I believe that's an issue of fact.
8 I believe Your Honor is very well qualified and is well
9 within your jurisdiction to decide, Your Honor, whether a
10 man of the size that is -- the description that you're
11 going to hear from the witnesses would qualify as extreme
12 activity or not.

13 Dr. Bittrick also says on the question on Page
14 22, 17, "Would it be fair to say that the most proximate
15 cause of this heart attack was his pre-existing coronary
16 artery disease?"

17 And he says, "That was substrate for his heart
18 attack."

19 The questions are getting into very small
20 nuances and words. You have to have the substrate and
21 then you have to have some elucidating condition, and
22 that elucidating condition that he's referring to is the
23 precipitating factor -- trigger. Does it -- was there a
24 trigger there? Mr. Worthen was -- did a series of tests
25 in a pre-op which is part of the defense's APAs. Six --

1 eight months prior to that he had a foot surgery, and his
2 blood tests came out completely normal.

3 Your Honor, to say this didn't happen when all
4 of the, you know, clues point to it, I mean, if it walks
5 like a duck and it talks like a duck, Your Honor, it is a
6 duck. It happened just -- just when he was lifting this
7 unusually large man. It was a trigger enough -- the
8 symptoms were -- were very similar for all of these
9 experienced paramedics to put him on a 12 point lead to
10 get an EKG strip. To say that that's all coincidence,
11 Your Honor, is just not reasonable. And Dr. Bittrick
12 says to a reasonable degree of medical certainty, Page 8,
13 Line 4 was the question and his answer was: "Do you
14 believe to a medical degree of reasonable certainty that
15 it was activity, one of lifting a 400 to 500 pound
16 patient, that caused Mr. Worthen's heart attack?"

17 And his answer on Line 17, "My assumption at
18 that -- at the time is that this was a precipitating
19 factor."

20 Precipitating factor, Your Honor. Trigger.
21 Did this activity trigger the heart attack or not, and
22 the case law is quite clear on that. He might have had a
23 pre-existing condition. So what? That doesn't -- that
24 doesn't exclude him from getting the benefits under
25 workers' compensation laws. That -- that's not a bar to

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1 recovery under workers' compensation laws. Our courts
2 have been quite clear on that, Your Honor.

3 That's all I have, Your Honor.

4 THE COURT: Mr. Kale?

5 MR. KALE: Just a couple of things, Your
6 Honor. Mr. Desai did not read on. I asked the doctor
7 when he says substrate, what he was talking about. I
8 said, "What are you talking about with a substrate? Is
9 that the coronary artery disease?"

10 He said, "Yes, coronary artery disease."

11 So you have to have the coronary artery
12 disease before you have the plaque to rupture. Basically
13 what happens with a heart attack is somebody has coronary
14 artery disease and plaque has built up in their arteries,
15 and then you can have something that causes the plaque to
16 rupture and it releases some cholesterol into the blood
17 and that caused a blood clot which causes an occlusion
18 which causes the heart attack. And basically without the
19 coronary artery disease, you can't have that type of
20 heart attack. Now, you can have other types of heart
21 attack if somebody has a blow right to their heart, you
22 could have a heart attack that way. But this is the
23 normal way.

24 I would point out on Page 22, I asked, "And I
25 mentioned this before. The purpose of the bypass surgery

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1 was to correct the blood flow problems he had from the
2 coronary artery disease?"

3 "Yes."

4 Then I asked, "Would he have needed that
5 surgery even if he had not had the myocardial
6 infarction?"

7 Answer, "Yes."

8 So it's clear that the treatment that he
9 received was for his coronary artery disease, not for the
10 myocardial infarction.

11 As far as Dr. Bittrick's opinion on causation,
12 I would point out that when the questionnaire was sent by
13 Mr. Desai, Dr. Bittrick said, "I assumed he was a 500
14 pound patient that was lifted." The evidence, we
15 believe, is going to show that that's not the case. So
16 basically that would negate Dr. Bittrick's opinion since
17 it was based upon facts that were incorrect.

18 That's all I have.

19 MR. DESAI: Your Honor, he doesn't answer
20 under oath to the question that specifically says 400 to
21 500 pound range. More importantly it does say when that
22 surgery -- why that surgery might have been necessary.
23 In there it says -- he clearly says, "It could have been
24 ten years down the road; is that right?" And the answer
25 to that is, Yes, it could have been ten years down the

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1 road. Not today.

2 THE COURT: Anything else, Mr. Desai?

3 MR. DESAI: No, sir.

4 THE COURT: Anything else, Mr. Kale?

5 MR. KALE: No, sir.

6 THE COURT: Mr. Desai, you want to call your
7 first witness?

8 MR. DESAI: Yes, Your Honor. Your Honor, we
9 call Michael Worthen.

10 THE COURT: In just a minute I'm going to
11 swear you in. I have two requests for you. One, please
12 speak loudly enough so that both of the attorneys, this
13 young lady who is making a record of the proceeding, and
14 I can all hear you.

15 THE WITNESS: Yes, sir.

16 THE COURT: And then second is if you are
17 asked a yes or no question, please respond with yes or
18 no.

19 THE WITNESS: Yes.

20 THE COURT: Uh-huh and uh-huh get
21 misunderstood. And if you shake or nod your head,
22 especially in this configuration, she's going to have to
23 turn around to see what you're doing and then she's got
24 to enter that into the record. All that takes time. So
25 if you're asked a yes or no, please answer yes or no.

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1 THE WITNESS: Yes, sir.

2 (MICHAEL PHILIP WORTHEN, being duly sworn to
3 tell the whole truth and nothing but the truth, testified
4 as follows:)

5 THE COURT: Please state and spell your full
6 name for the record.

7 THE WITNESS: Michael Philip Worthen. Last
8 name is W-O-R-T-H-E-N. Philip is spelled P-H-I-L-I-P.
9 One L, not two.

10 THE COURT: Very good. Mr. Desai.

11 MR. DESAI: Thank you, Your Honor.

12 DIRECT EXAMINATION

13 BY MR. DESAI:

14 Q. Mr. Worthen, please state your date of birth
15 for the record.

16 A. 9/8/56.

17 MR. DESAI: And, Your Honor, if I can just
18 lead the witness through the first part here to save a
19 little bit of time if Mr. Kale has no objection to that?

20 THE COURT: Do you have any objection to that,
21 Mr. Kale?

22 MR. KALE: Not for the preliminaries about his
23 education and work history, that type.

24 BY MR. DESAI:

25 Q. You are 54 years of age; is that right?

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1 A. Yes, sir.

2 Q. And you are married to a Terri Worthen?

3 A. Yes, sir.

4 Q. And you currently work as an EMT?

5 A. Yes, sir.

6 Q. And where is it that you work?

7 A. Laurens County EMS.

8 Q. You are six-two and 254 pounds; is that right,

9 sir?

10 A. Right now I'm about 270. I've lost a good bit

11 of weight from before.

12 Q. And you are right-handed, you do have a valid

13 South Carolina driver's license, and you do drive every

14 day; is that right?

15 A. Yes, sir.

16 Q. Do you have any felony convictions in the last

17 ten years?

18 A. No, sir.

19 Q. The last grade completed was the 11th; is that

20 right?

21 A. Pardon?

22 Q. Eleventh grade was the last grade that you

23 completed?

24 A. Yes, sir. I took a GED.

25 Q. And as far as vocational schools or tech

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1 schools go, you've been to an EMT school; is that right?

2 A. Yes, sir.

3 Q. Talk about your military service. Have you
4 ever served in the military?

5 A. Yes, sir.

6 Q. Tell us about that.

7 A. I was in both the Navy and the Army. I served
8 as a medic in the Army, and I served on a SEAL team in
9 the Navy.

10 Q. What years were those?

11 A. '75 through '81, and then I was '83 to '88 in
12 the Army.

13 Q. Honorably discharged?

14 A. Yes, sir.

15 Q. And you said you were a SEAL for the United
16 States Navy; is that right?

17 A. Yes, sir.

18 Q. And were you full-time in the Army or were you
19 in Reserves?

20 A. Reserves.

21 Q. But you were full-time active duty in the U.S.
22 Navy?

23 A. Yes, sir.

24 Q. Can you read and write well?

25 A. Yes, sir.

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1 Q. Do you handle your family finances?

2 A. I'm married. No.

3 Q. Are you pretty proficient with a computer?

4 A. I get by. I'm not a genius with it.

5 Q. Let's talk about your health prior to the
6 accident. What was your general state of health before
7 this accident?

8 A. I was being treated by Dr. Gerard (phonetic),
9 internal medicine, for diabetes. And I was under
10 medication and seeing him every three months for
11 treatment of the diabetes and all my medicines and
12 everything was being adjusted to better the diabetes
13 which has continued to go down. And I was in the process
14 of losing weight to help out with the diabetes and all.

15 Q. Before we keep talking about the injury, let's
16 talk about the date of the injury. Were you injured on
17 February 26th of 2011 or February 27th? Some of the
18 records have the 27th on them.

19 A. The 26th. It's got the 27th on it because
20 that's when I -- it was after midnight when I went into
21 the hospital.

22 Q. Fair enough. So the day it's billed on is
23 over on the 27th; is that right?

24 A. Yes, sir.

25 Q. All right. Did your employer know about your

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1 prior health issues, about your diabetes, et cetera?

2 A. Yes, sir. Everybody knew I had diabetes.

3 Q. All right. Did you have any injuries prior to
4 the date of the accident?

5 A. I had had that injury on my foot back in June
6 where I had ended up in the hospital with that.

7 Q. All right. While you were in the hospital for
8 that injury, did they do any pre-op procedures -- any
9 pre-operative procedures, tests, et cetera?

10 A. Yes, sir.

11 Q. Tell us about that, please.

12 A. They did blood work and an EKG.

13 Q. Okay. What kind of blood work did they do?

14 A. To see if I was at risk for the surgery.

15 Q. Okay. And the --

16 A. I don't know what the tests were that they
17 did, but they did blood work and the EKG.

18 Q. Did they find you at risk?

19 A. No, sir.

20 MR. KALE: Your Honor, I'm going to object to
21 the hearsay.

22 BY MR. DESAI:

23 Q. Did you go through with the surgery?

24 A. Yes, sir. Two hours later.

25 Q. Have you ever taken a Department of

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1 Transportation physical or any kind of physicals like
2 that?

3 A. Yes, sir.

4 Q. Okay. Do you remember when?

5 A. When I was working at the BMW Fire Department
6 Fire and Rescue. We had to do one every year to remain
7 working with the company I was working with, Fire and
8 Rescue. I've been with Greer Fire Department just prior
9 to that when I took the -- I had to take physicals every
10 year.

11 Q. What was the reason for that?

12 A. It was because the fire service. The DOT
13 requires firemen to have the physical. I also had
14 physicals when I worked at the City of Greer Fire
15 Department.

16 Q. Did you ever have a CDL license?

17 A. Yes, sir, at one time.

18 Q. I'm just going to go through your work history
19 quickly. Please correct me if I misstate anything.
20 Starting in 1982 to 1991, you were with Greer Fire
21 Department as a firefighter; is that right?

22 A. Firefighter, yes.

23 Q. From '91 to '94, you were at Pelham Fire
24 Department also as a firefighter?

25 A. I was a lieutenant for the shift and

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1 firefighter.

2 Q. And from '94 to '99, you went back to Greer?

3 A. Yes, sir. I was back there as a lieutenant
4 also.

5 Q. You worked at BMW as a firefighter from
6 August 2001 through August 2007?

7 A. Yes, sir. I was a firefighter and I was the
8 sergeant engineer, second in charge.

9 Q. And since leaving BMW in 2007, where have you
10 been employed?

11 A. At Laurens County.

12 Q. And you've been there since then?

13 A. Yes, sir.

14 Q. In addition to being a firefighter, what were
15 your duties? Were you expected to do any kind of
16 emergency medical services?

17 A. Yes, sir. I was also an EMT -- certified as
18 an EMT there. And one time in the City of Greer, I was
19 an EMT -- also an EMT-I there and I was also an
20 instructor for first responder in CPR and everything.

21 Q. When was the first time you received your EMT
22 certification?

23 A. Quite some time ago.

24 Q. More than 15 years ago?

25 A. Yes, sir.

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1 Q. More than 20 years ago?

2 A. It was back in -- the first time that I worked
3 with the City of Greer.

4 Q. Was that in 1982?

5 A. In -- yeah, around -- around the early '80s
6 when I got it the first time.

7 Q. When did you get out of the military? In '88;
8 is that right?

9 A. That's when I got out of the Reserves, yes,
10 sir, for the Army. I got out of the Navy -- my total six
11 year enlistment in the Navy was up in '81.

12 Q. Did you have to have any special training to
13 be a medic in the Army?

14 A. They took me because I was also an EMT, and
15 they do have medical training schools in there for it.

16 Q. Part of being an EMT, do you have to recognize
17 signs and symptoms of certain -- or preliminary signs and
18 symptoms of certain conditions as a heart attack or a,
19 you know, stroke or something like that?

20 A. Yes, sir.

21 Q. And do you go through an extensive training
22 period for that?

23 A. It's -- I believe it's like six months long,
24 the school for EMT.

25 Q. Did you successfully complete that?

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1 A. Yes, sir.

2 Q. And let's talk about your work history with
3 the defendant. You started in 2007 or '08 somewhere?

4 A. It was September of 2007. I believe it was.

5 Q. How would you rate your attendance?

6 A. Flawless. If I've been out, I've called in
7 ahead of time. I've never been late.

8 Q. And what were your job duties for your current
9 employer or defendant in this case?

10 A. We do emergency medical calls for -- when
11 people call 911, we go out and treat what we can and we
12 transport them to the hospital for further treatment.

13 Q. Do you stay in communication with the ER to
14 kind of get guidance from them?

15 A. Yes, sir. We have radios in the truck.

16 Q. Do you have any training in putting EKG leads
17 or reading EKG strips?

18 A. I've been to classes. I'm not certified to,
19 you know, do the EKG part of it because that's an
20 advanced thing. But I've been to several EKG classes
21 myself, my own -- on my own.

22 Q. Is it fair, then, to say that you are trained
23 to look for an irregular strip?

24 THE COURT: Your Honor, I'm going to object to
25 the leading at this point.

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1 BY MR. DESAI:

2 Q. What kind of training do you have in reading
3 an EKG?

4 A. It's on-the-job service, talking to the
5 paramedics that I work with, them showing me stuff, what
6 to look for, and from the classes that I've attended.

7 Q. Let's talk about the physical requirements of
8 your job leading up to the date of the injury. Did you
9 have to lift --

10 A. Yes.

11 Q. -- as part of your job --

12 A. Yes.

13 Q. -- as an EMT?

14 How many -- how many runs have you been on
15 since you've been an EMT?

16 A. Thousands.

17 Q. When you say "thousands," tell us -- can
18 you -- can you narrow it down a little bit? More than
19 10,000, less than 10,000?

20 A. At Laurens County we have three shifts and
21 we're averaging about 10,000 to 12,000 calls a year, and
22 that's divided over the three shifts. The calls that I
23 had with the city and Greer Fire Department and the calls
24 at BMW Fire Department and Pelham Fire Department, it's
25 been several thousands.

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1 Q. And of those calls how many times have you had
2 an opportunity to lift someone over 400 pounds?

3 A. I'm going to say maybe one in every 100,
4 something like that, or one every 1,000.

5 Q. How about 350?

6 MR. KALE: Your Honor, that's very leading.

7 MR. DESAI: I'm just asking him if he can
8 answer that question or not. If he can't, then just I
9 can't answer it or I don't know.

10 THE WITNESS: I don't know.

11 THE COURT: I'll allow that, but let's be very
12 careful.

13 THE WITNESS: I don't know the number of times
14 like that.

15 BY MR. DESAI:

16 Q. Okay. Did you have to walk a lot,
17 extensively, during your employment with Laurens County
18 EMS?

19 A. We have to walk every call and everything.
20 The one station we're at, you know, it was a good walk to
21 the truck from there.

22 Q. Did you have to stand a lot?

23 A. Pardon?

24 Q. Did you have to stand a lot?

25 A. Yes, sir.

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1 Q. What about sitting?

2 A. We will sit in the truck, sit in the back of
3 the truck. It's a lot of kneeling.

4 Q. How about bending, stooping, and squatting?

5 A. Yes, sir.

6 Q. How about climbing?

7 A. Not a whole lot of that except at the station.

8 Q. How about pushing and pulling?

9 A. Yes, sir.

10 Q. Give us an example of when you would have to
11 push or pull.

12 A. With the stretcher when you have a patient
13 going to the patient or have a patient on the stretcher
14 and you have one person pushing at the back and one
15 person pulling at the front.

16 Q. How about reaching?

17 A. Yes, sir.

18 Q. And twisting and turning?

19 A. Yes, sir.

20 Q. Give us an example of a time when you would
21 have to twist or turn.

22 A. If you go to get a person out the nursing home
23 or somewhere like that, these assisted living homes, they
24 have their beds here and sometimes you have to reach over
25 to get them because you can't get around the bed or

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1 behind the bed.

2 Q. When you say "here," are you pointing to your
3 right?

4 A. Or anywhere, you know, where they -- they'll
5 have it in a corner or something and you can't get around
6 it and then you have to reach across the bed to get ahold
7 of the person to bring them over to the stretcher.

8 Q. Let's talk about what's a normal shift at
9 Laurens County EMS?

10 A. Twenty-four hours.

11 Q. You work a 24-hour day?

12 A. Yes, sir.

13 Q. You get to sleep when a call is not --

14 A. After our daily duties are done and we don't
15 have a call, we can sleep.

16 Q. What about -- after working 24 hours, how many
17 days do you get off?

18 A. Two days, 48 hours.

19 Q. So it's 24 on/48 off?

20 A. Yes, sir.

21 Q. Is that usual and customary in that -- in that
22 industry?

23 A. Most of them do that. There's some that do
24 different hours.

25 Q. How much were you making? Well, actually,

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1 that's not -- I don't think that's in dispute. Before I
2 talk about the accident, let me show you Defendant's APA
3 13, Page 316. Can you tell us what this is, please?

4 A. That's one of the stretchers that we use in
5 the service.

6 Q. Is that the particular stretcher that you used
7 on the day of the accident?

8 A. It looks like the type that we use.

9 Q. Okay. How would you know that?

10 A. It has the motor, the battery-operated on it
11 for lifting the stretcher up and down -- the wheels of
12 the stretcher up and down.

13 Q. Please explain to most of us who have never
14 operated this thing how it works as far as -- just kind
15 of demonstrate to us or explain to us, talk us through
16 how you would transfer a patient from the bed to that
17 stretcher.

18 A. If you can't get around them, you try to get
19 them in the sheet like a hammock or get your arms around
20 their chest. If you can't reach all the way around their
21 chest, go underneath their arms and get their wrists and
22 lift them up and move them onto the stretcher.

23 Q. So the stretcher doesn't go underneath and
24 scoop them up?

25 A. No, sir.

1 Q. So the only thing this stretcher does is go up
2 and down and it's mobile, right?

3 A. Yes, sir.

4 Q. It has wheels underneath?

5 A. Yes, sir.

6 Q. You lock those wheels when you're trying to
7 transfer somebody on?

8 A. Yes, sir. You always do.

9 Q. Does that stretcher have rails?

10 A. Yes, sir.

11 Q. Does it have any other way of securing the
12 patient?

13 A. It has straps that are attached at the leg,
14 around the thigh and knee area and the chest area.

15 Q. Are they built into the stretcher?

16 A. Yes, sir.

17 MR. DESAI: It's already a part of the APAs.
18 I don't need to admit it.

19 BY MR. DESAI:

20 Q. Let's talk about the day of the accident. You
21 said earlier February 26th of 2011; is that right?

22 A. Yes, sir.

23 Q. And would you say approximately -- would you
24 please tell us approximately what time this accident took
25 place?

1 A. Around 10:00. Between 10:00, 10:30, somewhere
2 around there.

3 Q. Tell us what happened, please.

4 A. We had received a call to NHC of Clinton,
5 National Health Care of Clinton, for a respiratory
6 distress. Upon arrival we got to the room, there were
7 several nurses and nurses aids that told us this is the
8 patient. We observed the patient. The initial
9 observation was he was gasping and in severe respiratory
10 distress. We said we've got to go. We turned around and
11 all the nurses and everybody had gone. Me and my partner
12 lifted the individual onto the -- off the bed onto the
13 stretcher and went. And when I lifted the individual up,
14 that's when I felt the first pain.

15 Q. Did you lift the head end of the patient or
16 the foot?

17 MR. KALE: Objection. He's leading again.

18 THE COURT: Rephrase the question.

19 MR. DESAI: Thank you, Your Honor.

20 BY MR. DESAI:

21 Q. Which side of the patient, the top or the
22 bottom, did you lift?

23 A. I got his upper torso. I got underneath his
24 arms. And I was unable to reach around his chest, so I
25 got his wrists to lift him into the -- onto to stretcher.

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1 Q. Describe this gentlemen that you lifted off
2 the bed onto the stretcher for us, please.

3 A. He was a very large individual.

4 Q. All right. When you say "very large," was he
5 bigger than you?

6 A. Yes, sir.

7 Q. You were outside talking to Magistrate
8 O'Brien?

9 A. Yes, sir.

10 Q. Was he larger than him?

11 A. Yes, sir.

12 Q. Significantly larger than him?

13 A. Yes, sir.

14 Q. Can you estimate as to how tall the gentleman
15 might have been?

16 A. He -- he was about eight inches feet, hung off
17 about eight inches passed the end of the stretcher, and
18 someway he was -- I'm estimating he was somewhere around
19 six-seven, six-eight.

20 Q. Tell us what the reason for your estimate is.

21 A. Because the stretcher, on an average, a six
22 foot person will fit on the stretcher. He was extending
23 passed the end of the stretcher.

24 Q. And there's no question in your mind about
25 that?

1 A. No, sir.

2 Q. Let me show you the same exhibit I showed you,
3 13, Page 316. This is a page from the manufacturer that
4 states how long the stretcher is. Can you tell us what
5 it says as far as the length, the standard size?

6 A. It's 76.5 inches.

7 Q. What is that, six-four?

8 A. Six -- yeah, six-three, six-four. Somewhere
9 around there.

10 Q. And it's your testimony today that this
11 patient's legs were extending beyond --

12 MR. KALE: Leading, Your Honor.

13 MR. DESAI: I'm just trying to clarify it.
14 He's already stated the legs extend over.

15 THE COURT: He's already said that. I'll
16 allow that.

17 BY MR. DESAI:

18 Q. Is it your testimony today, then, that the
19 legs of this patient that you were lifting extended
20 passed the stretcher?

21 A. Yes, sir.

22 Q. Let's talk about the width. Were you able to
23 raise the side rails?

24 A. No, sir.

25 Q. Why not?

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1 A. The individual was over the width of the --
2 the stretcher. He was too large. We couldn't raise them
3 up.

4 Q. And let me again show you the same exhibit and
5 can you please tell us per the manufacturer's page --
6 information page, what does it say the width of that
7 stretcher is?

8 A. Twenty-three inches.

9 Q. And that's 23 inches. Do you know if it's 23
10 inches from one edge of the stretcher or the other or do
11 you know?

12 A. No, sir, I don't. I don't know how they
13 measure it.

14 Q. So if you're not able to secure this patient
15 with the side rails, what did you have to do?

16 A. Well, we have -- also have the straps on the
17 stretcher. His leg straps went around and would fasten.
18 The chest straps would not. We extended them out all the
19 way and still would not reach around his chest. So in
20 the back of the stretcher, the head part that lifts up,
21 it had pockets and there's larger straps in there to
22 attach the patient to secure them to the stretcher and we
23 had to use a nine foot strap.

24 Q. Is that -- is that an unusual thing to do?

25 A. Yes.

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1 Q. Why is that an unusual thing to do?

2 A. Most of our patients -- the majority of our
3 patients are not that large. The upper strap will secure
4 them.

5 Q. You testified earlier that you have made
6 thousands of runs; is that fair?

7 A. Yes, sir.

8 Q. Of those thousands of runs, how many times
9 have you had to use a nine foot strap to secure an upper
10 body of a patient?

11 A. In the total number of years I've done it,
12 maybe -- I'm going to say maybe ten times.

13 Q. So ten out of --

14 A. Thousands.

15 Q. -- thousands? Why is that?

16 A. Because most of the time our patients are --
17 we can reach the strap around them. They're not
18 over-obese like this.

19 Q. You say our straps, so that means straps built
20 into the stretcher?

21 A. Yes, sir.

22 Q. Okay. So most of the time you are able to use
23 those straps, the manufacturer's straps?

24 A. Ninety-nine percent of the time.

25 Q. This nine foot strap that you mentioned

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1 earlier, is that a -- is that -- is that something that
2 you actually just carried on the ambulance or --

3 A. I think it's a requirement that we have to
4 have so many nine foot straps on the unit.

5 Q. But that does not come standard with the
6 stretcher, does it?

7 A. No, sir, that I know of.

8 Q. All right. So continue. Well, let me -- let
9 me actually back up. How far was the stretcher
10 positioned from where the bed was? Can you describe the
11 room to us, to the Commissioner? As you walk into the
12 patient's room, please -- please take us from there.

13 A. It's just a square room and the patient's bed
14 was over close to the wall. They had like a heater or
15 air conditioner thing there that wouldn't let it go all
16 the way against the wall. We came in and it was about --
17 I'm going to say about three feet to the end of the
18 bed -- the foot of the bed and you couldn't get behind
19 the bed the way they had it secured, you know, the wheels
20 locked down and everything like that. And at that point
21 we had to grab the man and go, and the stretcher was
22 right next to the patient's bed.

23 Q. If you had to guess, how many seconds did you
24 actually have to free lift the patient in order for you
25 to get him from the bed to the stretcher?

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1 MR. KALE: Your Honor, if he's guessing, I
2 don't think that's proper evidence. It's speculation.

3 MR. DESAI: I can list the weight of it. Not
4 admissibility. I mean, Your Honor can --

5 MR. KALE: Speculation is not admissible.

6 BY MR. DESAI:

7 Q. Can you -- do you recall --

8 MR. DESAI: I retract my question, Your Honor.

9 BY MR. DESAI:

10 Q. Do you recall how many -- how much time you
11 spent free lifting the patient basically just with your
12 body from the bed to the stretcher?

13 A. I'm going to say -- I'm not 100 percent sure,
14 but I'd say about seven to eight seconds of holding,
15 going to the stretcher.

16 Q. And while you were transferring that patient
17 from the bed to the stretcher, was most of that
18 patient -- where was the patient's body weight? What
19 part of your body was supporting most of the body weight?

20 A. I had to lean across like this and then I had
21 the bulk of his weight on my arms to move him over like
22 this to the stretcher. (Witness indicates.)

23 Q. Describe the amount of exertion that it took
24 for you to do that.

25 A. Considerable.

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1 Q. What is "considerable?"

2 A. I had to really strain to get that -- that
3 individual up off of the bed because of the contour of
4 the bed and being sitting in there so long, they're hard
5 to get out of the bed and I had to really strain to get
6 him up onto the stretcher with his weight with just me
7 and my one partner.

8 Q. You mentioned that the patient was
9 significantly larger than Magistrate O'Brien outside?

10 A. Yes, sir.

11 Q. I'm certainly not going to ask you to guess
12 the weight, but on how many different occasions have you
13 had to encounter that -- that kind of strain in the past?

14 A. That -- that -- I can't really even tell. I'm
15 going to say since I've been at Laurens County, two,
16 maybe three times I've had to -- but we've always had
17 somebody else there -- had time to get somebody else
18 there to help lift.

19 Q. Okay. That was my next question. When you
20 encounter somebody that size, do you -- is it protocol or
21 do you normally call for help?

22 A. Yes, sir.

23 Q. Who would you call?

24 A. We usually call the dispatch and ask them to
25 get the fire department to come and give us lifting

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1 assistance.

2 Q. And has that happened in the past?

3 A. Yes, sir.

4 Q. Quite a few times?

5 A. Yes, sir.

6 Q. Why not on this occasion?

7 A. We had to go with the man. It was imperative,
8 that we didn't have the time to wait for the fire
9 department to be called out, drive where we were, get to
10 the room where we were. This man had to go.

11 Q. Is there such a thing as a prescheduled run
12 for EMS as in you know if you have to transport somebody?

13 A. No, sir. No, sir. That's -- it's EMS. It's
14 emergency. You don't know what you've got until you get
15 there.

16 Q. If you knew the size of the person that you
17 were going to encounter at National Health Care Center or
18 National Health Care, would you have taken some help with
19 you?

20 A. Yes, sir. We would have asked for the fire
21 department to be dispatched along with us.

22 Q. Tell us what you experienced when you were
23 lifting Mr. Coon, the patient, off the bed onto the
24 stretcher.

25 A. I felt a sharp pain which was behind my

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1 shoulder blade and heaviness in the chest, like something
2 sitting on my chest.

3 Q. All right. And on how many different
4 occasions did you experience that?

5 A. When I first lifted him off, I experienced it
6 then and it lasted just a short time. Then wheeling him
7 to the stretcher, I had the heaviness on my -- I mean, to
8 the truck, I had the heaviness and difficulty breathing
9 going to the stretcher -- I mean, to the truck wheeling
10 him on the carpet in the nursing home. And lifting him
11 into the truck and then lifting him out of the truck, I
12 still experienced a heaviness and difficulty breathing.
13 Then when we went into the hospital to take him off the
14 stretcher and put him on the bed, I also had the torso
15 again and we had several other nurses help us there
16 transfer him to the bed and I experienced the pain again
17 behind my shoulder blade and the heaviness of the chest
18 and difficulty breathing. I was sweating profusely.

19 Q. Again, I hate to keep going back to the
20 stretcher, but that stretcher doesn't help you load
21 someone onto the ambulance?

22 MR. KALE: Object to leading, Your Honor.

23 THE COURT: Rephrase.

24 BY MR. DESAI:

25 Q. Do you have any assistance behinds humans as

1 to lifting -- transferring somebody --

2 A. That stretcher when we put it in, it has a bar
3 in the front. There's a hook on the floor of the truck.
4 We push it in to where that bar is passed the hook, bring
5 it back and hook it. That holds the front two wheels --
6 the upper two wheels on the bottom of the stretcher
7 itself in place on the truck. Then you have to lift it
8 up off the ground, push a button to raise the wheels up
9 to it and then roll it into the truck. You have to do it
10 in reverse to take it out.

11 Q. So do you have -- you mentioned you have to
12 lift it until the wheels come up. Do you actually have
13 to hold that stretcher until the wheels mechanically come
14 up?

15 A. Yes, sir, because it won't go in the truck.

16 Q. And all of that weight is on your upper body?

17 A. Yes, sir.

18 Q. How long does it take for the wheels to come
19 up from bottom to top?

20 A. The whole process, 15 to 20 seconds getting
21 them in and -- holding them and getting them in and the
22 wheels coming up and it depends on how strong the battery
23 is.

24 Q. Is it fair to say the same thing when you're
25 taking them back off?

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1 A. Yes, sir.

2 Q. And I'm assuming the process of taking the
3 patient off the stretcher back onto the bed at the ER, is
4 that similar to taking them from the bed and then putting
5 them back on?

6 A. Yes, sir, exactly.

7 Q. Okay. Did you not -- did you not roll the
8 patient -- I was a paramedic in the military and we were
9 taught to roll patients.

10 A. No.

11 Q. Did you not roll the patient?

12 A. No.

13 Q. Why not?

14 A. If he had been on his belly on the stretcher,
15 we would have rolled him and we wouldn't have been able
16 to treat him or anything like that.

17 Q. Are there any kind of physical conditions that
18 prevented you from rolling him?

19 A. Just his size, really. He would not have --
20 he would not have been on the stretcher right.

21 Q. You've -- you've -- you've had some problems
22 with your left shoulder before, have you not?

23 A. Yes, sir.

24 Q. And you went to the hospital for that?

25 A. Yes, sir.

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1 Q. I saw a note in Defendant's APA where the
2 doctor talks about the fact that he doesn't know what
3 caused that shoulder injury. Do you know anything about
4 that?

5 A. Yes, sir.

6 Q. Tell us about that.

7 A. I was out prior to this incident and I had the
8 flu. I had a doctor's statement and everything and I had
9 the stomach flu, and I was laying in bed and I had a
10 garbage can next to the bed and I was vomiting. And it's
11 one of those you can't get too far away from anything
12 because I was just -- it was just -- it hit me real hard.
13 And I turned real quick in the bed and fell out and
14 landed on my shoulder on the floor trying to vomit into
15 the garbage can.

16 Q. Did you report the mechanism of that injury to
17 the doctor?

18 A. Yes, sir. I told him what I did.

19 Q. Do you know why the doctor would have said
20 that the patient is not aware of the mechanism --

21 A. No, sir.

22 MR. KALE: Object to what his speculation is
23 about what the doctor thought.

24 THE COURT: Sustained. You can't tell me what
25 someone told you.

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1 BY MR. DESAI:

2 Q. And just if there's an objection, I want you
3 to hold your answer until the judge rules on it. Okay.
4 Thank you.

5 So once -- once you -- once you transferred
6 this patient to the ER, what did you do? What happened?

7 A. I went and got the truck back in service. My
8 partner give the report to the nurse. He came out. I --
9 at that time I told him, I said, I think I'm still
10 suffering from the flu. Call the supervisor and ask him
11 to get somebody to come in and take my place. I was
12 going home.

13 Q. And your partner, please tell us for the
14 record what his name is?

15 A. Mike Lundis.

16 Q. Mike Lundis. And is Mr. Lundis here today?

17 A. Yes, sir.

18 Q. All right. Have you talked to Mr. Lundis
19 about your case at all?

20 A. No, sir.

21 Q. Have you talked to him about how to testify
22 about your case?

23 A. No, sir.

24 Q. Prior to today when was the last time you saw
25 Mr. Lundis?

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1 A. That night.

2 Q. You haven't seen him since --

3 A. I haven't seen him until he walked in the door
4 here.

5 Q. Have you talked to him since then?

6 A. No, sir.

7 Q. All right. So you told your partner that you
8 were having flu-like symptoms. Then what happened?

9 A. We went back to the station and he put me on
10 the O2 monitor, see my O2 stat, and then stuck me on a
11 monitor because I was showing the severe sweating and was
12 still complaining of the heaviness in the chest. He put
13 me on the monitor and it showed the EKG strip.

14 Q. All right. And did he tell you what was
15 unusual about your EKG strip?

16 A. He said I needed to go to the hospital.

17 Q. What's your understanding as to why you needed
18 to go to the hospital?

19 MR. KALE: Your Honor, that would be hearsay.

20 MR. DESAI: I just said what his understanding
21 was, not what he said.

22 THE COURT: You can tell me what you
23 understand.

24 THE WITNESS: That there was something wrong
25 with the EKG strip that he seen on it because he stated

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1 that you need --

2 BY MR. DESAI:

3 Q. Don't talk about what he said. Just tell us
4 what your understanding is.

5 THE COURT: Just your understanding.

6 BY MR. DESAI:

7 Q. So what was your understanding?

8 A. That I was having some problems with the EKG
9 strip. There was something going on with my heart.

10 Q. Okay. At that point what did you do?

11 A. We waited for the relief to get there, which
12 was Mr. O'Brien, and we showed him the strip and he also
13 advised me I needed to go to the hospital.

14 Q. Let me show you what's been marked and
15 admitted as Plaintiff's APA 1, Page 2. Do you know what
16 this is?

17 A. Yes, sir. It's an EKG printout off of our
18 monitors.

19 Q. Is it the actual printout or is it a copy of
20 it?

21 A. It is the actual one.

22 Q. All right. And is this the EKG that was --

23 A. Yes, sir.

24 Q. -- taken that day?

25 A. Yes, sir.

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1 Q. And what you testified to earlier?

2 A. Yes, sir.

3 Q. And who -- who is the one that hooked you on
4 the leads?

5 A. Mike Lundis.

6 Q. And this is the EKG that was the subject of
7 conversation that you testified to earlier?

8 A. Yes, sir.

9 Q. All right. So did you voluntarily go to the
10 hospital or were you talked into going to the hospital?

11 A. Well, I had to -- when Mike O'Brien got there,
12 he told me I was going to the hospital one way or the
13 other. But, yes, I did voluntarily get into the unit and
14 go.

15 Q. All right. Who was the driver of that unit
16 that day?

17 A. Mr. O'Brien.

18 Q. Okay. And who is Mr. O'Brien?

19 A. He's a paramedic that works at Laurens County
20 EMS and he's also a magistrate.

21 Q. In Greenville County?

22 A. Yes, sir.

23 Q. Do you remember anything about that ride that
24 was unusual or anything like that?

25 A. We just -- at that point I wasn't experiencing

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1 any pain, but I still had the heaviness on my chest. And
2 at one -- one point I described it to him it felt like an
3 elephant sitting on my chest.

4 Q. What -- which hospital were you going to?

5 A. Went to Greenville Memorial.

6 Q. There's no question that you haven't been the
7 healthiest man; is that right?

8 A. Pardon?

9 Q. There's no question that you are not the most
10 healthiest man; is that right?

11 A. No, sir.

12 Q. And you've got some problems with your health,
13 do you not?

14 A. Yes, sir.

15 Q. What kind of problems were you having prior to
16 this accident?

17 A. All I had was the diabetes and I was -- had
18 been cleared by my doctor to work out at the gym to lose
19 weight and everything prior to this. I was getting my
20 diet under control, my diabetes and my blood sugar, all
21 my lab work and everything was in decline, was going
22 down, was getting better.

23 Q. Let's go back to what you said. Your doctor
24 cleared you to work out?

25 A. Yes, sir.

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1 Q. And you were able to lift weights in the gym?

2 A. Yes, sir.

3 MR. KALE: Object to the leading, Your Honor.

4 MR. DESAI: I retract my question, Your Honor.

5 BY MR. DESAI:

6 Q. What kind of activities could you do in the
7 gym?

8 A. I would -- I had a personal trainer set up a
9 weight lifting segment for me, and I would weight lift
10 on -- every other day and I would do cardio every other
11 day. And I had to have the -- with the -- for the YMCA
12 gym, the clearance from my doctor before they would do it
13 for me.

14 Q. Why is that?

15 A. For the medical reasons because of lifting the
16 weights and the personal trainer making you do the cardio
17 and everything.

18 Q. How often did you work out?

19 A. I went just about every day that I wasn't
20 working.

21 Q. For how long?

22 A. I would be there an hour to two hours every
23 day.

24 Q. What was the duration? How many days, how
25 many months?

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1 A. I started January 4th of that year except for
2 the time I had the flu prior to this incident every day
3 that I was off.

4 Q. Did you lose any weight?

5 A. I had lost a considerable amount. Well, I had
6 lost about 18 pounds so far to that point from what I was
7 before.

8 Q. So you were making progress; is that right?

9 A. Yes, sir.

10 Q. You're back at work now; is that right?

11 A. Yes, sir.

12 Q. Are you back at full duty?

13 A. Yes, sir.

14 Q. And are you able to perform your normal work
15 duties as you were prior to the accident?

16 A. Yes, sir. But I -- if I come across a heavier
17 patient, not necessarily as large as this patient here,
18 we always call for lift assistance and I don't lift the
19 stretcher now by myself. I always get my partner to help
20 lift the stretcher out.

21 Q. There's certain things -- are there any
22 medications you're taking now --

23 A. Yes.

24 Q. -- that you were not taking prior to the
25 accident?

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1 A. Yes, sir.

2 Q. All right. And what are those medications?

3 A. Warfarin is a cousin of Coumadin, and I'm not
4 100 percent sure on the other -- the other names. But
5 I'm taking, I think, four medications.

6 Q. Fair enough. They're all in the medical
7 records, so you don't need to name them all. So you're
8 taking four medications that you weren't taking prior to
9 the accident?

10 A. Yes, sir.

11 Q. Is there any -- any physical change in your
12 body that -- is there any -- you have a defibrillator. I
13 think we --

14 A. Yes, sir.

15 Q. Okay. Did you have any indications whatsoever
16 that you might need surgery?

17 A. No, sir.

18 Q. Has any doctor in the past that you've seen
19 indicated to you that you were a surgical candidate --

20 MR. KALE: Object to the hearsay, Your Honor.

21 THE COURT: That is hearsay. He can't tell me
22 what the doctor said.

23 MR. DESAI: Yes, Your Honor.

24 BY MR. DESAI:

25 Q. Tell me about your understanding as to you

1 being a surgical candidate. Have you ever understood
2 yourself to be a surgical candidate?

3 A. For the surgery I had on my foot and I've had
4 surgery on my back prior years and years ago, so I know I
5 was.

6 Q. Based on your meetings with the doctors in
7 past, all of the doctors in past, has it ever been your
8 understanding that you needed a surgery?

9 A. No, sir.

10 Q. Has it ever been your understanding that you
11 might even need surgery ten years down the road?

12 A. No, sir.

13 Q. Has it been your understanding that you're
14 prone to a heart attack?

15 A. No, sir.

16 Q. Have you missed any time from work due to this
17 injury?

18 A. Pardon?

19 Q. Have you missed any work due to this injury?

20 A. Yes, sir.

21 Q. Can you tell us the dates, please?

22 A. The day that it happened until I went back to
23 work on July the 2nd.

24 Q. How were you able to manage financially during
25 that time?

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1 A. I have a separate policy for short-term
2 disability that I was able to put a claim on that and it
3 went for three months. And then that last month that I
4 was out, the county has a long-term disability that paid
5 one month or part of a month.

6 Q. Are you still seeing Dr. Bittrick?

7 A. Yes, sir.

8 Q. How often?

9 A. I go every month to get my Coumadin checked
10 and every three months to get my pacemaker and
11 defibrillator analyzed and see Dr. Bittrick.

12 Q. Who pays for that medical treatment?

13 A. My insurance.

14 Q. Could you have worked during the time that you
15 were out of work?

16 A. Could I have worked? No, sir.

17 Q. Were you paid workers' compensation for the
18 time that you missed?

19 A. No, sir.

20 Q. You've never received any checks from workers'
21 comp; is that right?

22 A. Nothing.

23 Q. And your duties with -- with your current
24 employer and -- well, the defendant and your employer,
25 does that keep you from enjoying your life in general?

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1 A. It has restricted me.

2 Q. How so?

3 A. I can't walk like I used to in the woods. I
4 get real tired. My legs get real weak. My legs get real
5 weak and I don't have the stamina that I did, and I
6 cannot do some of the shooting sports that I used to do.

7 Q. What kind of sports did you enjoy?

8 A. I like to do a lot of competition long range
9 shooting and everything, and I can't do it now because I
10 can't shoot off the left-hand side and part of the
11 criteria is you have to make shots from your weak side.
12 And I can't draw a bow back to shoot my bow anymore. And
13 I can't scuba dive no more.

14 Q. What part of your body -- what parts of your
15 body have been affected due to this injury?

16 A. Well, my breastbone is off center. It's off
17 where they did the CPR. It's healed back instead of
18 flush, it's now off center roughly about an eighth to a
19 quarter of an inch. And every now and then it will --
20 like the rib pops. I don't have the stamina for walking
21 or doing the things I did before. My legs get weak.

22 Q. Did you have an incident while you were in the
23 hospital after the surgery -- why is there a
24 defibrillator in you?

25 A. Because they did the bypass surgery on

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1 Wednesday, and the following Monday -- they woke me up on
2 Saturday and I was doing good. The following Monday they
3 had me sitting up in a chair waiting for the recovery
4 room to come open, and I had an episode where my heart
5 stopped and they did CPR and shocked me.

6 Q. Are you getting better?

7 A. Yes, sir.

8 Q. You wanted to go back to work, did you not?

9 A. Oh, yes. My house got small.

10 Q. What kind of activities do you do currently?
11 Do you -- and when I say activities, physical activities.
12 Do you sit, walk, things of that nature?

13 A. I walk. I have a little area that I walk
14 around the block at my house, and it's roughly about --
15 about a quarter of a mile that I walk down and back just
16 trying to build things up.

17 Q. What kind of -- what do you -- what would you
18 like for the Commissioner to do for you today?

19 A. Pay the bills and, you know, what's needed.
20 The medical bills are -- I'm getting hounded by the
21 people all the time for them.

22 Q. Is that the deductible, what the insurance
23 company is not paying?

24 A. Yeah, what the insurance company is not
25 paying.

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1 Q. Okay. And did you give notice of this injury
2 to anyone? Did you tell one of your supervisors that you
3 had a heart attack?

4 A. The supervisor that was on duty, yeah, was
5 informed.

6 Q. Do you know what his name was?

7 A. Doug Maynard.

8 Q. And who informed Doug, you?

9 A. No. It was Mike Lundis and, I believe -- oh,
10 Earnest O'Brien did. Mr. O'Brien did because I had to
11 tell them -- get permission to go to Greenville and they
12 told them that it was cardiac related.

13 Q. So someone had to replace you in the middle of
14 your shift, right?

15 A. Yes, sir.

16 Q. And your supervisor had to find that
17 replacement?

18 A. Yes, sir. He had to pull the individual off a
19 squad truck.

20 MR. DESAI: I don't have any questions -- any
21 additional questions. Please answer any questions
22 Mr. Kale has for you.

23 CROSS-EXAMINATION

24 BY MR. KALE:

25 Q. Mr. Worthen, you have described some of the

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1 general medical conditions that you had prior to the
2 accident or your heart attack. You had diabetes melitis
3 type II, correct?

4 A. Yes, sir.

5 Q. And in 2011, prior to this heart attack, you
6 were taking Glipizide and Novolin R, correct?

7 A. No.

8 Q. What were you taking?

9 A. Novolin 70/30.

10 Q. Okay. But you were taking the Glipizide?

11 A. I think that's the one I'm on.

12 Q. And has your diabetes gotten worse since 2011?

13 A. No, sir, it's gotten better.

14 Q. Did you have a foot problem?

15 A. I stepped on something and got an infection
16 because all the -- there was particles still in the foot
17 that I didn't get out that caused an infection.

18 Q. Did your diabetes prevent it from healing
19 correctly?

20 A. No, sir.

21 Q. You also had high blood pressure or
22 hypertension?

23 A. No, sir.

24 Q. You didn't take Quinapril?

25 A. That Quinapril is the lowest amount there and

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1 it is there for the kidneys. It's prescribed by my
2 doctors to help my kidneys. I was never diagnosed with
3 high blood pressure.

4 Q. Did you have hyperthyroidism?

5 A. Yes, sir. I have a thyroid problem, but I've
6 been taking medication for it and that's all under
7 control. The only thing that was not under control was
8 the diabetes.

9 Q. And you take Levothyroxine?

10 A. Levothyroxine.

11 Q. And you also had hyperlipidemia which is a
12 cholesterol problem, correct?

13 A. I have been treated for that too, and all my
14 lab work showed improvement in that. Everything was
15 almost normal.

16 Q. I'm looking at a medical report of your family
17 doctors. This is Internal Medicine Associates of
18 Greenville. And on January 22, 2011 it says,
19 "Hypertension which began recent diagnosis."

20 A. I've never been told I had it, but they --

21 Q. But you're taking medication for high blood
22 pressure?

23 A. Yes, sir. I take five milligrams of it for
24 the -- and I was told it was to help the kidneys, is what
25 I was informed of.

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1 Q. Now, when you were at Greenville Memorial
2 Hospital, they did a catheterization; is that not
3 correct?

4 A. Yes, sir.

5 Q. That's the first catheterization that you ever
6 had?

7 A. Yes, sir.

8 Q. And basically what that shows is the state of
9 your coronary arteries?

10 MR. DESAI: Objection. Leading, Your Honor.

11 MR. KALE: It's cross-examination.

12 MR. DESAI: He can ask him what it shows, not
13 answer -- ask the question and answer it.

14 MR. KALE: I can lead. It's
15 cross-examination.

16 THE COURT: I don't think it was out of
17 bounds. Proceed.

18 BY MR. KALE:

19 Q. That shows you the state of your coronary
20 arteries, does it not?

21 A. I believe so. I'm not 100 percent sure what
22 those are because I'm not trained in that.

23 Q. Were you aware that you had three arteries
24 that were totally occluded?

25 A. Not until afterwards. I actually wasn't even

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1 told how many was done. The just told me they scheduled
2 surgery.

3 Q. You knew you had coronary artery disease?

4 A. No, sir.

5 Q. After the catheterization you didn't know it?

6 A. No, sir. All they told me was they were
7 setting -- setting me up for surgery.

8 Q. What are stents used for?

9 A. To open an artery up.

10 Q. And before they did the bypass surgery, they
11 put in stents?

12 A. No, sir.

13 Q. They never did put in the stents?

14 A. No, sir, they did not.

15 Q. They decided to do the bypass instead of the
16 stents?

17 A. Yes, sir.

18 Q. Okay. But wasn't it apparent -- you talked
19 about putting in the stents, correct?

20 A. They said they were going to take me into the
21 cath lab to put stents in.

22 Q. Didn't it kind of occur to you that when
23 they're talking to you about doing stents and about doing
24 quadruple bypass surgery that you had a coronary artery
25 problem?

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1 A. No, sir.

2 Q. It didn't occur to you?

3 A. No, sir.

4 Q. And you're an EMT?

5 A. Yes, sir.

6 Q. Wow. Do you know now that you had coronary

7 artery disease?

8 A. Yes, sir, everybody does.

9 Q. Okay. So you did on February 26, 2011 have

10 coronary artery disease?

11 A. I guess. I don't know.

12 Q. Well, you've looked at these medical reports,

13 haven't you?

14 A. Pardon?

15 Q. You've looked at these medical reports,

16 haven't you?

17 A. No, I haven't.

18 Q. You haven't looked at the medical reports?

19 A. No, sir.

20 Q. Did you talk to Dr. Bittrick?

21 A. Yeah.

22 Q. You were there at his deposition, were you

23 not?

24 A. Yes, sir.

25 Q. Did you become aware from your treatment with

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1 Dr. Bittrick that you had pre-existing coronary artery
2 disease?

3 A. He said that I had it, yeah.

4 Q. Do you know what causes arteries to become
5 occluded?

6 A. Plaque. From what people eat.

7 Q. Cholesterol, correct?

8 A. Uh-huh.

9 Q. Is that a yes or no?

10 A. Yes, sir.

11 Q. And basically you had a problem with what you
12 ate because you were weighing 288 pounds at that point in
13 time and you had high cholesterol?

14 A. That was not at that time.

15 Q. What was not at that time?

16 A. I had the high cholesterol prior to that and
17 was being treated for it and I had changed my diet.

18 Q. But you're being treated for high cholesterol
19 because you had high cholesterol?

20 A. Years before.

21 Q. And you had a weight problem?

22 A. Yes, sir, which I was being -- correcting.

23 Q. But in February of 2011, you weighed
24 288 pounds, didn't you, according to your own doctor's
25 medical records?

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1 A. (Witness nods head.)

2 Q. Is that a yes or no?

3 A. That's -- yes, sir. That's with clothes and
4 everything on.

5 Q. Now, on February 26th, you went to National
6 Health Care to transport a resident that was in
7 respiratory distress, I think you testified?

8 A. Yes, sir.

9 Q. And you were using a power stretcher that has
10 hydraulics that raise or lower the stretcher?

11 A. Yes, sir.

12 Q. And isn't what you do is bring the stretcher
13 up to the height of the bed?

14 A. As close as you can, yes.

15 Q. Isn't that what you did on that day?

16 A. Yes, sir.

17 Q. Now, most nursing homes have a draw sheet
18 under their patients, correct?

19 A. Most of them, I guess. I don't know.

20 Q. Did you use the draw sheet?

21 A. No, sir. We grabbed the man and just went
22 with it.

23 Q. Why did you not use the draw sheet?

24 A. Honestly, a sheet ain't going to hold him,
25 ain't going to move him.

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1 Q. Did you try?

2 A. No, sir. It was imperative that we went and
3 we grabbed him and we go.

4 Q. Well, the nursing home puts a draw sheet
5 underneath these patients because that's what they use to
6 move the patients; isn't that correct?

7 A. I don't know. I don't know what they do.

8 Q. Well, you've been around nursing homes,
9 haven't you, Mr. Worthen?

10 A. Pardon?

11 Q. You've been around nursing homes?

12 A. Yes, sir. But I don't know what they do, how
13 they move patients.

14 Q. Isn't that what a draw sheet is for?

15 MR. DESAI: It's been asked and answered.
16 We're going into the same question over and over again.
17 He's already said he doesn't know.

18 MR. KALE: It's cross-examination, Your Honor.

19 MR. DESAI: I understand that, Your Honor, but
20 it's been asked and answered. He said he doesn't know
21 what nursing homes do. He keeps asking the same question
22 over and over again.

23 MR. KALE: I am able to challenge that in my
24 examination.

25 THE COURT: To a point.

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1 MR. KALE: Pardon me?

2 THE COURT: To a point.

3 MR. KALE: That's correct.

4 THE COURT: Go ahead.

5 BY MR. KALE:

6 Q. But you didn't try to use the draw sheet that
7 was available to you?

8 A. No, sir.

9 Q. Now, you mentioned that when you pulled
10 Mr. Worthen (sic) over onto the stretcher, you felt a
11 pain in your left shoulder -- behind your left shoulder;
12 is that correct?

13 A. Yes, sir.

14 Q. Today you've testified that you felt a
15 heaviness in your chest?

16 A. Yes, sir.

17 Q. That isn't what you testified at your
18 deposition, was it?

19 A. I said it was -- I believe I said that it was
20 heaviness -- felt heavy, like something was on my chest.

21 Q. Let me show you your deposition. Page 23.
22 Start looking at Line 6. Read your testimony.

23 A. "Me and my partner, we lifted him off of the
24 bed onto the stretcher and I felt a little pain behind my
25 shoulder, indicating on the left side, and it went away."

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1 Q. And then going on down, I asked: "So you
2 lifted the stretcher?" That's on Line 18. You see that?

3 A. Yes, sir.

4 Q. What was your response?

5 A. You said, "So you lifted him on -- on the
6 stretcher?"

7 Q. And what did you say?

8 A. "Uh-huh. I meant, I believe I said onto the
9 stretcher from the bed onto the stretcher."

10 Q. "Felt a pain in which shoulder?"

11 A. "Behind the left shoulder blade."

12 Q. Go on. Keep reading.

13 A. "It wasn't in the chest area, indicating it
14 was in the back, where I felt the pain."

15 Q. You said, "Behind my left shoulder blade,
16 indicating" -- that's the court reporter -- "in the back.
17 It wasn't in my chest area. Indicating. It was in the
18 back where I felt the pain."

19 A. Uh-huh. Yes, sir.

20 Q. You didn't say anything in your deposition
21 about having this heaviness in your chest, did you?

22 A. No, I didn't. I guess not if it wasn't in
23 there.

24 Q. And when you went to the hospital and were
25 lifting the patient onto the bed, you said you had,

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1 again, a pain behind your shoulder blade?

2 A. Yes, sir.

3 Q. Again, you never said anything about having
4 any kind of heaviness in your chest, correct?

5 A. The people at the hospital seen that I was
6 having problems breathing. But, no, I didn't say -- I
7 didn't say to anybody at the hospital.

8 Q. Now, when you're lifting this person, you're
9 not doing that alone, correct?

10 A. No, sir, I have a partner.

11 Q. So he's bearing part of the weight?

12 A. He was on the feet.

13 Q. Okay. And you mentioned that you put him on
14 the stretcher and his feet hung off the stretcher?

15 A. Yes, sir.

16 Q. Now, that -- how far would -- the feet would
17 hang off the stretcher would depend on how far up on the
18 stretcher his head was?

19 A. Yes, sir.

20 Q. If his head is five or six inches below the
21 head or top of the stretcher, his feet are going to hang
22 off more, correct?

23 A. Yes, sir.

24 Q. You did not measure his height, did you?

25 A. No, sir.

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1 Q. You're just guesstimating?

2 A. Yes, sir.

3 Q. And as far as the weight, you're just
4 guesstimating?

5 A. That's all it is, is a guesstimation.

6 Q. In fact, you told Dr. Bittrick that he weighed
7 500 pounds, didn't you?

8 A. I said between 450 and 500 pounds.

9 Q. Dr. Bittrick has in his notes --

10 A. That's what he wrote.

11 Q. -- 500 pounds. Okay. So you're denying you
12 told him that?

13 A. I said between 450 to 500 pounds.

14 Q. Okay. When I took your deposition, you said
15 400 to 450 pounds.

16 A. Well, it's all in that range right in there.

17 Q. Again, you're just guesstimating?

18 A. No, sir.

19 Q. Nobody weighed Mr. Coon?

20 A. No, sir. We don't have no scales to.

21 Q. You mentioned about you would normally call
22 the fire department. The nursing homes have staff that
23 regularly lift their residents, do they not?

24 A. They have a hoist that they take into the room
25 and lift their very heavy patients with.

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1 Q. Okay. And did you attempt to use the hoist to
2 lift him?

3 A. You're not hearing. We did not have the time
4 to find this equipment or call anybody. This man was in
5 severe respiratory distress.

6 Q. Did you --

7 A. It was a load-and-go thing.

8 Q. Did you have time to call some of the staff at
9 the nursing home?

10 A. No, sir. They were there when we got in the
11 room. Turned around and they were gone.

12 Q. And you didn't go out and try to get them?

13 A. No, sir, we did not have time.

14 Q. Now, you had testified on direct examination
15 that you went on to lift someone of Mr. Coon's size maybe
16 one in 1,000 patients; is that right?

17 A. Maybe.

18 Q. When I took your deposition, you testified
19 something different, didn't you?

20 A. I don't know. I don't remember.

21 Q. Okay. Well, let me refresh your memory.

22 A. I don't remember.

23 Q. Look at Page 39. My question beginning on
24 Line 17 was: "And how usual is it for you to carry a 400
25 to 450 pound patient on a stretcher or gurney, I'm

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1 assuming?" And what was your response? Just read it
2 off.

3 A. "We come across them, you know, a lot of times
4 on a daily basis depending on where we are and everything
5 like that, I mean. But as far as, you know, you can say
6 probably at least out of a month time of working, we'll
7 probably get three that are rather large individuals."

8 Q. So you said in a month's time you may have to
9 lift three large individuals?

10 A. Yes, sir. And we usually call the fire
11 department for help.

12 Q. Would you -- would you -- and when you're
13 saying large people, you're talking about 400 to 500
14 pounds?

15 A. Just a guesstimated rather obese person.

16 Q. Someone that was 250 to 260 pounds, you see
17 those people frequently, don't you?

18 A. Yes, sir.

19 Q. Okay. Now, while you were out on -- out of
20 work, did you take vacation time?

21 A. I only had a day or two of vacation time.

22 Q. Did you take sick leave?

23 A. I had very little bit of that.

24 Q. How many days?

25 A. I'm not 100 percent sure, but I just used some

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1 for being out with the flu prior to this. So I didn't
2 have a whole lot left.

3 Q. Did you get short-term disability?

4 A. Yes, sir.

5 Q. And how many months did you get short-term
6 disability?

7 A. Three months.

8 Q. And how much did you get per month?

9 A. \$1,600 a month on my policy.

10 Q. And have you returned to work?

11 A. Yes, sir.

12 Q. Full-time?

13 A. Yes, sir.

14 Q. And is that without restrictions?

15 A. Pardon?

16 Q. Is it with or without restrictions?

17 A. Without restrictions. I put restrictions on
18 myself right now.

19 Q. Now, let me ask you about this power
20 stretcher. You said it takes 15 to 20 seconds for the
21 wheels to come off?

22 A. And put them in the truck with --

23 Q. How long does it take to get the wheels up?

24 A. It depends on the strength of the battery. If
25 the battery is almost dead from trying to lift the heavy

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1 patient and working several hours during the day, you
2 actually have to hold it and one person pull the legs up.

3 Q. Well, let's say the battery is good. How long
4 does it take?

5 A. Roughly, the wheel -- to pull the wheels up
6 and push that patient in, about 15 seconds.

7 Q. Okay. My question was, how long does it take
8 the wheels to come up? Is that about three seconds? The
9 wheels come up pretty fast?

10 A. I'd say somewhere around five seconds,
11 somewhere around there. I'm not sure.

12 Q. Then you just roll it into the ambulance?

13 A. No. You have to hold it and guide it into the
14 hooks up front where you line the wheels up and then push
15 it over to lock it. It's just not pushing it in. You
16 have to physically push it -- push it in, line it up with
17 the brackets up at the front to line the front wheels up
18 to hold it, and then push it over into the lock.

19 Q. Now, the defibrillator, that came about as a
20 result of another incident that you had at the hospital;
21 is that correct?

22 A. That's when my heart stopped.

23 Q. And the defibrillator is to make sure that
24 your heart doesn't stop anymore?

25 A. It's -- it's designed if my heart does stop or

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1 I go into an irregular ventricular rhythm, that it will
2 shock it.

3 Q. And start it back?

4 A. Hopefully.

5 MR. KALE: That's all I have, Your Honor.

6 THE COURT: Mr. Desai.

7 REDIRECT EXAMINATION

8 BY MR. DESAI:

9 Q. Has your heart ever stopped prior to this
10 surgery?

11 A. No, sir.

12 Q. So it wasn't until the surgery that the heart
13 stopped?

14 A. Yes.

15 MR. KALE: Object to the leading, Your Honor.

16 BY MR. DESAI:

17 Q. You mentioned there were no scales on the
18 stretcher?

19 A. No, sir.

20 Q. Are there any scales at the hospital?

21 A. Not at that time.

22 Q. And let me make sure I clarify this. One out
23 of 1,000 we talked about, was that a response -- and I'm
24 not sure -- to my question of how many times have you
25 used a nine foot strap?

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1 A. Yes.

2 Q. Okay. Not how many times have you picked up a
3 patient that size or have been on a run for a patient
4 that size?

5 A. Yes, sir.

6 Q. Do you know who filled out this report that's
7 Plaintiff's APA No. 1, Page 4, 5, and 6? It's a report
8 of his own transport.

9 A. That would have been Mike Lundis.

10 Q. Did you ever have an opportunity to read it?

11 A. Just since I've got it. Yes, sir.

12 Q. Can you read the signs and symptoms of that,
13 please?

14 A. Yes, sir.

15 Q. Read it, please.

16 A. "Cardiac chest pain, pressure, tightness and
17 respiratory dis."

18 Q. Did Mike Lundis, and you might not know this,
19 just come up with this on his own or is that something
20 you told him?

21 A. I don't know what he based it on writing it.
22 We talked going to the hospital and I guess --

23 Q. Did you tell Mike Lundis that you were having
24 chest pain?

25 A. Yes, sir.

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1 Q. Pressure?

2 A. Pressure. It felt like something sitting on
3 my chest.

4 Q. And that was an hour or so after the heart
5 attack while you were being transported?

6 A. Yes, sir, while I was being transported.

7 Q. And do you know when your deposition was
8 taken?

9 A. No, not the date.

10 Q. Months after the incident?

11 A. Yes, sir, months after.

12 MR. DESAI: I don't have anything else.

13 RECROSS-EXAMINATION

14 BY MR. KALE:

15 Q. You testified at the deposition that any
16 problems you had in chest -- chest pressure did not come
17 until after the second time that y'all lifted the
18 patient, correct?

19 A. I think so. I don't know the exact wording.

20 Q. Didn't have that the first time?

21 A. Yes, I did. I may not have said something
22 about it, but I did.

23 Q. But you didn't say anything about it in your
24 deposition?

25 A. I don't know.

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1 Q. That's all I have.

2 A. I don't know how you worded it.

3 THE COURT: Anything else?

4 FURTHER REDIRECT EXAMINATION

5 BY MR. DESAI:

6 Q. Were you thinking workers' compensation two
7 hours after your heart attack?

8 A. No, sir.

9 Q. Was that thought even in your mind?

10 A. That was the furthest thing from my mind.

11 Q. So you certainly didn't tell Mr. Lundis that
12 you had chest pressure and that your chest was hurting in
13 order to get a workers' compensation claim, did you?

14 MR. KALE: Your Honor, he's testifying. He's
15 not even asking a question.

16 MR. DESAI: I'll retract my question. Thank
17 you. I have nothing else.

18 FURTHER RECROSS-EXAMINATION

19 BY MR. KALE:

20 Q. And you were thinking about workers' comp when
21 you gave your deposition, though, weren't you?

22 A. Pardon me?

23 Q. You were thinking about workers' comp when you
24 gave your deposition, weren't you?

25 A. Yeah.

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1 MR. KALE: That's all I have.

2 THE COURT: Anything else?

3 MR. DESAI: No, sir, Your Honor.

4 THE COURT: You may step down. Call your next
5 witness.

6 (Off the record.)

7 THE COURT: In just a minute I'm going to
8 swear you in. I have a couple of requests for you.
9 First is, it's imperative that you speak loudly enough so
10 that both of the attorneys, this young lady who is making
11 a record of the proceeding, and I can all hear you.

12 THE WITNESS: Yes, sir.

13 THE COURT: And the other is if you are asked
14 a yes or no question, please answer with yes or no.
15 Uh-huh or unh-unh get misunderstood. And if you shake or
16 nod your head, she especially in this configuration
17 literally has to turn and look and it slows down the
18 whole process.

19 THE WITNESS: Yes, sir.

20 THE COURT: So if you will do that for me.
21 All right.

22 (MICHAEL LUNDIS, being duly sworn to tell the
23 whole truth and nothing but the truth, testified as
24 follows:)

25 THE COURT: Please state and spell your full

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1 name for the record.

2 THE WITNESS: Michael Lundis. M-I-C-H-A-E-L,
3 L-U-N-D-I-S.

4 THE COURT: All right. Thank you, sir. Mr.
5 Desai.

6 MR. DESAI: Thank you, Your Honor.

7 DIRECT EXAMINATION

8 BY MR. DESAI:

9 Q. Mr. Lundis, please state your date of birth
10 and your address for the record.

11 A. 5/28/77. 106 Santee Drive, Piedmont, South
12 Carolina, 29673.

13 Q. Fair enough. And how long have you lived
14 there?

15 A. Two years.

16 Q. Let me kind of get to the heart of this
17 matter, Mr. Lundis, and ask if you recall where you were
18 on February 26th of 2011?

19 A. I was working at Laurens County EMS Station
20 Two in Clinton, South Carolina.

21 Q. And just kind of jump a little. What do you
22 do? Where are you employed currently?

23 A. I'm currently employed by Vital Care EMS as a
24 paramedic.

25 Q. Is that a -- what do they do?

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1 A. Private non-emergency transport.

2 Q. Explain that.

3 A. Dialysis patients, doctor's appointments,
4 discharges, nursing home facilities and the like.

5 Q. So you take patients from a facility to a
6 treatment facility?

7 A. Yes, sir.

8 Q. From a long-term treating facility to a
9 doctor's office, et cetera?

10 A. Yes, sir.

11 Q. And is that done via ambulance?

12 A. Yes, sir.

13 Q. Are there any qualifications that you have to
14 meet in order to work there?

15 A. We employ all levels of certifications.
16 However, I am a paramedic and have been since 2005.

17 Q. Is that an EMTP?

18 A. Yes, sir.

19 Q. All right. And how is that different than a
20 basic paramedic?

21 A. It's a two year program to get your paramedic.
22 It's more extensive than the EMT basic. The EMT basic is
23 currently a six month program.

24 Q. What are some of the things that you are able
25 to do that an EMT basic would not be able to do?

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1 A. I can initiate IVs, cardiac monitoring,
2 administer medications, endotracheal intubation, alter an
3 airway, interosseous infusions.

4 Q. Are you able to read EKG strips?

5 A. Yes, sir.

6 Q. Are you trained to do that?

7 A. Yes, sir.

8 Q. And what kind of training do you receive to
9 read those kind of strips?

10 A. We receive one semester of cardiology at the
11 technical college.

12 Q. Does the on-the-job training help at all?

13 A. Yes. It also builds your efficiency and the
14 ability to detect things.

15 Q. So you have formal training in reading
16 preliminary EKG strips. Is that fair to say?

17 A. Yes.

18 Q. And is it also fair to say that you then know
19 how to put the leads on and in the proper places?

20 A. Yes.

21 Q. What are some of the -- describe -- describe
22 your every day -- what's your typical day with your
23 current employer?

24 A. A typical day is I transfer patients to and
25 from doctor offices and dialysis clinics after their

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1 treatment, assist in their vital signs, making sure
2 they're comfortable, treating them with oxygen as
3 necessary, make sure they're comfortable, good customer
4 relation.

5 Q. Are most of your -- are most of your
6 transports scheduled?

7 A. Yes, most of them are.

8 Q. You know ahead of time who you're going to
9 get?

10 A. We don't know who we're going to get, but
11 we -- the call taker and dispatcher assigns calls based
12 on who is available.

13 Q. Do you know the size of the patient that
14 you're about to pick up?

15 A. Typically, yes.

16 Q. And why is that important?

17 A. That's so we can send the appropriate number
18 of resources out to lift the patient safely and also to
19 prevent any injuries to any crew members.

20 Q. Explain that in detail. For example, a 200
21 pound man versus a 300 pound man versus a 400 pound man,
22 what would be the difference?

23 A. Anyone at my current employer -- anyone under
24 300 pounds gets just a simple response. Anybody over
25 300 pounds is classified as bariatric. They get a

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1 special stretcher and a minimum of four people.

2 Q. What kind of special stretcher?

3 A. It's rated for 1,600 pounds and it's
4 approximately 35 to 40 inches wide.

5 Q. Let me show you a picture of a stretcher.

6 MR. DESAI: Your Honor, again, it's
7 Defendant's APA No. 13, Page 316.

8 BY MR. DESAI:

9 Q. The special stretcher you're talking about is
10 not this stretcher, is it?

11 A. No, sir, it's not.

12 Q. What -- what is that stretcher?

13 A. That is the standard stretcher that we have on
14 the ambulances that are rated for 700 pounds with a
15 hydraulic lifting mechanism on it.

16 Q. Explain the hydraulic lifting mechanism.

17 A. It's got a 24 volt battery that detaches to
18 it. Actually, it's a hydraulic pump to raise and lower
19 the stretcher.

20 Q. Does the life of the battery kind of dictate
21 how fast the stretcher goes up and down?

22 A. The life of the battery as well as the weight
23 of the patient. The heavier the patient, the slower the
24 stretcher will come up.

25 Q. Fair enough. Let me -- let me kind of draw

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1 your attention to the width and the length of the
2 stretcher as well, please, sir, if you don't mind.

3 A. Width, it says 23 inches, and the length is 76
4 and a half, but it will collapse to 55 inches.

5 Q. Okay. When you say collapse --

6 A. The head will fold -- lift up and then the
7 carriage will slide forward into the frame.

8 Q. Fair enough. The special stretcher you were
9 mentioning about overweight people or bariatric people
10 that you transport, is it a little lighter than a normal
11 stretcher?

12 A. Yes, it is. Like I said, it's between 35 and
13 40 inches.

14 Q. Verses a 23 inch; is that right?

15 A. Yes.

16 Q. Okay. Why is that important?

17 A. Better center gravity, better balance loading
18 the patient. It's also more comfortable for the patient
19 and provides for a safe means for transporting the
20 patient.

21 Q. Are you able to raise -- does it have side
22 rails?

23 A. It does.

24 Q. Is that important in transporting a patient?

25 A. Yes. It helps keep the patient on the

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1 stretcher should there be any rolling action in the back
2 of the truck or going over any uneven terrain as well as
3 the straps that are provided.

4 Q. Let me take you back to the night of
5 February 26, 2011. Do you recall transporting a patient
6 from National Health Care Center named Joe Coon?

7 A. Vaguely. I remember -- I don't remember the
8 patient's name, but I do remember going out to the
9 facility.

10 Q. And do you remember that your partner at the
11 time -- do you remember who your partner was at the time?

12 A. Mr. Worthen.

13 Q. Was that transport unusual than others?

14 A. Besides the patient was larger than our
15 average sized patient.

16 Q. Please explain that to us.

17 A. The patient was wider than the stretcher. We
18 were unable to raise the rails because of this. It was
19 unbalanced moving the stretcher around. The patient also
20 was in excess of the height of the stretcher.

21 Q. All right. Let's talk about that for a little
22 bit. We're talking about a sixty -- we're talking about
23 a 76 and a half inch stretcher which is six four and a
24 half, I think. I'm not -- they don't teach math very
25 well in law school. Seventy-six and a half. Okay. Is

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1 it your testimony -- okay. Where was the head, let me
2 ask you that, of the patient?

3 A. Approximately three inches was over the top of
4 the stretcher and the feet were hanging off the bottom of
5 the stretcher.

6 Q. So the head was actually over hanging -- the
7 head was hanging over the top?

8 A. Yes, sir.

9 Q. And the feet were dangling at the bottom. Is
10 that fair to say?

11 A. Yes, sir.

12 Q. Okay. So a six foot four inch and a half
13 stretcher was not sufficient enough for this gentleman
14 that you transported; is that fair?

15 A. Yes, sir.

16 Q. And you said obviously you weren't able to
17 bring the rails up, so he was wider than 23 inches; is
18 that right?

19 A. Yes, sir.

20 Q. What precautions do you use when you're not
21 able to raise side rails up in cases like this?

22 A. We use extra strapping. We have -- the
23 stretcher straps on the ambulance. There are nine foot
24 straps available to help secure the patient. And also
25 typically we have assistance for fire department or other

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1 county resources in that situation. In my present
2 situation where I'm employed, we send additional
3 personnel for all patients that size.

4 Q. And I don't really expect you to take a guess
5 as to what this patient weighed, but you put -- do you
6 recall filling out this report?

7 MR. DESAI: And, Your Honor, it's
8 Plaintiff's -- it's Defendant's APA No. 14, Page 318.
9 It's a run report for Joe Coon.

10 BY MR. DESAI:

11 Q. Do you recall filling out the report?

12 A. Yes, I do.

13 Q. All right. And if you look at the left of it,
14 top left, there is a weight. It says 350 pounds.

15 A. Yes, I see that.

16 Q. Did you measure Mr. Coon?

17 A. No, I guessed.

18 Q. You guessed?

19 A. Just put a rough estimate of the patient's
20 weight.

21 Q. Do you think Mr. Coon was 350?

22 MR. KALE: Objection, Your Honor. He's
23 already indicated that's what he put down as a guess.
24 He's crossing his own witness.

25 MR. DESAI: I'm just asking if he really

1 believes that or if he was just guessing.

2 THE COURT: I'll allow it. Be careful.

3 THE WITNESS: I believe that he could have
4 been well in excess of that weight, yes.

5 BY MR. DESAI:

6 Q. Are you -- are you pretty good at guessing?

7 A. No, I'm not.

8 Q. If you had to say what your flaw was in
9 guessing, what would it be?

10 A. Underestimating weights.

11 Q. Do you often underestimate weights?

12 A. Yes, I do.

13 Q. You were outside talking to Magistrate
14 O'Brien, Emo. Comparing the patient to Mr. Emo or
15 Mr. O'Brien who will testify next, how -- was that
16 patient bigger than Mr. Emo or Mr. O'Brien or do you
17 think that patient was smaller?

18 A. The patient was larger than the Magistrate.

19 Q. Was he taller than the Magistrate?

20 A. Yes.

21 Q. Was he wider than the Magistrate?

22 A. Yes.

23 Q. You don't have any idea what the Magistrate
24 weighs, do you?

25 A. I have no idea.

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1 Q. If you had to take a guess, what would it be?

2 A. Three, 325.

3 Q. And it's your testimony today that the patient
4 was taller and wider?

5 A. Yes.

6 MR. KALE: Object to the leading, Your Honor.

7 MR. DESAI: I'm just restating it, Your Honor.

8 BY MR. DESAI:

9 Q. You mentioned that in your current job there
10 is additional help available to you if somebody 300 or
11 over --

12 A. Yes, sir.

13 Q. -- has to be transported. Why didn't you guys
14 get any help that day when you transported Mr. Coon?

15 A. I don't recall.

16 Q. Sir?

17 A. I don't remember. I believe we just tried to
18 make the best of the situation we had.

19 Q. Yeah. Let's talk about the situation. When
20 you got there, what kind of shape was Mr. Coon in?

21 A. He was experiencing some respiratory distress
22 and he had swelling in his legs. He had fluid in his
23 lungs upon listening to them.

24 Q. And is it your job then to get him to --

25 A. Yes, transport him to the emergency

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1 department.

2 Q. As quickly as possible?

3 A. In a manner as quickly and safely as possible.

4 Q. Did any of the staff help you at NHC with
5 lifting or transporting --

6 A. No, sir.

7 Q. Did you guys ask them for any help?

8 A. I did ask the nurse aid for additional
9 assistance and she said she would be back, but the
10 patient's condition did not dictate waiting forever.

11 Q. So they just left the room?

12 A. Yes.

13 Q. Nice. Somewhere in here, let me see, it says
14 -- and I'll just point you to the second line from the
15 bottom. Defendant's APA, Page 319. Where it says,
16 "Patient transported non-urgently to Laurens."

17 A. Yes.

18 Q. If he was in a respiratory distress, why was
19 he transported non-urgently?

20 A. Because he did not have a -- he had valid DNR
21 order from South Carolina which in turn dictates that he
22 not be transported with lights and sirens because other
23 procedures as well have to be withheld.

24 Q. What does DNR mean?

25 A. Do not resuscitate.

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1 Q. Which means if he's dying, let him die?

2 A. Yes.

3 Q. Okay. And you're following instructions and
4 protocol, right?

5 A. Yes.

6 Q. While you guys were transporting this patient,
7 kind of take me from the ambulance. When you arrived at
8 the National Health Care Center, what happened?

9 A. We gathered up our ALS bag, the oxygen and the
10 cardiac monitor, which is protocol for taking on every
11 call at Laurens County or it was at the time when I
12 worked there. We go into the room, assess the patient,
13 determined what was going on, moved him over to the
14 stretcher as best we could without any assistance, got
15 him out in the ambulance. I initiated an IV, put him on
16 oxygen, listened to his lung sounds. Then we prepared to
17 go -- to transport the patient. Mr. Worthen got in the
18 front seat and drove us to the hospital while I treated
19 the patient.

20 We got to the hospital, unloaded the patient.
21 I noticed that Mr. Worthen was having an unusual amount
22 of difficulty from other calls we had ran that day, and
23 he seemed to be exhibiting some distress at that point in
24 time.

25 We got the patient inside, transferred care,

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1 got back to the station and I asked Mr. Worthen if he was
2 feeling all right. He didn't look well to me. He said
3 he just -- he was complaining of some tightness in his
4 chest. So I said, well, let's go back out in the
5 ambulance and let me check you out and see what's going
6 on and make sure you're okay. That's when I determined
7 that he was having some changes on his EKG.

8 Magistrate O'Brien and I spent some time
9 talking to him. We finally convinced him that it was in
10 his best interest to go to the hospital, and we
11 transported him to Greenville Memorial Hospital to the
12 chest pain center.

13 Q. Did Mr. Worthen want to go to the hospital?

14 A. He wanted to drive himself. He did not want
15 to go in the ambulance.

16 Q. Is it then your testimony that Mr. Worthen
17 told you that day that he was experiencing tightness in
18 his chest?

19 A. Yes.

20 Q. No question about that?

21 A. No question.

22 Q. In fact, you and Magistrate O'Brien
23 transported him to Greenville Memorial, didn't you?

24 A. Yes, we did.

25 Q. Let me show you Defendant's APA 14, Page 318

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1 and 319 -- I'm sorry. Defendant's APA -- no, Plaintiff's
2 APA Page 4, 5, and 6. Do you recall this? Do you
3 remember filling this report out?

4 A. Yes, I do.

5 Q. And in the signs and symptoms can you read
6 that for us? What does it say?

7 A. "Cardiac chest pain, pressure, tightness,
8 respiratory dysthymia."

9 Q. Pressure, tightness?

10 A. Yes.

11 Q. Is that based on history, is that based on
12 what the patient told you, or was that just a guess you
13 took?

14 A. That's based on my observation and what the
15 patient told me.

16 Q. Fair enough. Let's talk about this EKG strip.
17 Plaintiff's APA Page 2. Do you recall what that is? Do
18 you know what that is?

19 A. Yes. It's a sinus rhythm with some ST segment
20 elevation in Lead V3 and possibly V4.

21 Q. Who is the patient in question there?

22 A. Based on the date and time, it would be
23 Mr. Worthen.

24 Q. Is there any identifying marks there? Is
25 there any names or anything on there?

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1 A. No, sir.

2 Q. Do you recall taking that strip?

3 A. Yes, I do.

4 Q. Better yet, let me show you the actual strip
5 that came off that EKG machine. Can you please tell us
6 what that is? Does it have better identifying marks on
7 there?

8 A. Yeah, minus the smudging. As I said before,
9 it's Mr. Worthen's EKG based on the date and time, and
10 based on the EKG there seems to be some slight ST
11 elevation V2, some ST elevation V3 and V4.

12 Q. Who administered the leads that produced that
13 strip?

14 A. I placed them on Mr. Worthen.

15 Q. And did you run that EKG machine?

16 A. Yes, I did.

17 Q. And is it -- what's unusual about that? Is
18 there anything unusual about that?

19 A. The elevation in the V2, V3, and V4 is
20 indicative of some problem with the heart. It's usually
21 an indication of a myocardial infarction or heart attack.

22 Q. It's not conclusive, right?

23 A. No, it's not conclusive.

24 Q. But it's a red flag?

25 A. It is a sign that something is going on.

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1 Q. No question. And is that the reason you
2 insisted that Mr. Worthen go to a hospital?

3 A. Yes, it is.

4 Q. What led you to take this EKG?

5 A. Based on his presentation and complaining of
6 the chest tightness and the trouble breathing and just
7 not generally feeling well.

8 MR. DESAI: And I'd like to admit that as
9 Plaintiff's Exhibit Number 1.

10 MR. KALE: No objection.

11 (Claimant's Exhibit No. 1, EKG Strip, was
12 marked and entered as evidence.)

13 BY MR. DESAI:

14 Q. Have you talked to Mr. Worthen since the day
15 of the injury?

16 A. Briefly.

17 Q. When was that?

18 A. The following day or two after he was taken to
19 the hospital.

20 Q. Have you talked to him about this case at all?

21 A. No, I have not.

22 Q. Did you know anything about this case until
23 recently?

24 A. No, I did not.

25 Q. Has anybody forced you, coerced you, or

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1 trained you how to testify today?

2 A. No, sir.

3 Q. Do you have any interest in this case today?

4 A. No, sir.

5 Q. You did say something that -- you said we
6 transported the patient the best way we could?

7 A. Yes.

8 Q. Explain that. What's the best way you could?

9 A. Ideally we would have had more assistance
10 moving the patient to the stretcher and moving the
11 patient to the ambulance and loading the patient.

12 Q. That wasn't the case?

13 A. No, sir.

14 MR. DESAI: Okay. I don't have anything else.
15 Please answer any questions the Commissioner or Mr. Kale
16 might have for you.

17 THE COURT: Okay. Mr. Kale.

18 CROSS-EXAMINATION

19 BY MR. KALE:

20 Q. Mr. Lundis, Mr. Desai asked you if you had any
21 conversations with Mr. Worthen. Have you had
22 conversations with Mr. Desai or members of his office?

23 A. No, I have not other than today.

24 Q. Haven't talked to him at all?

25 A. Not before this morning, no.

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1 Q. What did you talk this morning?

2 A. About Mr. Worthen and the call in question and
3 the date.

4 Q. Did he talk about the weight with you before
5 coming to this hearing?

6 A. No, sir.

7 Q. Didn't talk about the weight at all?

8 A. No, sir.

9 Q. Did he talk to you about whether your estimate
10 may be low?

11 A. No, sir.

12 Q. Did you understand that the weight was an
13 issue in this case?

14 A. No, sir.

15 Q. You didn't understand that at all?

16 A. No, sir.

17 Q. Now, you've indicated that when you filled out
18 the EMS run report, that -- you indicated 350 pounds; is
19 that correct?

20 A. Yes, sir.

21 Q. And was that your estimate at the time?

22 A. That was my guess at the time, yes.

23 Q. And you're still guessing?

24 A. Yes, sir.

25 Q. And basically people can look like they're

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1 heavier and not be as heavy as they look?

2 A. I suppose that's possible. Yes, sir.

3 Q. And what would really be the best evidence
4 would be the recorded weight that some facility did after
5 they actually weighed him?

6 A. Yes, sir.

7 Q. Now, you mentioned that the patient when you
8 arrived was in respiratory distress. What examination
9 did you do at that point in time?

10 A. Assessed his vital signs, listened to the
11 lungs.

12 Q. Tell me what that involved.

13 A. Blood pressure, respiratory rate, heart rate,
14 skin color, temperature, texture.

15 Q. How long does that take?

16 A. A few moments.

17 Q. What's a few moments, five minutes?

18 A. Less than five minutes.

19 Q. It takes you less than five minutes to put the
20 band around and then --

21 A. Yes, sir.

22 Q. So you did all that in five minutes?

23 A. Roughly, yes, sir.

24 Q. What else did you do?

25 A. Placed the patient on a pulse oximeter,

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1 listened to the lung sounds.

2 Q. How long did that take?

3 A. A minute or two.

4 Q. What else did you do?

5 A. We then placed the patient on oxygen by nasal
6 cannula which takes maybe a minute.

7 Q. What else did you do?

8 A. I asked the nurse aid that was in the room for
9 assistance in moving the patient, and she said she would
10 be right back. We waited a few moments, she did not
11 return, so we moved the patient.

12 Q. I assume that because after you had done the
13 vital signs, you didn't think this was such an emergency
14 that you had to use your blue lights and siren and all of
15 that, correct?

16 A. Correct.

17 Q. He was in distress, but it was not a critical
18 condition?

19 A. What do you mean by "critical condition?"

20 Q. That he might die.

21 A. It's a possibility he could have died.

22 Q. You weren't assessing him as being in that
23 kind of condition? Well, let me ask it this way: If you
24 thought he was in critical condition, would you have used
25 the sirens and the lights?

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1 A. No, I would not because he had a DNR order.

2 Q. So basically you didn't know whether at that
3 point whether he was going to be revivable or not, did
4 you?

5 A. Based on the fact that he had a do not
6 resuscitate order, he wouldn't be revived in the
7 ambulance anyway. So it would be against protocol and
8 the law.

9 Q. So there really was no rush at all is what
10 you're saying?

11 A. No. Our goal is to get the patient to the
12 hospital in a timely manner.

13 Q. But there wasn't any big rush because you
14 didn't use the siren or the blue lights because he had a
15 do not resuscitate?

16 A. That's just the way things are. You don't run
17 red lights and sirens.

18 Q. So it wasn't any real rush on how much -- how
19 fast you loaded him on the stretcher, was there?

20 A. We didn't seem to wait forever. We moved the
21 patient in a timely fashion to get him to the appropriate
22 facility for treatment.

23 Q. You left Laurens County; is that correct?

24 A. Yes, it is.

25 Q. And that was a resignation?

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1 A. Yes.

2 Q. Was that resignation a forced resignation?

3 A. I resigned for medical reasons.

4 Q. For medical reasons?

5 A. Yes.

6 Q. Was there anything going on in your employment
7 that necessitated you resigning at that point in time?

8 A. There were things going on, but I don't feel
9 it was necessary for me to resign at that time. I
10 resigned for medical reasons.

11 Q. Were you told to resign or you would be
12 terminated?

13 A. No, I was not.

14 Q. Now, you indicated that in your firm's
15 practice, someone weighing in the 200 pound range would
16 only require two people, correct?

17 A. Typically, yes.

18 Q. Do you see a lot of patients that weigh in the
19 200 pound range?

20 A. Yes, every day.

21 Q. Okay. Do you lift them and put them on
22 stretchers and transport them every day?

23 A. With the assistance of my partner, yes.

24 Q. And that would be true for anyone from 200 up
25 to 299, correct?

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1 A. Typically, yes.

2 MR. KALE: That's all I've got.

3 THE COURT: Mr. Desai.

4 REDIRECT EXAMINATION

5 BY MR. DESAI:

6 Q. Let's clear a few things. Mr. Kale talked
7 about guessing. No question you were guessing when you
8 put that 350 pounds on the report; is that right?

9 A. Correct.

10 Q. But there's no question you understand how big
11 Emo or Magistrate O'Brien is, don't you?

12 A. Yes.

13 Q. Mr. Kale asked you about would your -- would a
14 facility weighing a patient be a better or more accurate
15 figure than you guesstimated. Do you remember that
16 question?

17 A. Yes, I do.

18 Q. Do you have any knowledge of a facility
19 weighing this patient?

20 A. Not to my knowledge.

21 Q. How long have you been doing this job?

22 A. Almost 19 years.

23 Q. How many patients have you transported?

24 A. Again, guessing, six to nine thousand patients
25 over my career.

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1 Q. Six to nine thousand. Of those six to nine
2 thousand patients that you can recall, how many do you
3 remember to be as heavy as Mr. Coon?

4 MR. KALE: Object to the speculation, Your
5 Honor.

6 MR. DESAI: He can recall if somebody was
7 heavy or not, Your Honor.

8 THE COURT: Overruled.

9 THE WITNESS: Maybe 60, 70.

10 BY MR. DESAI:

11 Q. So from six to nine thousand patients -- I
12 know we're in an estimating ballpark. Let's just take
13 seven. Middle down the road. Is it your testimony that
14 only sixty, give or take a few, were the size of the
15 patient that you transported along with Mr. Worthen that
16 day?

17 A. Yes.

18 Q. How many patients do you actually use the
19 independent straps on, the nine foot straps?

20 A. To secure them to the stretcher, very few.

21 Q. Does that number decrease? Does that go down
22 from that 60?

23 A. I would say that number drops by about a half.

24 Q. So of the heavier patients that you mentioned,
25 you are actually able to raise the side rails built into

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1 that stretcher?

2 A. Yes.

3 Q. And are we talking about this stretcher right
4 here? Is that a normal stretcher that you use,
5 Defendant's APA Page 316?

6 A. That is the stretcher that Laurens County was
7 using at the time.

8 Q. Okay. Let's just kind of narrow our numbers
9 down to what -- to the time you that were employed with
10 Laurens County. How many patients do you think you
11 transported while you were with Laurens County?

12 A. Three to five thousand.

13 Q. Of those three to five thousand, how many of
14 those were the size of Mr. Coon?

15 MR. KALE: Object to the speculation, Your
16 Honor.

17 BY MR. DESAI:

18 Q. If you recall?

19 A. Maybe 30, 35.

20 Q. And of those 30 or 35, how many did you have
21 the need to use the nine foot independent straps to
22 secure them to the stretcher?

23 A. Maybe ten or 15.

24 Q. Is that fairly unusual?

25 A. Yes, it is not a typical situation.

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1 Q. Mr. Kale kept talking about you didn't have to
2 use the blue lights and siren to get him there. Is that
3 a state law or is that a protocol?

4 A. That's a protocol.

5 Q. Can you get in trouble for doing that?

6 A. Yes, you can.

7 Q. So you were not allowed to use blue lights and
8 the siren even if you wanted to, were you?

9 A. There's not blue lights on an ambulance
10 anyway.

11 Q. I'm sorry. Emergency equipment, I should say?

12 A. No, it's not permissible.

13 Q. I'm a former solicitor. I think about blue
14 lights all the time. Just because you're not activating
15 emergency equipment, that doesn't mean that you are to
16 let somebody die, is it?

17 MR. KALE: Objection to leading, Your Honor.

18 BY MR. DESAI:

19 Q. What does your duties say when you walk up as
20 an EMT to a scene and somebody is in distress --
21 respiratory distress? What are you supposed to do?

22 A. Treat the patient as given by the protocols,
23 the patient's presentation, and then transport them in a
24 timely fashion to the closest appropriate facility.

25 Q. And when does DNR kick in?

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1 A. When you see the do not resuscitate paper when
2 they are in cardiorespiratory arrest.

3 Q. So there's a fine line. You're still supposed
4 to help them, right?

5 A. Correct.

6 Q. You're just not supposed to resuscitate them?

7 A. It says no extraordinary measures.

8 MR. DESAI: Thank you.

9 RE CROSS-EXAMINATION

10 BY MR. KALE:

11 Q. Mr. Lundis, have you ever kept any records
12 about the weights of people that you transport?

13 A. No.

14 Q. So you don't know how many people that you've
15 transported that weigh in the 200 pound category or the
16 300 pound category or the 400 pound category, correct?

17 A. Not until my recent appointment.

18 Q. You didn't do it while you were at Laurens
19 County, did you?

20 A. No.

21 Q. And until you were asked that question a
22 moment ago, have you ever given any thought to how many
23 that you have transported that weigh a certain weight?

24 A. From time to time I do based on my current
25 employment and the number of large patients we transport

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1 there.

2 Q. When you were at Laurens County, had you ever
3 given any thought as to what -- what weight you
4 transported?

5 A. In random passing.

6 Q. In random passing. So, I mean, this is
7 something that you just came off the top of your head
8 today with as far as a number, correct?

9 A. Yes.

10 Q. You don't know whether that's accurate or not
11 accurate?

12 A. Correct.

13 Q. It's a wild guess?

14 A. Yes.

15 Q. Now, you've been around nursing homes before,
16 have you not?

17 A. Yes.

18 Q. You've transported patients from nursing
19 homes?

20 A. Yes.

21 Q. Do nursing homes keep vital statistics on
22 patients?

23 A. Thirty days.

24 Q. And that includes weight?

25 A. Not always.

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1 Q. But most of the time?

2 A. It's not been in my recent experience, no.

3 Q. Let me show you the weight in a record we got
4 from National Health Care. Does that give a height and
5 weight?

6 A. It does.

7 Q. So apparently it's the policy of National
8 Health Care to give the weight and height?

9 MR. DESAI: Your Honor, that asks for the
10 speculation on behalf of Mr. Lundis. He can't possibly
11 talk about National Health Care's policy.

12 THE COURT: Sustained.

13 BY MR. KALE:

14 Q. But you do know that some nursing homes do
15 take the weight and height of their patients?

16 A. Yes, and they have varying standards for that.

17 Q. And do they have machines that actually they
18 can put people in to weigh them?

19 A. They have various methods of weighing a
20 patient.

21 Q. Including machines?

22 A. They have scales, they have chairs, they have
23 lifts that weigh patients.

24 MR. KALE: That's all the questions I have.

25 THE COURT: Mr. Desai.

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1 FURTHER REDIRECT EXAMINATION

2 BY MR. DESAI:

3 Q. Keeping track of patient information, isn't
4 that violation of HIPAA laws?

5 A. What do you mean?

6 Q. Are you supposed to keep track of all the
7 patient information or is that confidential?8 A. That's confidential. You're not supposed to
9 keep that. Any information you obtain on your call,
10 you're supposed to destroy it in a shredder after the
11 call.12 Q. Tell me based on your experience, a nurse's
13 aid who doesn't return to help you, can they be counted
14 on to keep weight?

15 MR. KALE: Your Honor, that's ridiculous.

16 BY MR. DESAI:

17 Q. Did you -- did you believe that the nurse's
18 aid that was helping you that day could be relied upon?19 MR. KALE: Objection, Your Honor. All they
20 said was that she said she would be back in a moment.
21 That has no basis for determining her reliability.22 MR. DESAI: He can give an opinion of what he
23 thinks of that person.

24 THE COURT: Sustained.

25 MR. DESAI: Thank you, Your Honor.

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1 THE COURT: Anything else, Mr. Kale?

2 MR. KALE: Nothing from this witness.

3 THE COURT: All right. Thank you. You may
4 step down. Mr. Kale, do you have any objections to this
5 witness leaving?

6 MR. KALE: No.

7 THE COURT: All right. You're excused. All
8 right. Mr. Desai, call your next witness, please.

9 MR. DESAI: We call Magistrate O'Brien, also
10 known as Emo.

11 (EARNEST MICHAEL O'BRIEN, SR., being duly
12 sworn to tell the whole truth and nothing but the truth,
13 testified as follows:)

14 THE COURT: If you could state and spell your
15 full name for the record.

16 THE WITNESS: My full name is Earnest Michael
17 Patrick O'Brien, Sr. You want me to spell it sir?

18 THE COURT: Yes.

19 THE WITNESS: Last name is O, apostrophe,
20 capital B-R-I-E-N.

21 DIRECT EXAMINATION

22 BY MR. DESAI:

23 Q. Magistrate O'Brien or do you mind if I call
24 you Emo?

25 A. That's fine.

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1 Q. Please state your date of birth.

2 A. My date of birth is December 21, 1960.

3 Q. And where do you currently reside, sir?

4 A. Greenville, South Carolina.

5 Q. And what do you do for a living?

6 A. Full-time I'm a Magistrate judge in Greenville
7 County. Part-time I work for Laurens County EMS as a
8 paramedic.

9 Q. Do you know Mr. Worthen who is sitting right
10 here at the plaintiff's table?

11 A. I do.

12 Q. And how well do you know him?

13 A. Fairly well. We've worked together on a
14 number of shifts. We hunt together. So I know him
15 fairly well. I've known him a number of years as a
16 casual acquaintance before I went to work at Laurens
17 County.

18 Q. Would you consider him a friend?

19 A. Yes, I would.

20 Q. Would you lie for him?

21 A. No, I would not lie for anybody.

22 Q. Now that we got that out of the way, let's
23 talk about your work experience. How long have you been
24 an EMT?

25 A. I've been in EMS for 30 years.

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1 Q. Explain the difference.

2 A. Well, EMS encompasses a whole host of people
3 that qualify at different levels. I was a basic EMT for
4 five years. Then I went to paramedic school, and I've
5 been a paramedic for 25 years for a total of 30 years of
6 experience.

7 Q. So you have been doing this for 30 years?

8 A. Yes, sir.

9 Q. And in your 30 years of being a paramedic --
10 is that fair to say, 25 years as a paramedic and five
11 basic? Have you ever been an instructor, have you ever
12 trained anyone?

13 A. I've trained hundreds of people. And, yes, I
14 have been an instructor also as a basic EMT instructor.
15 I've assisted with a number of paramedic courses over the
16 years. I've had hundreds of students.

17 Q. Have you ever had any formal training in
18 reading an EKG strip?

19 A. I have.

20 Q. And what kind of training have you -- have you
21 had in that field?

22 A. I've had numbers of courses in how to
23 interpret 12 lead EKGs. Of course, when I first went to
24 school, we weren't even doing 12 lead EKGs. We were just
25 doing the basic three lead EKGs. So for a number -- I've

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1 been -- I've been reading EKG strips ever since I started
2 this 30 years ago.

3 Q. Have you trained people to read EKG strips?

4 A. I have.

5 Q. And are you certified in that regard?

6 A. I don't know that there's actually a
7 certification per se for reading EKG strips, but I've
8 been to a number of courses where I've passed the
9 courses.

10 Q. How many calls, if you can recall, have you
11 been to where you put a lead on someone and getting a
12 reading -- getting an EKG reading is required?

13 MR. KALE: Your Honor, I don't really know
14 what the relevance of going into reading -- I mean, it's
15 no question he had a myocardial infarction.

16 MR. DESAI: It's a denied case, Your Honor.
17 If he wants to admit that there was a heart attack, then
18 we can -- we can move on.

19 MR. KALE: We have never denied he had a heart
20 attack. We have denied the cause and whether it was
21 unusual or extraordinary, but we have never denied the
22 guy had a heart attack. That's in all the medical
23 records. Every doctor has said that. So, you know, I --

24 MR. DESAI: May we please go off the record,
25 Your Honor?

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1 THE COURT: Yes, we'll go off for a moment.

2 (Off the record.)

3 THE COURT: All right. Mr. Kale, do you have
4 a stipulation for the record so we can move on?

5 MR. KALE: Your Honor, there is no issue that
6 he -- that Mr. Worthen had a myocardial infarction on
7 February 26th of 2011. The issue is what caused it and
8 whether it was an unusual and extraordinary condition of
9 employment.

10 THE COURT: All right. Thank you. Mr. Desai.

11 MR. DESAI: Thank you, Your Honor.

12 BY MR. DESAI:

13 Q. In your 30 years in EMS, how many patients
14 have you transported?

15 A. I would think at least 15,000 people I've seen
16 over the course of 30 years.

17 Q. And of those 15,000 people -- by the way, how
18 much do you weigh?

19 A. I weigh 325 pounds.

20 Q. And how tall are you?

21 A. Six foot one.

22 Q. And what -- what -- what's your waist size?

23 A. Possibly a 46, 48.

24 Q. There's a reason for those questions. I
25 didn't mean to embarrass you.

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1 A. That's fine.

2 Q. Of those 15,000 people that you've
3 transported, sir, how many weighed many excess of let's
4 just say 350 pounds?

5 MR. KALE: Object to the speculation, Your
6 Honor.

7 MR. DESAI: If you can recall?

8 THE COURT: From your recollection.

9 THE WITNESS: Over 350 pounds?

10 BY MR. DESAI:

11 Q. Yes.

12 A. Over 350 pounds probably, I'd say, five
13 percent.

14 Q. Five percent. And if I were to say 400
15 pounds, of course, if you can recall, would that number
16 go up or down?

17 A. It goes down.

18 Q. What would that number be?

19 A. Over 400 pounds, probably --

20 MR. KALE: Same objection, Your Honor.
21 Speculation.

22 THE COURT: From your recollection.

23 THE WITNESS: From my recollection, over 400
24 pounds, probably about two and a half percent, two
25 percent.

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1 BY MR. DESAI:

2 Q. If that number goes up to 450, to the best of
3 your recollection --

4 A. Probably at that point down to about one half
5 of a percent. Maybe a percent at the most.

6 Q. Let me show you Defendant's APA Page 316. Can
7 you please tell us what that is, sir?

8 A. It's a picture of a stretcher made by Striker.
9 It's an electrically device to help with lifting of
10 patients.

11 Q. Does -- does -- does the speed of the
12 stretcher going up and down depend on variables?

13 A. The speed?

14 Q. Yes.

15 A. Well, certainly the battery life. The amount
16 of battery power that's in the battery pack at that time.

17 Q. How about weight of the patient?

18 A. Weight of the patient certainly has an effect.
19 I believe it has a maximum of 600 pounds if I'm not
20 mistaken. Seven hundred pounds according to this.

21 Q. Are you familiar with -- and let me also draw
22 your attention to the specifications, the width and the
23 length of that stretcher. Can you please tell us that
24 is?

25 A. I'm sorry. Would you repeat the question?

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1 Q. The length and the width of that stretcher
2 according to the manufacturer, what is that?

3 A. The width of the stretcher would be the width
4 from side to side where the rails are. The length would
5 be from the head down past the feet to the end of the
6 stretcher where the attendant would grab the stretcher
7 and be able to lift from that end.

8 Q. So that's interesting. So that's -- is it 76
9 and a half?

10 A. Yes.

11 Q. So that's not just the area where the patient
12 is lying. That includes the grab rails?

13 A. That's correct. It would be about -- probably
14 about three to four inches of distance at the end of the
15 stretcher. So the actual bed reaches probably right at
16 six feet.

17 Q. Got you. And, again, how tall are you?

18 A. Six foot one.

19 Q. Do you remember on February 26th of 2011 being
20 called in to relieve a crew member of yours?

21 A. I do.

22 Q. And can you tell us a little bit about that
23 day, sir?

24 A. I was working on a one-man vehicle. We call
25 them quick response vehicles. I was called by the

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1 supervisor to come up to the Clinton station to relieve a
2 crew member who was going to have to go home.

3 Q. Okay. When you got there, did you -- what did
4 you observe?

5 A. When I first got there, the crew was not
6 there. They arrived shortly thereafter. I was
7 immediately told by Mike -- and, I'm sorry, I forget
8 Mike's last name. I'm just drawing a blank. But I was
9 told by Mike that his partner was having chest pain and
10 he showed me an EKG strip and he said, You take a look at
11 this and you tell me what you think.

12 Q. Do you remember -- let me show you Plaintiff's
13 APA 1, Page 4, 5, and 6. Can you please tell us what
14 that is?

15 A. This is a computer-generated copy of a patient
16 care report involving Mr. Worthen.

17 Q. And can you read the signs and symptoms
18 section of it?

19 A. Yes, sir. It says, "Cardiac chest pain,
20 pressure, tightness, respiratory -- respiratory dyspnea,"
21 which is shortness of breath.

22 Q. Is that based on what the patient tells you?
23 Is that a patient history? Basically whatever the
24 patient tells you?

25 A. It's based on what the patient tells us and

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1 what we observe.

2 Q. And who filled out -- did Mr. Lundis fill that
3 out?

4 A. Yes, I'm sure he did.

5 Q. Okay. What did you observe -- did you observe
6 anything peculiar about Mike Worthen when you arrived at
7 the station to relieve him?

8 A. I could look -- I could look at his face and I
9 could tell that he didn't feel good, first of all. His
10 color was just slightly off to me. Just didn't look
11 quite right. And like I said, I had been told that he
12 was having chest pain and I was given an EKG strip to
13 look at to give my opinion on what I thought was there
14 and/or what might need to be done.

15 Q. Had you ever seen Mr. Worthen like that
16 before?

17 A. No, I had not.

18 Q. We were talking about the bed rails as to how
19 wide somebody has to be in order for those bed rails to
20 work. When you've got an excessively large patient with
21 that Striker stretcher, what do you have to do to secure
22 that patient on the stretcher?

23 A. Certainly the bed rails are there for the
24 purposes of protecting the patient from coming off the
25 stretcher. But if you can't get the rails up, you can't

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1 get the rails up. Some of the stretcher straps are
2 somewhat longer than others. If the stretcher straps
3 will fit, certainly we're going to put the stretcher
4 straps on to protect the patient. If not, then we'll
5 have to use something else to secure the patient to that
6 stretcher. For example, we carry on the ambulance nine
7 foot straps, and we could use nine foot straps to wrap
8 literally around the patient and the stretcher itself to
9 secure them to the stretcher.

10 Q. That's interesting you say that. How often do
11 you use a nine foot strap?

12 A. Not very often.

13 Q. When you say not very often, what's that?

14 A. Probably one and a thousand, maybe.

15 Q. Is that -- is that unusual?

16 A. Yes, it is. I've rarely -- I've rarely had to
17 use nine foot straps over the years.

18 Q. Would that patient have to be unusually large?

19 A. Yes.

20 MR. DESAI: I don't have anything else.
21 Please answer any questions Mr. Kale or Your Honor might
22 have.

23 THE COURT: Mr. Kale.

24 CROSS-EXAMINATION
25

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1 BY MR. KALE:

2 Q. Mr. O'Brien, you were not present when
3 Mr. Worthen and Mr. Lundis transported the patient to
4 Laurens County Hospital, correct?

5 A. I was not.

6 Q. So you never saw the patient?

7 A. I did not.

8 Q. You do not know what his size is?

9 A. Only from what I've been told from when they
10 came to the station. They said they had just transported
11 a large --

12 Q. But you don't know from your own knowledge?

13 A. Not from my own knowledge. I never saw the
14 person.

15 Q. So you don't know if this patient weighed
16 250 pounds, 350 pounds, or 450 pounds?

17 A. I have no knowledge.

18 Q. And your testimony has been that you have, as
19 a paramedic, lifted people who weighed over 400 pounds?

20 A. I have before. Yes, sir.

21 Q. That's part of your job as a paramedic?

22 A. Yes, sir.

23 Q. You're going to run into people weighing that
24 amount?

25 A. I have done it. But if you're asking me if I

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1 have done it by myself, the answer is no.

2 Q. No. But with a partner?

3 A. Partner and/or other help, yes.

4 Q. So it has happened that you have, as a
5 paramedic, had to with a partner lift somebody weighing
6 350 pounds or 400 pounds or even more?

7 A. Yes, with help.

8 Q. Okay. And let me ask you, what is a draw
9 sheet?

10 A. A draw sheet could be any number of devices
11 that could be used. It could be a blanket. It's
12 something you put under the patient to help move them
13 from one bed to another. It could be a blanket, it could
14 be a sheet, it could be a heavy cloth of some sort.

15 Q. When you're moving heavy patients, do you
16 normally use a draw sheet to pull them over on a
17 stretcher?

18 A. Sometimes, but not often. Most of the time
19 they don't have draw sheets under them and draw sheets
20 don't always work very well anyway.

21 Q. But it is your experience that you have had,
22 with your partner, to lift people weighing to the 300
23 pound range and the 400 pound range?

24 A. Yes, sir. With a proviso that I don't usually
25 try to move them by myself, with my partner, if they're

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1 that large because there is a danger of that excessive
2 weight hurting you.

3 Q. But you have done that?

4 A. I have done it under unusual circumstances.
5 Yes, sir.

6 MR. KALE: That's all the questions I have.

7 THE COURT: Mr. Desai.

8 REDIRECT EXAMINATION

9 BY MR. DESAI:

10 Q. You said unusual circumstances --

11 A. Yes, sir.

12 Q. -- is that right?

13 A. Yes, sir.

14 Q. What would be -- what would that be? What
15 would be an example of that?

16 A. Well, when I get to a patient that I realize
17 is larger than I feel is safe for me to try to move, I'm
18 going to call for help if I have the time to do so. If I
19 don't have the time to do so, if I think the patient is
20 in serious enough condition that I need to make a
21 decision to move the patient at that point in time, then
22 I have done it before with just myself and my partner.
23 But an unusual circumstance would be a person who was
24 critical, who needed definitive care in a quicker manner
25 than I had the time to just sit on the scene and take my

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1 time and do things.

2 Q. Would respiratory distress be considered an
3 unusual circumstance?

4 A. It could be. Yes, sir.

5 Q. Is there an extraordinary amount of exertion
6 that takes place in lifting somebody that heavy?

7 A. Yes. Number one, you're reaching across your
8 stretcher to the other bed, so you're already in a
9 stretching or a reaching motion. So you take a danger of
10 hurting yourself and hurting your back. Certainly when
11 you're lifting that much weight on a dead lift, it's a
12 very stressful maneuver on your body in general.

13 Q. Mr. Kale asked you have you done it, and the
14 answer was yes, you have lifted someone that heavy?

15 A. Yes, sir.

16 Q. How rarely?

17 A. Very rarely by myself or with my partner. If
18 they're that large -- if they're as large as I'm being
19 told this person was, it would be an extremely rare
20 occurrence.

21 MR. DESAI: Thank you, sir. Appreciate your
22 time.

23 THE COURT: Mr. Kale.

24 RECROSS-EXAMINATION

25

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1 BY MR. KALE:

2 Q. If you had a patient who was DNR, do not
3 resuscitate, is there any rush to have to lift him on the
4 stretcher?

5 A. A DNR only says that I'm not going to be doing
6 any extraordinary resuscitative measures. But a person
7 with a DNR who is still breathing, who is still
8 treatable, I'm still going to treat them just as if they
9 didn't have that DNR unless their heart stopped.

10 Q. Would you wait for help with a patient with a
11 DNR?

12 A. No, I would not.

13 MR. KALE: That's all the questions I have.

14 MR. DESAI: Nothing further from me.

15 THE COURT: Thank you, sir.

16 MR. DESAI: Your Honor, may be ask that Mr.
17 O'Brien be excused?

18 MR. KALE: I have no objection.

19 THE COURT: Mr. Kale, do you have any
20 witnesses?

21 MR. KALE: I'm not going to call any
22 witnesses.

23 THE COURT: All right. Then that concludes
24 this hearing.

25 (The hearing was concluded.)

Kimberly T. Power, CCR
kimberlytpower@aol.com

**Transcript of
Full Commission Panel Hearing
held on April 16, 2013**

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1103604

Mike Worthen,)
)
Employee,)
)
v.)
)
Laurens County,)
)
Employer,)
)
and)
)
Association of Counties,)
)
Carrier/Defendants.)
-----)

(COPY)

FULL COMMISSION PANEL HEARING

Tuesday, April 16, 2013
11:00 a.m. - 11:22 a.m.

The Full Commission Panel Hearing was held before the South Carolina Workers' Compensation Commission, 1333 Main Street, 5th Floor, Columbia, South Carolina, on the 16th day of April, 2013 before Jill H. Vickers, Certified Court Reporter and Notary Public in and for the State of South Carolina.

1 **COURT REPORTER:** Today is April 16th, 2013. This is
2 South Carolina Workers' Compensation Case
3 Number 11033604. This is the case of Mike
4 Worthen, Claimant, versus Laurens County,
5 Employer, and Association of Counties is the
6 Carrier. The Appellant is the Defendant
7 represented by Richard B. Kale. The Respondent
8 is represented by Monty D. Dasai.

9 **MR. KALE:** May it please the panel. Mr. Worthen was
10 employed as EMT with Laurens County. On
11 February 26th of 2011, he suffered a myocardial
12 infarction. Subsequent testing revealed that
13 Mr. Worthen had severe coronary artery disease.
14 He had three main coronary arteries totally
15 occluded, the left anterior descending, the
16 circumflex and the proximal right coronary
17 artery. His risk factors for developing
18 coronary artery disease were diabetes, family
19 history of coronary disease, high cholesterol
20 and smoking. That's according together
21 Dr. Bittrick in his deposition testimony. The
22 issue on appeal is whether the claimant met the
23 standard for compensability of heart attacks,
24 and that is an unusual strain or overexertion
25 or unusual or extraordinary conditions of

1 employment. The claimant contended that his --
2 that the cause was unusual or extraordinary
3 because he was lifting a patient that weighed
4 very heavy. The amount or the weight of the
5 patient was in dispute at the hearing. On
6 February 26th, 2011, the claimant and his
7 partner, a paramedic, had gone to National
8 Healthcare in Clinton to transport a resident
9 who was in respiratory distress. In the
10 initial report to his cardiologist, Mr. Worthen
11 indicated that the patient weighed 500 pounds.
12 Subsequently, at the hearing, he said that the
13 patient weighed 400 to 450 pounds. However, he
14 indicated in his testimony that he was just
15 guessing at the weight, and I had put in the
16 handout, the testimony where he said he was
17 just guessing at how much the fellow weighed.
18 He also presented the testimony of the
19 paramedic, Mike Lundis, who had initially
20 estimated the weight as being 350 pounds, then
21 upon questioned by Mr. Desai, he said, "Well,
22 it could have been much more that, but he also
23 admitted that he was just guessing as to the
24 weight. Contrary to the guessing by the
25 claimant and his partner, we submitted a report

1 from the National Healthcare, and that is
2 included in the documents that I submitted,
3 that indicate that the patient, who was a Joe
4 Koon, weighed 262 pounds. Neither the claimant
5 nor his partner actually weighed. They were
6 just guessing at his weight. So, here, we have
7 a document from the facility where the patient
8 was a resident that indicates that his weight
9 was 262 pounds, not the 400 to 450 pounds as
10 indicated by Mr. Worthen. The Hearing
11 Commissioner in his Finding of Fact Number 7
12 found that the evidence showed the range being
13 262 to 500, but based on the evidence, it was
14 reasonable to conclude that the patient's
15 weight was closer to the low end of the range,
16 but he didn't make a specific finding as to
17 what the actual weight was. No appeal was
18 taken by the claimant to that finding. We did
19 file an exception saying, "He should have found
20 that the patient weighed 262 pounds, because
21 that is the best evidence, and Mr. Lundis
22 admitted that the best evidence would be the
23 weight shown by some facility that actually
24 weighed the patient. Now, accepting that the
25 weight was 262 pounds or close to it, the issue

1 is, whether lifting a patient weighing that
2 much was unusual or extraordinary. We submit
3 it was not. In fact, Mr. Worthen testified at
4 Page 71, and I submitted his testimony, that he
5 frequently lifted patients weighing 250 to 260
6 pounds. Likewise, Mr. Lundis also admitted
7 that he would frequently lift patients weighing
8 200 to 299 pounds. That's at Page 101 of his
9 testimony. So, we would submit that the
10 greater weight of the probative evidence in
11 this case showed that the patient weight 262
12 pounds, and that it was not unusual or
13 extraordinary for paramedics or EMTs to lift
14 someone weighing that weight. We also
15 submitted as an error that the Hearing
16 Commissioner erred in having us pay for Mr.
17 Worthen's bypass surgery. It is undisputed in
18 this record -- both doctors testified that the
19 bypass surgery was necessitated by Mr.
20 Worthen's pre-existing coronary artery disease.
21 Dr. Bittrick testified that the reason for the
22 surgery was to treat his coronary artery
23 disease, and he also testified that he was
24 going to need that surgery whether he had had
25 this heart attack or not. In other words, it

1 was a preventive type surgery to prevent him
2 from having further heart attacks because he
3 had clearly insufficient coronary capacity
4 because of his coronary artery disease.

5 **COMMISSIONER BARDEN:** Was his need for the surgery
6 accelerated by this event?

7 **MR. KALE:** It depends on what you mean by
8 "accelerated". I mean, this event brought it
9 to the attention of everyone that he had
10 coronary artery disease. Once it became to
11 anybody's attention, they were going to
12 recommend that he have the bypass surgery. So,
13 it didn't worsen the condition, if that's what
14 you mean by accelerated, but it did bring it to
15 the attention of his doctors that he had this
16 coronary artery disease and that it was
17 sufficiently severe that he needed to have the
18 bypass. If he had had a stress test and it
19 showed that same severe artery disease, even if
20 he hadn't had a heart attack, they would have
21 recommended this same procedure. So, from that
22 standpoint, I don't think that's what the Act
23 is talking about when it says "accelerated".
24 It basically brought it to ---

25 **COMMISSIONER BARDEN:** You're saying it exposed it?

1 **MR. KALE:** Yeah, it exposed it, and once they knew
2 about it, they recommended that he have bypass
3 surgery. So, our position is, we shouldn't
4 have to pay for that, because that was
5 something that was caused by his pre-existing
6 disease that had been naturally acquired. It
7 wasn't caused by his employment. It was caused
8 by the medical conditions, the risk factors
9 when I mentioned to you earlier, and in the
10 same vein, if you find that the bypass surgery
11 shouldn't be the liability of the defendants,
12 the seven weeks he was out when he had the
13 bypass surgery, we should not be liable for,
14 either. So, it's our position in this case
15 that the greater weight of the probative
16 evidence indicates that the complaint lifted a
17 patient weighing 262 pounds which was not
18 unusual or extraordinary, and therefore, it
19 doesn't meet the standards for compensability
20 of a heart attack in this case, and it's also
21 our position that the bypass surgery and any
22 lost time that he had because of the bypass
23 surgery shouldn't be the defendant's liability
24 in any event, because that is basically to cure
25 his personal condition, not anything that

1 resulted from the myocardial infarction. Thank
2 you.

3 **MR. DESAI:** May it please the panel and Mr. Kale, I
4 believe in reaching a decision, a commissioner,
5 as you well know, has to consider two different
6 things. One is the facts presented at the
7 hearing, and the other is the medical evidence,
8 the causation. The facts presented at the
9 hearing are undisputed. Mr. Kale very
10 accurately stated the legal standard in a heart
11 attack case which is, it can be caused by an
12 overexertion or an unexpected strain or unusual
13 conditions at work. This is not a case of
14 clear evidence where, you know, we can look at
15 something and say this is black or white.
16 We're in a gray area, and that's why we're
17 here. Some of the things that help us clarify
18 the weight issue is, there's testimony by
19 several people, including Mr. Kale's report.
20 Mr. Kale's report says that -- and it was from
21 National Healthcare Center, and it says "262
22 pounds". I think Mr. Kale has no choice but to
23 concede that 262 pounds is the least the
24 claimant ---

25 **COMMISSIONER BECK:** Why is it even relevant how much

1 the patient weighed? Is it unusual or
2 extraordinary or unexpected that an EMT could
3 show up at the scene of any call -- is it
4 really out of the ordinary to find somebody or
5 treat somebody that weighs 250, 300, 350
6 pounds?

7 **MR. DESAI:** Absolutely not, Commissioner. As a
8 matter of fact, it's not unusual, and it was
9 actually testified to that effect. However,
10 the distinguishing fact in this case is,
11 anytime they encounter somebody in that weight
12 area, they would require, or they would call
13 the Laurens County Fire Department to assist
14 them in lifting and transporting that patient.
15 They did not have that choice in this case.
16 There was a patient that was in respiratory
17 distress when they got into that room. There
18 was testimony that the room they entered into
19 had a strange configuration. There was an air
20 conditioner unit that was by the bed. There's
21 testimony that the claimant had to reach over,
22 had to get under the claimant's arms, had to
23 grab the claimant by the wrist. Bulk of the
24 claimant's weight was supported by -- well, the
25 patient's weight was supported by the

1 claimant's upper body while standing in an
2 awkward position. So, to answer your question,
3 Commissioner, it's not unusual at all.
4 However, what's unusual are the circumstances
5 surrounding that particular incident. Again,
6 their report -- I mean, I think it's important
7 that it says 262 pounds. It was dated February
8 1st, and it also says that it could be within
9 30 days -- accurate within 30 days of the
10 report, which could then take us back to
11 January 1st. So, we're talking in the last 60
12 days, essentially, the claimant could have
13 weighed 262 pounds. More importantly, we don't
14 really know the accuracy of that weight. We
15 don't know if the CNA actually weighed this
16 patient. Did they just take the weight over
17 from the time they were admitted and just carry
18 it on over? What we do know is that Mike
19 Lundis and Mr. O'Brien and the claimant stated
20 that there was a stretcher that was
21 76-and-a-half inches, and the patient's body
22 extended -- the legs extended 8 inches beyond
23 that stretcher. What's also important ---

24 **COMMISSIONER JAMES:** Mr. Desai, didn't I just hear
25 you say to Commissioner Beck, though, that the

1 weight is not what makes this unusual?

2 **MR. DESAI:** Well, it doesn't if we're talking about
3 262 pounds here. Mr. Kale's argument here is
4 that 262 ---

5 **COMMISSIONER JAMES:** So, the order is not -- even in
6 your -- what your argument is and what you're
7 saying, if I heard it correctly, is that the
8 order doesn't even state the exact reason that
9 you contend it was unusual.

10 **MR. DESAI:** That's correct, but the Commissioner
11 said is that it was always influx. When we
12 were talking to Dr. Bittrick -- and when
13 Dr. Bittrick was talking about the weight, and
14 while my client might have stated that the
15 weight was 500 pounds initially, that with a
16 guesstimate, no question about that. However,
17 what is a true gauge, I believe, is that Mr.
18 Lundis stated that the patient was bigger than
19 Mr. O'Brien who was 325 and 6 foot 1 inches.
20 Comparatively speaking, he was bigger than 325
21 he weighed more than 325. He was taller than
22 6' 1". I mean, I believe that's important,
23 Commissioner, for the fact that ---

24 **COMMISSIONER JAMES:** But you're saying that that
25 combined with the fact that they would have

1 somebody else. It's not unusual for multiple
2 people to lift a person of a greater size, but
3 you're saying, the thing that makes it unusual
4 is they didn't have all the people they needed?

5 **MR. DESAI:** They didn't have all the right people.
6 They didn't have the right conditions. They
7 didn't have the right space normally speaking
8 to be able to wheel out that bed, get in a
9 proper position where they could anchor their
10 knees or buckle their feet down, and they could
11 lift in a proper lifting position. They didn't
12 have the luxury of doing any of that. They had
13 to get this guy in and out of there -- or they
14 had to get in and get this guy out of there
15 before he died, and that was the -- and again,
16 and as a panel is quite aware, I only need to
17 prove one prong or the other. I don't have to
18 prove both prongs. It could be overexertion or
19 an unexpected strain or the unusual work
20 condition. If the commission were to find that
21 this was not unusual for an EMT to go in there
22 and perform these type of duties, the over
23 exertion and the strain, I can still meet my
24 burden by showing that, by proving that
25 particular prong, and the weight kind of goes

1 to ---

2 COMMISSIONER BECK: I'd like you to dwell on that
3 component for just a minute, because the thing
4 I'm wrestling with is, these seem to be
5 expected duties of an EMT.

6 MR. DESAI: Correct.

7 COMMISSIONER BECK: And I'm still grasping at why
8 this is so unexpected or why this amounts to
9 over exertion in this particular case.

10 MR. DESAI: And Commissioner, there's caselaw that
11 says that it's not the duties as an EMT in
12 general that matters. It's duties with a
13 particular defendant/employer that matters.
14 And the claimant has testified, and so has Mr.
15 O'Brien, that with that particular
16 defendant/employer, Laurens County, they had a
17 protocol that anytime they encounter somebody
18 over a particular weight, they were to call for
19 backup. They were to call the Fire Department
20 to assist in lifting and transportation. That
21 was the protocol. That's undisputed. I don't
22 think there's any question about that. So, the
23 point that I'm trying to make by demonstrating
24 the size of this patient is that, that patient
25 was outside that threshold to where they would

1 have normally ordinarily required assistance,
2 and in this case, they weren't able to get
3 that. Combine that with the fact that ---

4 **COMMISSIONER BECK:** What is the threshold?

5 **MR. DESAI:** They said anybody over 200 or 250
6 pounds. Mr. Kale went in there and asked Mr.
7 Lundis another thing, and I think the
8 Commissioner needs to be aware of, is that, you
9 know, "Were you ordinarily transporting 200 to
10 299 pound people", and the answer that Mr.
11 Lundis gave was "Yes, we do", but the
12 distinguishing characteristic there is or the
13 distinguishing fact there is that Mr. Lundis is
14 not currently employed with Laurens County.
15 He's working for a non-emergent vital care
16 system which transports patients back and forth
17 for dialysis. They have the luxury of taking
18 their time. They have the luxury of getting
19 there when they need to get there. They're not
20 in a hurry. No one is dying. No one is in a
21 hurry. They've got proper equipment, proper
22 rooms to move these patients. So, I mean, I
23 think it's important to note that while it
24 might be ordinary for Mr. Lundis to do that at
25 his current job in a non-emergent facility,

1 that wasn't the case back then with Laurens
2 County EMS where he was actually responding to
3 an emergency situation. More importantly,
4 Dr. Bittrick's testimony and Dr. Ellison's
5 testimony is very relevant, Commissioners, in
6 the sense that both of them have said --
7 Dr. Bittrick says -- and the Hearing
8 Commissioner stated it very well, "While the
9 weight might have been influx, looking at that
10 deposition in its entirety, Dr. Bittrick says
11 that it was that strenuous event. It was that
12 particular stress of lifting that overweight
13 patient that triggered that heart attack."
14 Second, Dr. Ellison, who the defendants had
15 hired to do a records review said the same
16 thing, and we've quoted that in our brief, that
17 despite this pre-existing, which we all know is
18 not relevant. The caselaw is very clear that,
19 even if somebody has a pre-existing condition,
20 that doesn't matter. The fact of the matter
21 is, did this particular strenuous event trigger
22 the heart attack, and was it the cause of the
23 heart attack. And the answer is very clear --
24 the answer is quite clear. Both doctors have
25 stated that to a reasonable degree of medical

1 certainty that that strenuous event is the
2 cause of the heart attack. Thank you.

3 **MR. KALE:** May it please the panel. It is not
4 enough that you show that something that
5 occurred at work triggered the heart attack.
6 Otherwise, every heart attack that occurs at
7 work would be compensable. The standard is,
8 you have to show that, even if the work caused
9 it, that the work was an unusual or
10 extraordinary condition of employment or
11 unusual or extraordinary strain. That is the
12 issue in this case, and we submit that the
13 evidence shows that, basically -- the greater
14 weight of the evidence that the patient weighed
15 262 pounds, that it was not unusual to have to
16 pick up patients weighing that weight, both Mr.
17 Worthen and the other claimant's witness, Mr.
18 Lundis ---

19 **COMMISSIONER BECK:** What about the overexertion prong
20 of that? Basically, there's two prongs to
21 that, the extraordinary strain or overexertion
22 or the unusual or extraordinary.

23 **MR. KALE:** Our position was that it wasn't an
24 overexertion. In the materials are the type of
25 stretchers that they use which have motorized

1 -- that pull up and down -- basically, what
2 they had to do was pull him onto the stretcher.
3 Now, I think he's misstating the evidence as
4 far as when they would call for assistance.
5 The testimony was when it got a patient in the
6 400 to 450 range, they would sometime call for
7 the Fire -- I don't think it was in the 200 --
8 I don't think you'd call for the Fire
9 Department to come assist you when you're
10 lifting a 200 pound patient. There's been
11 reference to Mr. O'Brien or Magistrate O'Brien.
12 He wasn't there. He had no personal knowledge.
13 He is a paramedic, I believe, and they brought
14 him in and asked some questions, but he didn't
15 know what the weight was, and he didn't know
16 what occurred at the facility. So, I think
17 it's clear that this fellow had a serious
18 pre-existing coronary artery disease, and that
19 basically, anything that he did could have
20 brought on a heart attack, because he had
21 insufficient blood flow, and that's not an
22 issue. The issue is whether what he was doing
23 at work on that day was either an unusual or
24 extraordinary strain or an unusual or
25 extraordinary condition of employment. Based

1 upon the competent evidence which is that this
2 patient weighed 262 pounds, not the 450 to 500
3 that the claimant testified to, we don't think
4 it was either unusual or extraordinary strain
5 or an unusual or extraordinary condition of
6 employment.

7 **COMMISSIONER JAMES:** That concludes this hearing.

8 (Whereupon, the Full Commission Panel Hearing
9 concluded at 11:22 a.m.)

Appellant's APA Submission #2

 [Print this Page](#)

Worthen, Mike

Sex:M

BD:09/08/1956

MR#:971366670

DISCHARGE SUMM**Mar 14, 2011 08:00**

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF DISCHARGE: 03/14/2011

REASON FOR ADMISSION: Angina and coronary artery disease.

FINAL DIAGNOSIS:

1. Hypothyroidism.
2. Hypertension.
3. Hyperlipidemia.
4. Type 2 diabetes mellitus.
5. Non-Q-wave myocardial infarction (MI)
6. Postop ventricular fibrillation arrest requiring implantable cardioverter-defibrillator (ICD) placement.

PROCEDURES:

1. Left heart catheterization on 02/28/2011.
2. Coronary artery bypass grafting (CABG) x 4 with left internal mammary artery to the diagonal artery (D1), saphenous vein graft to the left anterior descending (LAD), saphenous vein graft to the obtuse marginal (OM) 1, saphenous vein graft to the right coronary artery, left ventricular (LV) aneurysmectomy and left ventricular (LV) thrombectomy on 03/02/2011 by Dr. Barry Davis.
3. Implantable cardioverter-defibrillator (ICD) placement on 03/08/2011 by Dr. Manfredi.

CONSULTING PHYSICIANS:

1. Dr. Manfredi, EP.
2. Dr. Horton, endocrinology.
3. Dr. Treece, pulmonary medicine.

REFERRING PHYSICIAN: Dr. Ross, Upstate Cardiology.

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: Patient is a 54-year-old white male who presented with acute myocardial infarction on 02/27/2011. Patient had a troponin that peaked at 2.6. He did have a non-Q-wave MI. He was taken to the cath lab 48 hours after admission where his cardiac catheterization showed severe, multivessel coronary artery disease with totally occluded LAD that filled by collaterals and totally occluded circumflex system and right system, filled via collaterals as well. EF was estimated at 30% with anterior apical hypokinesis. The echo showed a questionable mural thrombus with ejection fraction of 30%. It was felt that CABG, LV aneurysmorrhaphy were indicated. A MRI was recommended, however due to the patient's claustrophobia, this could not be done. The patient did have an echocardiogram, again that demonstrated LV thrombus. As part of the preoperative evaluation for CABG, Dr. Horton from endocrinology, was consulted secondary to uncontrolled hyperglycemia, diabetes mellitus. Dr. Treece from pulmonary medicine was also consulted for preoperative clearance. The patient had a carotid duplex preoperatively, demonstrated bilateral B1 with 15% stenosis with antegrade vertebral flow. It was felt that the patient had sleep apnea but was cleared from a pulmonary standpoint. He was taken to the OR on 03/02/2011 where he underwent CABG x 4. Left internal mammary artery was used to the diagonal, saphenous vein graft to distal LAD, saphenous vein graft to the OM and saphenous vein graft to right coronary artery. Intraaortic balloon pump was placed at the time of surgery LV aneurysmorrhaphy with LV

thrombectomy was performed by Dr. Barry Davis. At the time of surgery, the patient had a subacute anterior MI with large amount of edematous as well as the inferior wall. Ejection fraction was 25% prior to cardiopulmonary bypass. The patient had a large amount of laminate clot as well as free floating clot in the left ventricle. The patient tolerated procedure and was transferred to the CV ICU. In the CV ICU Dr. Treece, from pulmonary medicine, continued followup for critical care management. The patient was hemodynamically stable with a hematocrit of 24, BUN and creatinine were stable at 15 and 1.3. He remained intubated and sedated on pressure support. Dr. Horton, from endocrinology, continued to follow the patient. He was placed on an insulin drip for hyperglycemia control. On postoperative day 2, the patient's intraaortic balloon pump was removed without difficulty. Upstate Cardiology continued to follow the patient. Again, he was intubated and sedated. He was weaned off all pressor support. Patient was scheduled to be transferred to 4D telemetry bed, however the patient developed V-fib arrest requiring CPR and defibrillation. This time, Dr. Manfredi from EP was consulted. The patient had an ICD placed on 03/08/2011 by Dr. Manfredi. The patient was also continued on IV Amiodarone. Patient was subsequently transferred to 4D telemetry bed. From here, his hospital course has been fairly uneventful. His pacing wires and XL tubes were removed without difficulty. He has been ambulating with the assistance of physical therapy and HeartLife. He was started on Coumadin for his LV aneurysm thrombus. He was weaned off all oxygen. His blood sugars were under good control with the help of endocrinology. He will be discharged to home on 03/14/2011. On the day of discharge, the patient's vital signs included temperature 97.7, heart rate 66 and regular, blood pressure 122/74, 98% on room air. His lab values on the chart include white blood cell count is 12.3, hemoglobin 10.3, hematocrit 30.8, platelets are 333, potassium is 4, BUN is 12, creatinine 1.1.

MEDICATIONS ON DISCHARGE:

1. Enteric coated aspirin 81 mg 1 p.o. daily.
2. Coreg 3.125 mg 1 p.o. twice daily.
3. Quinapril 5 mg 1 p.o. daily.
4. Pravachol 80 mg 1 p.o. daily.
5. Ultracet 1 to 2 p.o. q. 4 to 6 hours p.r.n. for pain.
6. Coumadin 4 mg 1 p.o. daily.
7. Levothyroxine 250 mcg 1 p.o. daily.
8. Prilosec OTC as taken at home.
9. Spiriva HandiHaler 1 inhalation daily.
10. Amiodarone taper 200 mg 1 p.o. b.i.d. x 1 week then decrease to 1 p.o. daily.
11. Novolin N 30 units subcutaneously q a.m. and q p.m.
12. NovoLog sliding scale as directed by Dr. Horton.

The patient's level of activity is restricted to no heavy lifting, no pushing or pulling with arms for 8 to 10 weeks, no driving for 4 weeks. He is instructed to wash all incisions daily with warm soapy water and keep clean and dry. He is encouraged to abstain from smoking and to attend cardiac rehab. If he has problems or questions prior to seeing Dr. Davis in 2 weeks, he is instructed to call 455-6800. The patient also has follow up appointment with Dr. Ross in 1 month and with Upstate Coumadin Clinic on 03/17/2011 at 10:30 a.m. for PT INR check. Again, the patient is on 4 mg tablets. His INR range needs to be between 2 and 3. He is on it for LV aneurysm repair with LV thrombus at the time of surgery and ventricular arrhythmias postoperatively. The patient, again, is encouraged to abstain from smoking, to attend cardiac rehab.

DICTATED BY: Sarah K. Miller, PA-C.

Barry R. Davis, MD

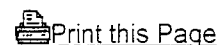
cc: Barry R. Davis, MD

Charles D. Ross, MD

D: 03/14/2011 02:49 P T: 03/14/2011 04:04 P zhj/C DVI: 287163 C/S#:
3308480

Page created: Wednesday, June 29, 2011 8:28 AM For: BAT09C

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Worthen, Mike

Sex:M

BD:09/08/1956

MR#:971366670

OP NOTES/GI LAB

Mar 02, 2011 08:00

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

Patient Location:

084D4429AM

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

DATE OF OPERATION: 03/02/2011

REFERRING PHYSICIAN: Dr. Charles Ross.

SURGEON: Dr. Barry Davis.

PREOPERATIVE DIAGNOSIS: Ischemic coronary artery disease with left ventricular aneurysm, ejection fraction of 20% with congestive heart failure.

PROCEDURES: Left ventricular aneurysmorrhaphy with left ventricular thrombectomy, coronary artery bypass graft (CABG) x 4 using left internal mammary artery for bypass graft to the diagonal coronary artery, the saphenous vein for reverse coronary artery bypass graft to the distal left anterior descending coronary artery, the obtuse marginal coronary artery and right coronary artery.

INDICATIONS FOR OPERATION:

A 54-year-old gentleman who presented with 2 week history of flu-like symptoms. He presented here and was found to have a troponin of 3.03, consistent with a non-Q-wave MI. He had an echocardiogram that demonstrated an ejection fraction of about 25% to 30% with left ventricular thrombus. The cardiac cath showed severe 3 vessel coronary artery disease with the LAD 100% occluded, the circumflex 100% occluded and the right coronary artery 100% occluded. The LAD and circumflex system filled via homocollaterals and the right coronary artery system filled via heterocollaterals.

FINDINGS AT OPERATION:

The left internal mammary artery was small but had excellent flow. He had severe left ventricular hypertrophy. Had subacute myocardial infarction. His entire anterior wall was severely edematous as was his inferior wall. Ejection fraction was around 25% prior to cardiopulmonary bypass. After doing the bypass, it was around 50%. His diagonal, where it was bypassed, was 1.5 mm. The saphenous vein was excellent quality. The distal LAD was 1.5 mm. The obtuse marginal was 1.5 mm. The right coronary artery was greater than 2 mm. He had an apical left ventricular aneurysm with a significant amount/large amount of laminated clot, as well as free floating clot in the left ventricle.

OPERATION:

The patient was taken to the operating room and placed in the supine position on the operating table. Following application of general anesthesia via oral endotracheal tube, the chest, abdomen and legs were prepped with DuraPrep and draped in a sterile fashion. The saphenous vein was harvested from both thighs via the endoscopic vein method. Drains were placed in the thighs. The wounds were closed in all layers with Vicryl in a running manner. Simultaneously, median sternotomy skin incision was made with the knife. Incision was carried to the sternum. The sternum was divided with by the power saw. The left pleural cavity was entered. The left internal mammary was harvested from the level of the first rib to its bifurcation at the diaphragm. Following systemic heparinization, an ACT of 400 seconds was obtained, it was divided on the chest wall and ligated with metallic clips. An XL drain was placed in the left pleural cavity and secured to skin. The pericardium was opened in an inverted "T" fashion and

tacked to the chest wall. There was a significant amount of pericarditis noted along that. After systemic heparinization and ACT of 400 seconds, routine standard cannulation was performed. The patient was placed on cardiopulmonary bypass and cooled to 30 degrees Centigrade. The aorta was cross-clamped. Seven hundred and fifty mL of blood cardioplegia solution administered antegrade through the root and 500 mL retrograde through the coronary sinus catheter. This resulted in cold, flaccid arrest of the heart. Blood cardioplegia solution was supplemented intermittently retrograde throughout the aortic cross-clamp time, the last does being given warm. The heart was reflected.

The distal right was identified, opened longitudinally. A distal saphenocoronary anastomosis was made with 7-0 Prolene in a continuous fashion. The vein graft was tested with cardioplegia solution and found to run well. It was cut to the appropriate length. A 4.0 punch was made then made in the aorta and the proximal anastomosis was made with 6-0 Prolene in a continuous fashion. Prior to doing the bypasses, a left ventriculotomy was created parallel to the left anterior descending coronary artery, near the apex of the ventricle, for about 4 cm. A significant amount of laminated and free-floating clot was identified and removed manually. Great care was taken to wash the ventricle out, and suck it out in order to prevent any clot from embolizing. There was a significant amount of clot that was sent to pathology.

The left ventricle aneurysm, in the transition zone, was then seen and the left ventricle plicated here over felt strips using 3-0 Prolene in a horizontal mattress fashion. BioGlue was then placed along the anastomosis and another piece of felt strip placed on the suture line and then a separate suture of 3-0 plain was then run in 2 layers over the ventriculotomy.

Following completion of this, attention was turned to the coronary anastomosis. I have already described 1 of the grafts. The LAD and the obtuse marginal, distal and proximal vein grafts anastomosis was performed as previously described. The diagonal was identified, opened longitudinally, rewarming begun. The mammary artery was anastomosed here with 7-0 Prolene a continuous fashion. Following the last anastomosis, warm blood was supplemented with aspartate and glutamate. It was administered retrograde. Deairing was achieved, the aortic cross-clamp was removed. The heart defibrillated several times requiring electrocardioversion. AV pacing wire was inserted and secured to the skin. The patient was warmed and being ventilated after which time de-airing was achieved and the needle vent was removed and the site secured. An intraaortic balloon pump was inserted into the right femoral artery in the modified Seldinger technique.

The patient was volume loaded easily and slowly weaned from cardiopulmonary bypass. The venous cannula was removed, the site secured. Heparin was reversed with Protamine given intravenously, and the arterial cannula was removed, and the site doubly secured. Hemostasis was maintained in what was felt to be a satisfactory fashion. Two 40 chest tubes and 1 XL drains were placed in the mediastinum and exteriorized on the skin. The sternum was approximated with heavy wire. The remainder of the wound was closed in three layers of Vicryl in a running manner.

ADDENDUM: Please add William A. Spaugh as the physician assistant.

Barry R. Davis, MD

cc: Barry R. Davis, MD

Charles D. Ross, MD

D: 03/02/2011 12:59 P

T: 03/03/2011 02:54 P

zhj/C1/kjr mee

DVI: 279906 / 288497

C/S#: 3299382

(Replacement Copy - Addendum added to original 03/16/2011 kjr)

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER

GREENVILLE MEMORIAL HOSPITAL

MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF DISCHARGE: 03/14/2011

REASON FOR ADMISSION: Angina and coronary artery disease.

FINAL DIAGNOSIS:

1. Hypothyroidism.
2. Hypertension.
3. Hyperlipidemia.
4. Type 2 diabetes mellitus.
5. Non-Q-wave myocardial infarction (MI)
6. Postop ventricular fibrillation arrest requiring implantable cardioverter-defibrillator (ICD) placement.

PROCEDURES:

1. Left heart catheterization on 02/28/2011.
2. Coronary artery bypass grafting (CABG) x 4 with left internal mammary artery to the diagonal artery (D1), saphenous vein graft to the left anterior descending (LAD), saphenous vein graft to the obtuse marginal (OM) 1, saphenous vein graft to the right coronary artery, left ventricular (LV) aneurysmectomy and left ventricular (LV) thrombectomy on 03/02/2011 by Dr. Barry Davis.
3. Implantable cardioverter-defibrillator (ICD) placement on 03/08/2011 by Dr. Manfredi.

CONSULTING PHYSICIANS:

1. Dr. Manfredi, EP.
2. Dr. Horton, endocrinology.
3. Dr. Treece, pulmonary medicine.

REFERRING PHYSICIAN: Dr. Ross, Upstate Cardiology.

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: Patient is a 54-year-old white male who presented with acute myocardial infarction on 02/27/2011. Patient had a troponin that peaked at 2.6. He did have a non-Q-wave MI. He was taken to the cath lab 48 hours after admission where his cardiac catheterization showed severe, multivessel coronary artery disease with totally occluded LAD that filled by collaterals and totally occluded circumflex system and right system, filled via collaterals as well. EF was estimated at 30% with anterior apical hypokinesis. The echo showed a questionable mural thrombus with ejection fraction of 30%. It was felt that CABG, LV aneurysmorrhaphy were indicated. A MRI was recommended, however due to the patient's claustrophobia, this could not be done. The patient did have an echocardiogram, again that demonstrated LV thrombus. As part of the preoperative evaluation for CABG, Dr. Horton from

DISCHARGE SUMMARY

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

endocrinology, was consulted secondary to uncontrolled hyperglycemia, diabetes mellitus. Dr. Treece from pulmonary medicine was also consulted for preoperative clearance. The patient had a carotid duplex preoperatively, demonstrated bilateral B1 with 15% stenosis with antegrade vertebral flow. It was felt that the patient had sleep apnea but was cleared from a pulmonary standpoint. He was taken to the OR on 03/02/2011 where he underwent CABG x 4. Left internal mammary artery was used to the diagonal, saphenous vein graft to distal LAD, saphenous vein graft to the OM and saphenous vein graft to right coronary artery. Intraaortic balloon pump was placed at the time of surgery LV aneurysmorrhaphy with LV thrombectomy was performed by Dr. Barry Davis. At the time of surgery, the patient had a subacute anterior MI with large amount of edematous as well as the inferior wall. Ejection fraction was 25% prior to cardiopulmonary bypass. The patient had a large amount of laminate clot as well as free floating clot in the left ventricle. The patient tolerated procedure and was transferred to the CV ICU. In the CV ICU Dr. Treece, from pulmonary medicine, continued followup for critical care management. The patient was hemodynamically stable with a hematocrit of 24, BUN and creatinine were stable at 15 and 1.3. He remained intubated and sedated on pressure support. Dr. Horton, from endocrinology, continued to follow the patient. He was placed on an insulin drip for hyperglycemia control. On postoperative day 2, the patient's intraaortic balloon pump was removed without difficulty. Upstate Cardiology continued to follow the patient. Again, he was intubated and sedated. He was weaned off all pressor support. Patient was scheduled to be transferred to 4D telemetry bed, however the patient developed V-fib arrest requiring CPR and defibrillation. This time, Dr. Manfredi from EP was consulted. The patient had an ICD placed on 03/08/2011 by Dr. Manfredi. The patient was also continued on IV Amiodarone. Patient was subsequently transferred to 4D telemetry bed. From here, his hospital course has been fairly uneventful. His pacing wires and XL tubes were removed without difficulty. He has been ambulating with the assistance of physical therapy and HeartLife. He was started on Coumadin for his LV aneurysm thrombus. He was weaned off all oxygen. His blood sugars were under good control with the help of endocrinology. He will be discharged to home on 03/14/2011. On the day of discharge, the patient's vital signs included temperature 97.7, heart rate 66 and regular, blood pressure 122/74, 98% on room air. His lab values on the chart include white blood cell count is 12.3, hemoglobin 10.3, hematocrit 30.8, platelets are 333, potassium is 4, BUN is 12, creatinine 1.1.

MEDICATIONS ON DISCHARGE:

1. Enteric coated aspirin 81 mg 1 p.o. daily.
2. Coreg 3.125 mg 1 p.o. twice daily.
3. Quinapril 5 mg 1 p.o. daily.
4. Pravachol 80 mg 1 p.o. daily.
5. Ultracet 1 to 2 p.o. q. 4 to 6 hours p.r.n. for pain.

DISCHARGE SUMMARY

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

6. Coumadin 4 mg 1 p.o. daily.
7. Levothyroxine 250 mcg 1 p.o. daily.
8. Prilosec OTC as taken at home.
9. Spiriva HandiHaler 1 inhalation daily.
10. Amiodarone taper 200 mg 1 p.o. b.i.d. x 1 week then decrease to 1 p.o. daily.
11. Novolin N 30 units subcutaneously q a.m. and q p.m.
12. NovoLog sliding scale as directed by Dr. Horton.

The patient's level of activity is restricted to no heavy lifting, no pushing or pulling with arms for 8 to 10 weeks, no driving for 4 weeks. He is instructed to wash all incisions daily with warm soapy water and keep clean and dry. He is encouraged to abstain from smoking and to attend cardiac rehab. If he has problems or questions prior to seeing Dr. Davis in 2 weeks, he is instructed to call 455-6800. The patient also has follow up appointment with Dr. Ross in 1 month and with Upstate Coumadin Clinic on 03/17/2011 at 10:30 a.m. for PT INR check. Again, the patient is on 4 mg tablets. His INR range needs to be between 2 and 3. He is on it for LV aneurysm repair with LV thrombus at the time of surgery and ventricular arrhythmias postoperatively. The patient, again, is encouraged to abstain from smoking, to attend cardiac rehab.

Dictated BY: Sarah K. Miller, PA-C.

ELECTRONICALLY
SIGNED BY
DAVIS, BARRY
R. - 11478
03/19/2011
08:18:23

Barry R. Davis, MD

cc: Barry R. Davis, MD
Charles D. Ross, MD

D: 03/14/2011 02:49 P T: 03/14/2011 04:04 P zhj/C DVI: 287163 C/S#: 3308480

DISCHARGE SUMMARY

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER

GREENVILLE MEMORIAL HOSPITAL

MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

DATE OF ADMISSION: 02/26/2011

DATE OF DISCHARGE: 03/14/2011

CONSULTING SERVICE: Pulmonary Disease Associates, Dr. Catherine Chang

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: Mr. Worthen is a 54-year-old white male who presented to Greenville Memorial Hospital with an acute myocardial infarction on 02/27/11. He had a troponin that peaked at 2.6 and was ruled in for a non Q-wave myocardial infarction. He was taken to the cardiac catheterization lab 48 hours after admission, where his heart catheterization showed severe multivessel coronary artery disease with a totally occluded left anterior descending that was filled by collateral and totally occluded circumflex system and right system filled via collaterals as well. His estimated ejection fraction was 30%. The echocardiogram also showed a questionable mural thrombus, again with an ejection fraction of 30%. He was taken to the operating room on 03/02/11 where he underwent coronary artery bypass graft times four. An intraaortic balloon pump was placed at the time of surgery and a left ventricular aneurysmorrhaphy with left ventricular thrombectomy was performed by Dr. Barry Davis. The patient had a large amount of laminate clot as well as free floating clot in the left ventricle. He was transferred to the cardiovascular intensive care unit for critical care management, where he was found to be hemodynamically stable with hematocrit of 24. Blood urea nitrogen and creatinine were stable at 15 and 1.3. On postoperative day number two, the patient's intraaortic balloon pump was removed without difficulty. He continued up until this time intubated and sedated. He was ultimately weaned off his pressor support and was scheduled to be transferred to the surgical floor. However, he developed v-fib arrest requiring CPR and defibrillation. Electrophysiology was consulted and the patient had an ICD placed on 03/08/11 by Dr. Manfredi. He was also continued at that time on intravenous amiodarone. He was ultimately transferred to the 4-D surgical floor and his hospital course from that point was fairly uneventful.

PULMONARY HISTORY: Mr. Worthen was followed in the cardiovascular intensive care unit and on the surgical floor by Dr. Catherine Chang. He does have a remote history of tobacco abuse, smoking one to two packs per day for approximately 12 years. He did quit in the 1970's. He did undergo pulmonary function tests while during his stay and these revealed an FVC of 3.84 which is 68% predicted, an FEV1 of 2.48 which is 57% predicted, and a FEV1/FVC of 65%. This did reveal moderate obstructive airway disease. This diagnosis of chronic obstructive pulmonary disease was a new diagnosis for him, as he had no history of chronic obstructive pulmonary disease. He also exhibited symptoms of obstructive sleep apnea during his preoperative evaluation, including snoring and family endorsed witnessed episodes of

DISCHARGE SUMMARY

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

apnea, choking, gasping and awaking with snoring. He also admitted to hypersomnolence for which he took frequent naps. He did undergo overnight oximetry while he was on the surgical floor, which did show mild desaturation in his oxygen level

FINAL LABORATORY DATA: White blood cell count 12.3, hemoglobin 10.3, hematocrit 30.8, platelets 333,000, prothrombin time 30.2, international normalized ratio 2.8, sodium 137, potassium 4, chloride 104, carbon dioxide 27, glucose 105, blood urea nitrogen 12, creatinine 1.1.

DISPOSITION; The patient is being discharged to home today.

PULMONARY FOLLOWUP: Mr. Worthen will be followed in our office by Dr. Catherine Chang. He will be seen in approximately four weeks for the following problems.

1. Newly diagnosed chronic obstructive pulmonary disease. We did start Mr. Worthen on Spiriva during his hospital stay. We also utilized Albuterol nebulizer treatments. He did quit smoking back in the 1970's but as above, his pulmonary function tests did reveal moderate obstructive pulmonary disease. We will obtain a full battery of pulmonary function tests and a chest x-ray on his return visit to us. We will make further recommendations pending those results.
2. Questionable obstructive sleep apnea. He did undergo overnight oximetry during the hospital stay. This did reveal several small desaturations in his oxygen status, but he did not require us to send him home with oxygen at night. He will undergo obstructive sleep apnea evaluation by Dr. Chang and likely will undergo polysomnography.
3. Questionable pleural effusion versus volume loss. Dr. Chang will obtain a chest x-ray and make further recommendations pending those results.
4. Post nasal drip. Mr. Worthen does have a history of several allergy type symptoms. He also has a significant history of post nasal drip. We will evaluate this on his arrival to our office and make further recommendations at that time.

As stated above, we will see Mr. Worthen back in our office in approximately four weeks. He will be followed by Dr. Chang and we will continue to make further recommendations pending his outcome.

Thank you for allowing us to participate in his care and we look forward to seeing him in our office.

Sandra T. Calmes, NP, dictating for:

DISCHARGE SUMMARY

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

Catherine Marie Chang, MD

cc: Catherine Marie Chang, MD

D: 03/19/2011 01:09 P T: 03/19/2011 01:40 P kjw DVI: 290503 C/S#: 3313167

DISCHARGE SUMMARY

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

Patient Location:

08CP9301AM

PATIENT NO: 000-971-36-6670 Billing NO: 080011157521

DATE OF ADMISSION 02/27/2011

HISTORY OF PRESENT ILLNESS: This is a 54-year-old gentleman who works with the EMS system and who apparently has a past history of hypothyroidism, hypertension, dyslipidemia, and diabetes. He has had approximately 2 weeks of complaints of left shoulder pain, musculoskeletal pain, and flu-like symptoms. Multiple instances the musculoskeletal type pain has been attributed to shoulder problems he has previously had. He denies any classic anginal symptoms and he denies any known history of coronary disease. On the current trip to the emergency room this morning, the patient had just moved a 500 pound patient with his EMT job and developed chest pain. This led to his presentation to the emergency room and workup here. Lab work demonstrated an elevated troponin at 3.03 consistent with a non-Q-wave myocardial infarction. We are asked to see the patient for this.

PAST MEDICINES:

1. Glipizide - dose unknown.
2. Novolin 70/30.
3. Gemfibrozil.
4. Lisinopril.
5. Levothyroxine.

SOCIAL HISTORY: Positive for alcohol. Negative for tobacco.

FAMILY HISTORY: Coronary artery disease.

PHYSICAL EXAMINATION:

GENERAL: This is an obese gentleman in no acute distress.

HEENT: Normocephalic, atraumatic.

NECK: Supple. There is no obvious JVD, thyromegaly, adenopathy, or bruits.

CARDIOVASCULAR: Regular rate and rhythm with a normal S1 and S2. There is no S3 or S4. There are no murmurs, rubs, or gallops.

LUNGS: Clear to auscultation throughout with no rhonchi, rales, or wheezes.

ABDOMEN: Soft, nontender, nondistended. Bowel sounds are normal.

EXTREMITIES: No cyanosis, clubbing, or edema.

SKIN: Warm and dry.

NEUROLOGIC: Intact.

ASSESSMENT AND PLAN:

HISTORY AND PHYSICAL

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
08CP9301AM

Patient Location:

PATIENT NO: 000-971-36-6670 Billing NO: 080011157521

1. Non-Q-wave myocardial infarction as evidenced by chest pain and troponin elevation. The patient will undergo initial medical therapy with ACE inhibitor, beta blocker, aspirin, statin, Plavix, and heparin drip. He will need to undergo cardiac catheterization as well within the next 36 hours. He is currently pain free and comfortable. We will assess for treatable risk factors prior to catheterization.
2. Diabetes. The patient is on Accu-Cheks and sliding scale.
3. Hypertension. He will be on antihypertensives medications.
4. Dyslipidemia. We will add a statin to his regimen.

Jon M. Bittrick, MD

cc: Jon M. Bittrick, MD

D: 02/27/2011 06:27 A T: 02/27/2011 11:03 A ztd DVI: 277799
C/S#: 3295398

HISTORY AND PHYSICAL
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ELECTRONICALLY
SIGNED BY
Bittrick, Jon
M. - 26730
03/21/2011
08:24:40

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF CONSULTATION: 03/01/2011

REQUESTING PHYSICIAN: Barry Davis, M.D.

SERVICE Pulmonary Disease Associates.

ATTENDING PHYSICIAN: Dr. Amy Treece.

CHIEF COMPLAINT: Preoperative evaluation for coronary artery bypass grafting.

HISTORY OF PRESENT ILLNESS: Mr. Worthen is a very pleasant 54-year-old obese white male with a history of hypertension, hypothyroidism, hyperlipidemia, diabetes mellitus, with a history of shoulder pain and musculoskeletal pain. He also was recently diagnosed with the flu and had just been recovering within the last week. He works for EMS and was working on Saturday, 02/26/2011, when he developed chest pain after helping move a 500 pound patient to the emergency department. His chest pain did develop shortly thereafter, and he was brought to the emergency department. His initial troponins were elevated at 3.03, which was consistent with a non-Q wave MI. He was admitted by the cardiology service for acute coronary syndrome and was given an Ace inhibitor, a beta-blocker, aspirin, a statin, Plavix, and was placed on a heparin drip. He then underwent cardiac catheterization today on 02/28/2011, which showed 3 vessel coronary artery disease. CABG was felt to be indicated. He was seen and evaluated by Dr. Barry Davis and was deemed a surgical candidate for surgical revascularization. Pulmonary Disease Associates was contacted for preoperative pulmonary evaluation.

Mr. Worthen does admit to shortness of breath, which he did experience on Saturday. He claims he usually only gets short of breath with exertion. His family endorses that, with any activity, he does get short of breath, even with talking over the last few weeks. He claims he is fairly active and has been exercising on a fairly regular basis. He claims he was on a treadmill within the last 2 weeks for about an hour with no chest pain or shortness of breath. He does admit to a cough, which he claims is secondary to postnasal drip. He denies any wheeze or hemoptysis. He denies any history of asthma, COPD, or emphysema. He does have a questionable history of bronchitis. He does admit to having pneumonia approximately 1 year ago, for which he was treated as an outpatient. He has had bronchitis in the past. He does have a history of gastroesophageal

CONSULTATION

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

reflux disease and is on Protonix at home. He does have allergy and sinus problems. He claims he does take Alka-Seltzers as needed. He denies any history of CVA, DVT, or pulmonary embolism. He does admit to a history of snoring, and his family does endorse questionable witnessed apneic events. He does admit that he wakes himself up at night from snoring. He does admit that he wakes several times per night to the use the bathroom. He does admit to hypersomnolence and does nap frequently. He has never undergone any sleep study evaluation.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Hyperlipidemia.
3. Diabetes mellitus.
4. Hypothyroidism.

PAST SURGICAL HISTORY: He has had an amputation of his third toe on the left foot. He has also had a diskectomy.

ALLERGIES: He is allergic to LANTUS.

HOME MEDICATIONS:

1. Glipizide.
2. Novolin 70/30.
3. Gemfibrazole.
4. Lisinopril.
5. Levothyroxine 250 mcg.

HOSPITAL MEDICATIONS:

1. Ambien 10 mg at bedtime.
2. Aspirin 325 mg daily.
3. Lopressor 25 mg q.8 h.
4. NovoLog 70/30 twice daily.
5. NovoLog sliding scale insulin.
6. Pravachol 80 mg at bedtime.
7. Lisinopril 5 mg daily.

SOCIAL HISTORY: He is engaged. He works with EMT or in the fire department for many, many years. He was a navy seal for 6 years and was in the army for 5 years after that. He does have a history of tobacco abuse, smoking approximately 1-1/2 packs per day for approximately 12 years. He did quit smoking in the 1970s. He does admit to occasional alcohol use. He denies any illicit drug use. He does admit to some possible asbestos exposures while working as a fire fighter. He does also admit to possible TB exposure, but has yearly PPDs that are checked and have been negative. He does have a lab at home.

CONSULTATION

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

FAMILY HISTORY: His father does have a history of coronary artery disease.

COMPREHENSIVE REVIEW OF SYSTEMS: CONSTITUTIONAL: Positive for sweats and chills from the flu. He has also had some intentional weight loss, fatigue and weakness. HEENT: Head is positive for sinus problems, coughing, and snoring. CARDIOVASCULAR: Positive for chest pressure. He denies chest pain, but does admit to chest pressures. RESPIRATORY: Positive for shortness of breath and cough. GASTROINTESTINAL: Positive for heartburn. MUSCULOSKELETAL: Positive for arthritis pain. ENDOCRINE: Positive for a history of diabetes and history of thyroid problems. All other systems are reviewed and are negative.

PHYSICAL EXAMINATION: VITAL SIGNS: Height 6'2", weight 275 pounds. Temperature 98.4. Pulse is 80. Respiratory rate is 18. Blood pressure is 124/82. Oxygen saturation is 95% on room air. CONSTITUTIONAL: Normal general appearance. The patient is an obese white male lying in bed, post-catheterization. HEAD: Normocephalic, atraumatic. Pupils are equal, round, and reactive to light. Extraocular muscles are intact. EARS, NOSE, MOUTH, AND THROAT: Normal inspection of the nasal mucosa, septum, turbinates, teeth, gums, and oropharynx. NECK: Normal neck appearance. No JVD. Thyroid is not palpable and nontender. He does have a large neck circumference. LYMPH NODES: No neck, supraclavicular, or axillary adenopathy. SKIN/EXTREMITIES: No rashes, or lesions, or ulcers. She does have trace pedal edema. RESPIRATORY: Chest is symmetric to normal chest expansion. Respiratory effort normal to auscultation. CARDIOVASCULAR: Regular rate and rhythm. No murmurs, gallops, or rubs. PERIPHERAL VASCULAR: Normal by observation and palpation. GASTROINTESTINAL: Normoactive bowel sounds. Soft and nontender. Obese abdomen. MUSCULOSKELETAL: Normal muscle strength, movement, and tone. No focal atrophy. NEUROLOGIC: Alert and oriented times 3. Cranial nerves II-XII are grossly intact. PSYCHIATRIC: Normal mood and affect.

LABORATORY DATA AND STUDIES: CBC showed a white count of 11.8. Hemoglobin 12.3, hematocrit of 36.4, platelets of 2.9. PT 52, PTT 14.4, INR 1.1. Sodium 134, potassium 3.9, chloride 101, carbon dioxide 26, BUN 18, creatinine 1.3, glucose 298.

He did have a left heart catheterization on 02/28/2011, which showed a right coronary artery proximally occluded that filled by collaterals of the left circumflex, OM2 occlusion fills by collaterals. LAD is occluded with left ventricular apical akinesis.

Total bilirubin of 0.4. Direct bilirubin of 0.1. Total protein of 6.5, albumin 3.4, AST 21, ALT 25, alkaline phosphatase 74.

CONSULTATION

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

Cholesterol 117. Triglycerides 229. HDL 25. LDL 46. VLDL 46.

Troponins 2.51, 2.79, 3.03, and 2.81 respectively. CK-MB of 5.0.
Myoglobin of 17.

TSH of 1.946.

He underwent an echocardiogram on 02/27/2011, which showed segmental wall motion abnormal with decreased systolic performance, indicative of coronary artery disease, left ventricular hypertrophy, left ventricular diastolic dysfunction, extensive apical akinesis with likely laminar apical thrombus with the rest of the wall mildly hypokinetic with an EF of 30-35%.

All the above labs and studies were incidentally reviewed by Dr. Amy Treece.

ASSESSMENT AND PLAN:

1. Dyspnea. This appears to be multifactorial, secondary to coronary artery disease, obesity, possible obstructive sleep apnea, and history of diabetes.
2. Postoperative evaluation. We will check arterial blood gas, pulmonary function tests, and chest x-ray.
3. Questionable obstructive sleep apnea. We will monitor postoperatively, and, if needed, he will be placed on CPAP or BiPAP after extubation. He will need a polysomnogram after discharge.
4. Tobacco abuse. He did quit smoking greater than 30 years ago and is stable. We will check pulmonary function tests.
5. Coronary artery disease. A coronary artery bypass grafting is pending.
6. Hypothyroidism. He was placed on Synthroid 250 mcg daily.
7. Diabetes mellitus. He is on sliding scale insulin and NovoLog 70/30.
8. Hypertension. He is on Lopressor and Lisinopril.
9. Non-Q wave myocardial infarction. He is on a heparin drip, as well as Lisinopril and Pravachol.
10. Hyperlipidemia. He is on Pravachol.
11. Prophylaxis. He is on Protonix. He will be on heparin subcutaneously postoperatively.

PLAN: Mr. Worthen is a 54-year-old obese white male with diabetes, hypertension, hyperlipidemia, hypothyroidism, who is an EMT. He did have complaints of chest pain on exertion with accompanied shoulder pain and shortness of breath. He did rule in for a non-Q wave MI with positive troponins. He does have a history of remote tobacco abuse. He had a cardiac catheterization with multivessel coronary artery disease, requiring

CONSULTATION

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

CABG. He does have a chronic cough, secondary to postnasal drip. He also has a history of gastroesophageal reflux disease. He is a good surgical candidate with low to moderate risk for postoperative pulmonary complications. There is known history of lung disease. He does have symptoms of obstructive sleep apnea. He may need CPAP at night postoperatively and will need outpatient sleep evaluation. We will check PFTs, given his history of tobacco abuse. We have discussed pulmonary risks, associated with surgery, to include but not limited to, prolonged ventilation, difficult oxygenation, atelectasis, pleural effusion, pneumonia, and pulmonary embolism. Also discussed pulmonary expansion modalities to include, incentive spirometry, deep breathing, early ambulation, and staying out of bed. We have also discussed pain control, glucose control, and DVT prophylaxis. He is agreeable to the above risks associated with surgery and would like to proceed at this time. We will make further recommendations pending the above studies.

Thank you for the above consult.

JENNIFER LASHLEY, PA-C, DICTATING FOR:

Amy Treece, M.D.

ELECTRONICALLY
SIGNED BY
Treece, Amy -
31474
03/04/2011
13:53:50

cc: Russell C. Moss, PA
April Treas, MD
Amy E. Treece, MD

D: 03/01/2011 02:34 P T: 03/01/2011 04:39 P zrw/c
DVI: 885070 C/S#: 3297471

CONSULTATION
Page 5 of 5

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
082E2514AM

Patient Location:

PATIENT MR#: 000-971-36-6670 Billing NO: 08001157521

DATE OF ADMISSION: 02/27/2011

DATE OF CONSULTATION: 03/07/2011

EP CONSULTATION

REFERRING PHYSICIAN: Dr. Barry Davis.

PRIMARY CARDIOLOGY CARE: Upstate Cardiology.

REASON FOR CONSULTATION: Status post VF arrest.

HISTORY OF PRESENT ILLNESS: Mr. Worthen is a 54-year-old gentleman with multiple cardiac risk factors who presented initially in late February with complaints of left shoulder pain, flu-like symptoms and chest pain. He was found to have Q-waves in his anterior septal leads and elevated troponins. He was brought to the cardiac catheterization lab where he was found to have severe 3-vessel coronary artery disease with an occluded LAD, circumflex, and right coronary artery with extensive collateralizations. His ejection fraction at that time was 30% with an LV aneurysm. He ultimately underwent coronary artery bypass graft with left ventricular aneurysmectomy on March 2, 2011. Postoperatively he had been recovering nicely with no significant ventricular arrhythmias until early this morning when he was being transferred out to a telemetry bed when he suddenly had a VF arrest. He was successfully resuscitated with a 200-joule cardioversion and 30 seconds of CPR. He was then given IV lidocaine and IV amiodarone drip and we were subsequently consulted for consideration of ICD for secondary prevention.

PAST MEDICAL HISTORY: Includes hypertension, hyperlipidemia, diabetes mellitus, hypothyroidism, and now coronary artery disease.

FAMILY HISTORY: Significant for early onset coronary artery disease.

SOCIAL HISTORY: Mr. Worthen is a local emergency medical technician. He quit smoking 30 years ago.

REVIEW OF SYSTEMS: He reported a recent viral-like illness and was diagnosed with the flu in the last several weeks. In addition he has been having intermittent left arm discomfort, dyspnea on exertion and easy fatigue. Otherwise the review of systems was negative.

CONSULTATION

Page 1 of 3

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

MEDICATIONS: He is currently on an amiodarone drip, aspirin 81 daily, dopamine recently restarted at 4 micrograms per minute, subcu heparin 5000 units every 8 hours, sliding scale insulin, Plavix 75 daily, Pravachol 80 at bedtime, Protonix 50 daily, Synthroid 250 micrograms daily, albuterol inhaler.

EKG currently shows an atrial paced rhythm at 80 beats per minute with an extensive anterior myocardial infarction with Q-waves in V1 through V6 and a right axis deviation.

Pre-procedural EKG in comparison to an EKG from February 26, 2010: His anterior Q-waves were less prominent and extended from V1 out to V4.

LABORATORY DATA: White count 11.9, hemoglobin 9.3, platelets 236. Sodium 134, potassium 5, chloride 101, bicarb 28, BUN 30, creatinine 1.3, glucose 164, magnesium 2.2. TSH 1.946.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 147/71, pulse rate is 80, respiratory rate is 26 and unlabored, saturating 100% on nasal cannula.

GENERAL: This is a well-developed, well-nourished gentleman in no acute distress with his wife at bedside.

NECK: Supple with no visible JVD and a prior triple lumen site in his right IJ.

HEART: Regular with no audible murmurs, rubs or gallops. His sternotomy wound appears to be healing well.

ABDOMEN: Obese, soft. Normoactive bowel sounds. No rebound or guarding.

EXTREMITIES: He has trace lower extremity edema with lower extremity TED stockings in place.

IMPRESSION: Severe 3-vessel coronary artery disease status post coronary artery bypass grafting with left ventricular aneurysmectomy, now 5 days postop with a sudden VF arrest.

PLAN AND RECOMMENDATIONS: I discussed today the risks, alternatives and benefits with regards to proceeding with a dual-chamber ICD implantation for secondary prevention with Mr. Worthen. He understands the associated risks and wishes to proceed.

CONSULTATION

Page 2 of 3

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 082E2514AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

We truly appreciate you allowing us to participate in the care of your patient. If you have any questions please feel free to contact me.

Joseph A. Manfredi, MD

cc: Joseph A. Manfredi, MD

D: 03/07/2011 03:05 P T: 03/07/2011 08:23 P mm
DVI: 282868 C/S#: 3302351

CONSULTATION

Page 3 of 3

ELECTRONI...
SIGNED BY
Manfredi,
Joseph -
29445
03/24/2011
10:16:54

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
084F4605AM

Patient Location:

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF CONSULTATION: 02/28/2011

ENDOCRINE CONSULT

CONSULT REQUESTED BY: Dr. Barry Davis.

REASON FOR CONSULTATION: Diabetes mellitus, preoperative evaluation.

HISTORY OF PRESENT ILLNESS: Mr. Worthen is a 54-year-old, white male who presented to the Emergency Department on the day above complaining of chest pain. He was found to have sustained non-ST elevation myocardial infarction. Left heart catheterization today revealed obstructive coronary artery disease and coronary artery bypass grafting surgery has been recommended. This will be performed 03/02/2011. He has had diabetes for approximately ten years. His current diabetes regimen consists of 70/30 insulin, 54 units with breakfast and 52 units with dinner as well as Glipizide unknown dose twice daily. Blood sugars at home range mid to high 100s. His self-reported hemoglobin A1C is 8.6%. He also has primary hypothyroidism for which he takes Levothyroxine 250 micrograms daily. TSH on the day of admission was 1.946. Since admission to the hospital, he has been maintained on 70/30 insulin 10 units twice daily. Blood sugars have ranged 226 to 290.

PAST MEDICAL HISTORY:

1. Type 2 diabetes mellitus.
2. Primary hypothyroidism.
3. Peripheral vascular disease.
4. Coronary artery disease.
5. Hypertriglyceridemia.

SOCIAL HISTORY: The patient drinks alcohol, but does not smoke. He is an emergency medical technician in Laurens County.

FAMILY HISTORY: Positive for coronary artery disease.

REVIEW OF SYSTEMS: A ten system review of systems is performed and is negative, except as stated in the history of present illness.

PHYSICAL EXAMINATION:

VITAL SIGNS: Stable. Afebrile.

NECK: No jugular venous distention or thyromegaly.

HEART: Regular rate and rhythm without murmur, rub, or gallop.

CONSULTATION

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 084F4605AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Soft, nontender, and nondistended with normoactive bowel sounds.

EXTREMITIES: No edema.

IMPRESSION:

1. Type 2 diabetes mellitus, uncontrolled.
2. Primary hypothyroidism.
3. Coronary artery disease status post acute myocardial infarction.
4. Obesity.
5. Hypertriglyceridemia.

PLAN:

1. Discontinue premixed insulin. Start treatment with NPH 40 units with breakfast and 30 units at bedtime, NovoLog 12 units with meals plus 3 units per 50 greater than 150 before meals, at bedtime, and 2:00 a.m.
I will check a hemoglobin A1C.
2. He should continue Levothyroxine 250 micrograms daily.
3. I will be happy to follow him and assist in management of his diabetes.

ELECTRONICALLY
SIGNED BY
Horton, James
Kyle - 27596
04/06/2011
16:41:50

James Kyle Horton, MD

cc: James Kyle Horton, MD

D: 02/28/2011 01:26 P T: 02/28/2011 01:42 P bnc
DVI: 278436 C/S#: 3296292

CONSULTATION

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000971366670CO 08001. 57521011478%%
GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 084F4605AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF CONSULTATION: 02/28/2011

REQUESTING PHYSICIAN: Dr. Ross

REASON FOR CONSULTATION: This patient is a 54-year-old gentleman who has diabetes mellitus, obesity and hypertension who has presented with substernal chest pain and has ruled in for a myocardial infarction. His troponins were up as high as 2.6. He had a non-Q-wave MI. He was taken to the Cath Lab 48 hours after admission where his cardiac cath showed severe multi-vessel coronary artery disease with a totally occluded LAD that filled by collaterals and totally occluded circumflex system and the right system filled via collaterals as well. The ejection fraction was only 30% with anterior apical hypo or akinesis. His echo showed a questionable mural thrombus with an ejection fraction of 30% as well and it was felt that CABG and possible LV aneurysmorrhaphy was indicated. He especially gets shortness of breath with exertion recently, but he has been exercising significantly over the last month.

CURRENT MEDICATIONS:

1. Glipizide
2. Novolin
3. Gemfibrozil
4. Lisinopril
5. Levothyroxine

PAST MEDICAL HISTORY: Pertinent for hypertension, hyperlipidemia, and hypothyroidism.

FAMILY HISTORY: Positive for coronary artery disease.

SOCIAL HISTORY: He works for EMS. He quit smoking 30 years ago.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies fever, chills, night sweats, weight loss, skin, hair or nail changes, itching rashes, sores or lumps.

HEENT: Head - denies headache, nausea, vomiting and visual changes. Eyes - denies vision loss, vision change or cataracts. Ears - denies hearing loss, tinnitus or vertigo. Nose and sinuses - denies rhinorrhea or epistaxis. Mouth, throat and neck - denies bleeding gums, hoarseness or sore throat.

PULMONARY: Denies dyspnea, cough, hemoptysis, wheezing, snoring, sleep apnea, shortness of breath, sputum, pneumonia, asthma, bronchitis or

CONSULTATION

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 084F4605AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

emphysema.

CARDIAC: Denies chest pain, dyspnea, palpitations, syncope, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, peripheral edema, hypertension, murmurs, angina or palpitations. As above.

GASTROINTESTINAL: Denies nausea, vomiting, constipation, hematochezia, diarrhea, indigestion, reflux, jaundice, appetite changes or dysphagia.

MUSCULOSKELETAL: Denies back pain, joint pain, muscle cramps, muscle pain, muscle weakness, arthritis or gout.

URINARY: Denies frequency, hesitation, urgency, polyuria, dysuria, hematuria or infection.

VASCULAR: Denies leg edema, claudication, varicose veins, thromboses and / or emboli.

NEUROLOGIC: Denies loss of sensation / numbness, tingling, weakness, paralysis, fainting, syncope, seizures, memory loss, stroke or dizziness.

HEMATOLOGIC: Denies anemia, easy bruising or bleeding, petechiae, purpura or transfusions.

PSYCHIATRIC: Denies depression or anxiety.

SKIN: He has a tattoo on his left hand.

ENDOCRINE: Denies heat or cold intolerance, excessive sweating, polyuria, polydipsia, polyphagia. Diabetes mellitus, no hypothyroidism.

PHYSICAL EXAMINATION:

GENERAL: Well-nourished, normally-developed. Exam essentially normal except for being obese.

VITAL SIGNS: Blood pressure ??, pulse ??, respirations ??, temperature ??.

SKIN: No rashes, bruises or lesions.

HEENT: Normocephalic, atraumatic. Pupils equal, round, reactive to light and accommodation. Extraocular movements are intact. No scleral icterus. Nose has no discharge. The mucosal membranes are normal.

NECK: No masses. Normal range of motion. There is no tracheal deviation. Thyroid size is normal.

LUNGS: Clear to auscultation and percussion. There is normal symmetry of the chest. There are no wheezing, crackles or rhonchi.

CARDIAC: Regular rate and rhythm without murmur, rub or gallop.

CAROTIDS: Normal upstroke and without bruits.

ABDOMEN: Soft, flat and nontender. No masses or organomegaly. Normal active bowel sounds.

VASCULAR: Femoral pulses are +2. There are palpable distal pulses.

EXTREMITIES: No clubbing, cyanosis or edema. No obvious venous varicosities nor lower extremity venous stasis changes.

NEUROLOGIC: The patient is alert and oriented times three. No focal motor nor sensory deficits. Cerebellar function appears intact. Mood and affect normal.

IMPRESSION: This gentleman has significant multi-vessel coronary artery

CONSULTATION

Page 2 of 3

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP Patient Location: 084F4605AM

PATIENT MR#: 000-971-36-6670 Billing NO: 080011157521

disease with decreased left ventricular function. He has a possible left ventricular aneurysm. MRA of the heart to look for viability and left ventricular dimensions will be obtained. Coronary artery bypass grafting with possible left ventricular aneurysmorrhaphy has been recommended. The increased risks due to the decreased left ventricular function. All risks have been thoroughly explained including bleeding, infection, transfusion, stroke, myocardial infarction, respiratory failure including heart block requiring a permanent pacemaker, gut and leg ischemia, death, etc. We will proceed with surgery in a few days.

Barry R. Davis, MD

cc: Barry R. Davis, MD

D: 02/28/2011 11:02 A T: 02/28/2011 12:05 P zla
DVI: 278304 C/S#: 3296184

CONSULTATION
Page 3 of 3

ELECTRONI...
SIGNED BY
DAVIS, BARRY
R. - 11478
02/19/2011
08:18:25

**GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD**

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 082E2514AM
Billing NO: 080011157521

ELECTROPHYSIOLOGIC REPORT:

DATE OF PROCEDURE: 03/08/2011

PROCEDURE PERFORMED: Dual-chamber ICD implantation.

INDICATION FOR PROCEDURE: Ischemic cardiomyopathy, status post VF arrest.

MEDICATIONS ADMINISTERED: 5 mg of Versed, 150 mcg of fentanyl, and 2 g of vancomycin.

PROCEDURE SEQUENCE: After informed consent was obtained, including risks and alternatives explained to the patient, patient was brought to the EP lab in a fasting state where his left infraclavicular region was prepped and draped in the usual sterile fashion by the EP lab staff. One-percent lidocaine was used to anesthetize the skin and subcutaneous tissue overlying the left infraclavicular region. A 10 blade was then used to make a 3-cm incision. Sharp and blunt electrocautery were used to dissect down to the pectoralis fascia. A Cook needle was then used to puncture the axillary vein, and two vascular wires were placed. Over the first vascular wire, an 8-French sheath was advanced. Dilator and wire were removed. Through this sheath, a right ventricular defibrillator lead was advanced in the distal RV septum and secured to the endocardium with an active-fixation screw. Intraoperative lead testing was performed and felt to be adequate. Peel-away sheath was removed and the lead secured to the pectoralis fascia using 0 Nurolon sutures. Next, over the second vascular wire, a 7-French sheath was advanced. Dilator and wire were removed. Through this sheath, the right atrial lead was advanced in the right atrium, and after mapping for adequate parameters, ultimately a low right lateral atrial position was accepted. The lead was secured to the endocardium with an active-fixation screw. Intraoperative lead testing was performed and felt to be adequate. The peel-away sheath was removed and the lead secured to the pectoralis fascia using 0 Nurolon suture. Following this, the pocket was irrigated with copious amounts of antibiotic solution and inspected for hemostasis. The leads were connected to the pulse generator and placed back in the preformed pocket. DFT testing was deferred due to the findings of a left ventricular mural thrombus at the time of bypass surgery and aneurysmectomy. The pocket was then closed with 2-0 Vicryl in interrupted fashion for the deep fascia and 3-0 Vicryl in interrupted fashion of the subcutaneous layer. Steri-Strips and a sterile Tegaderm dressing were applied. The patient tolerated the procedure well without any immediate complications.

The implanted device is a St. Jude Fortify DR, CD2231-40Q, serial #605186. The atrial lead is a St. Jude 2088TC, serial #CAU014887. The right ventricular defibrillator lead is a St. Jude 7120Q, serial #BJP032318.

EPL REPORT

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216

CHART COPY

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**GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD**

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 082E2514AM
Billing NO: 080011157521

LEAD PARAMETERS: P waves are 1.3 mV, capture threshold 1.5 volts at 0.9 msec, impedance 360 ohms. Sensed R waves are 12 mV, impedance 480 ohms, capture threshold 1 volt at 0.5 msec. Device is programmed to a mode of DDD, 60-120. A VF zone is set at 181 to receive all 40-joule shocks.

IMPRESSION: Successful dual-chamber ICD implantation for secondary prevention.

PLAN AND RECOMMENDATIONS: The patient will return to a telemetry bed. Intravenous antibiotics will be administered. A chest x-ray will be obtained.

Joseph A. Manfredi, MD

cc: Upstate Cardiology
Joseph A. Manfredi, MD

D: 03/08/2011 10:20 A

T: 03/08/2011 12:19 P jmt

DVI: 283261

C/S#: 3302904

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

DATE OF OPERATION: 03/02/2011

REFERRING PHYSICIAN: Dr. Charles Ross.

SURGEON: Dr. Barry Davis.

PREOPERATIVE DIAGNOSIS: Ischemic coronary artery disease with left ventricular aneurysm, ejection fraction of 20% with congestive heart failure.

PROCEDURES: Left ventricular aneurysmorrhaphy with left ventricular thrombectomy, coronary artery bypass graft (CABG) x 4 using left internal mammary artery for bypass graft to the diagonal coronary artery, the saphenous vein for reverse coronary artery bypass graft to the distal left anterior descending coronary artery, the obtuse marginal coronary artery and right coronary artery.

INDICATIONS FOR OPERATION:

A 54-year-old gentleman who presented with 2 week history of flu-like symptoms. He presented here and was found to have a troponin of 3.03, consistent with a non-Q-wave MI. He had an echocardiogram that demonstrated an ejection fraction of about 25% to 30% with left ventricular thrombus. The cardiac cath showed severe 3 vessel coronary artery disease with the LAD 100% occluded, the circumflex 100% occluded and the right coronary artery 100% occluded. The LAD and circumflex system filled via homocollaterals and the right coronary artery system filled via heterocollaterals.

FINDINGS AT OPERATION:

The left internal mammary artery was small but had excellent flow. He had severe left ventricular hypertrophy. Had subacute myocardial infarction. His entire anterior wall was severely edematous as was his inferior wall. Ejection fraction was around 25% prior to cardiopulmonary bypass. After doing the bypass, it was around 50%. His diagonal, where it was bypassed, was 1.5 mm. The saphenous vein was excellent quality. The distal LAD was 1.5 mm. The obtuse marginal was 1.5 mm. The right coronary artery was greater than 2 mm. He had an apical left ventricular aneurysm with a significant amount/large amount of laminated clot, as well as free floating clot in the left ventricle.

OPERATIVE REPORT

**GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD**

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

OPERATION:

The patient was taken to the operating room and placed in the supine position on the operating table. Following application of general anesthesia via oral endotracheal tube, the chest, abdomen and legs were prepped with DuraPrep and draped in a sterile fashion. The saphenous vein was harvested from both thighs via the endoscopic vein method. Drains were placed in the thighs. The wounds were closed in all layers with Vicryl in a running manner. Simultaneously, median sternotomy skin incision was made with the knife. Incision was carried to the sternum. The sternum was divided with by the power saw. The left pleural cavity was entered. The left internal mammary was harvested from the level of the first rib to its bifurcation at the diaphragm. Following systemic heparinization, an ACT of 400 seconds was obtained, it was divided on the chest wall and ligated with metallic clips. An XL drain was placed in the left pleural cavity and secured to skin. The pericardium was opened in an inverted "T" fashion and tacked to the chest wall. There was a significant amount of pericarditis noted along that. After systemic heparinization and ACT of 400 seconds, routine standard cannulation was performed. The patient was placed on cardiopulmonary bypass and cooled to 30 degrees Centigrade. The aorta was cross-clamped. Seven hundred and fifty mL of blood cardioplegia solution administered antegrade through the root and 500 mL retrograde through the coronary sinus catheter. This resulted in cold, flaccid arrest of the heart. Blood cardioplegia solution was supplemented intermittently retrograde throughout the aortic cross-clamp time, the last does being given warm. The heart was reflected.

The distal right was identified, opened longitudinally. A distal saphenocoronary anastomosis was made with 7-0 Prolene in a continuous fashion. The vein graft was tested with cardioplegia solution and found to run well. It was cut to the appropriate length. A 4.0 punch was made then made in the aorta and the proximal anastomosis was made with 6-0 Prolene in a continuous fashion. Prior to doing the bypasses, a left ventriculotomy was created parallel to the left anterior descending coronary artery, near the apex of the ventricle, for about 4 cm. A significant amount of laminated and free-floating clot was identified and removed manually. Great care was taken to wash the ventricle out, and suck it out in order to prevent any clot from embolizing. There was a significant amount of clot that was sent to pathology.

The left ventricle aneurysm, in the transition zone, was then seen and the left ventricle plicated here over felt strips using 3-0 Prolene in a horizontal mattress fashion. BioGlue was then placed along the anastomosis and another piece of felt strip placed on the suture line and then a separate suture of 3-0 plain was then run in 2 layers over the ventriculotomy.

Following completion of this, attention was turned to the coronary anastomosis. I have already described 1 of the grafts. The LAD and the obtuse marginal, distal and proximal vein grafts anastomosis was performed as previously described. The diagonal was identified, opened longitudinally, rewarming begun. The mammary artery was anastomosed here with 7-0 Prolene

**GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD**

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

a continuous fashion. Following the last anastomosis, warm blood was supplemented with aspartate and glutamate. It was administered retrograde. Deairing was achieved, the aortic cross-clamp was removed. The heart defibrillated several times requiring electrocardioversion. AV pacing wire was inserted and secured to the skin. The patient was warmed and being ventilated after which time de-airing was achieved and the needle vent was removed and the site secured. An intraaortic balloon pump was inserted into the right femoral artery in the modified Seldinger technique.

The patient was volume loaded easily and slowly weaned from cardiopulmonary bypass. The venous cannula was removed, the site secured. Heparin was reversed with Protamine given intravenously, and the arterial cannula was removed, and the site doubly secured. Hemostasis was maintained in what was felt to be a satisfactory fashion. Two 40 chest tubes and 1 XL drains were placed in the mediastinum and exteriorized on the skin. The sternum was approximated with heavy wire. The remainder of the wound was closed in three layers of Vicryl in a running manner.

ADDENDUM: Please add William A. Spaugh as the physician assistant.

Barry R. Davis, MD

cc: Barry R. Davis, MD
Charles D. Ross, MD

D: 03/02/2011 12:59 P T: 03/03/2011 02:54 P zhj/C1/kjr mee DVI: 279906 / 288497 C/S#: 3299382

(Replacement Copy – Addendum added to original 03/16/2011 kjr)

GMMC
PRIMARY

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

Patient Data

Complaint: Respiratory -- shortness of breath

Triage Time: Sat Feb 26, 2011 23:12

Urgency: 3-Urgent

Bed: ED CPC

Initial Vital Signs: 2/26/2011 23:06

BP:126/74

P:82

O2 sat:99 on RA

ED Attending: Barr, MD, Lisa

Primary RN: Saitz, RN, Joe

R:16

T:97.8

Pain:0

PRESENTING PROBLEM (23:12 DEV)

Presenting problems: Dyspnea - Adult, Chest Pain - Adult.

TRIAGE (Sat Feb 26, 2011 23:12 DEV)

PATIENT: NAME: Worthen, Michael P, AGE: 54, GENDER: male, DOB: Sat Sep 08, 1956, TIME

OF GREET: Sat Feb 26, 2011 23:05, Infectious Disease: Not Applicable, Travel History: No foreign

travel in past 10 days, Poss. H1N1 Flu: No contact with person with flu, Homicidal/Suicidal: Denies

homicidal tendencies / history, Smoking Cessation: Denies smoking in past 12 months, SSN:

264178874, MEDICAL RECORD NUMBER: 971366670, ACCOUNT NUMBER: 08011157521, PERSON

ID: 971366670. (Sat Feb 26, 2011 23:12 DEV)

ADMISSION: URGENCY: 3-Urgent, ADMISSION SOURCE: work, TRANSPORT: Laurens

County EMS - ALS, DEPT: Emergency, BED: CPC 01. (Sat Feb 26, 2011 23:12 DEV)

VITAL SIGNS: BP 126/74, Pulse 82, Resp 16, Temp 97.8, Pain 0, O2 Sat 99, on RA, Time 2/26/2011

23:06. (23:06 DEV)

COMPLAINT: Respiratory -- shortness of breath. (Sat Feb 26, 2011 23:12 DEV)

HISTORY OF PRESENT COMPLAINT: C/O SOB STARTED AFTER ANSWERING AN

EMS CALL ASSOCIATED WITH CHEST PRESSURE. (Sat Feb 26, 2011 23:12 DEV)

ASSESSMENT (Sat Feb 26, 2011 23:12 DEV)

TREATMENTS PRIOR TO ARRIVAL: Oxygen, IV: .9NS, IV KVO, Site: R arm, Gauge: 18,

Labs/X-Rays, BGL=222DL. (Sat Feb 26, 2011 23:12 DEV)

MEDICATIONS PRIOR TO ARRIVAL: Aspirin, dosage taken: 324MG. (Sat Feb 26, 2011

23:12 DEV)

TREATMENTS IN TRIAGE: No treatment. (Sat Feb 26, 2011 23:12 DEV)

PROVIDERS: TRIAGE NURSE: Delia Velasquez, RN, PRIMARY NURSE: Delia Velasquez, RN.

(Sat Feb 26, 2011 23:12 DEV)

ADMIN

PATIENT DATA CHANGE: Attending changed from (none) to Lisa Barr, MD. (23:30

LB01)

A08 CHPFQP02 by Interface, Zip code: 29680, Language: ENGL, Race: W, Phone number:

(864)915-0039. (23:47)

Admit Room: pend. (Sun Feb 27, 2011 06:44 SLJ1)

A04 CHPFADIT by Interface. (Sun Feb 27, 2011 06:50)

Primary Nurse changed from Delia Velasquez, RN to Matthew Farnham, RN. (Sun Feb 27, 2011

07:22 MSF)

Extender changed from (none) to Nikki Braddock, NST. (Sun Feb 27, 2011 09:29 NNB)

Primary nurse changed from Farnham, RN Matthew to Velasquez, RN Delia. (Sun Feb 27, 2011

19:34 MSF)

Admit Room: pend/MB. (Mon Feb 28, 2011 01:05 KDK)

Primary Nurse changed from Delia Velasquez, RN to Joe Saitz, RN. (Mon Feb 28, 2011 07:16

JFS2)

Extender changed from Nikki Braddock, NST to Arthur Wright, NST. (Mon Feb 28, 2011 09:11

AWW)

BEDBOARD ENTRY: Request Date/Time: Feb 27, 2011 06:39, Bed Type: Monitored bed,

Update admitroom: OK, Diagnosis: ACS, DRO: *None Known, Special Code: Not applicable,

Admitting Doctor: Bittrick, Mode of Travel: Stretcher, Going to prior to room: *To room, Comments:

**GMMC
PRIMARY**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157321

Upstate Card. admitting, Admit Room: (none), Bed Status: (none). (Sun Feb 27, 2011 06:39

BLB)

Request Date/Time: Feb 27, 2011 06:39, Special Code: Not applicable, Mode of Travel: Stretcher,

Admit Room: PEND/MB, Bed Status: (none). (Mon Feb 28, 2011 02:01 KDK)

KNOWN ALLERGIES

Lantus

VITAL SIGNS

VITAL SIGNS: BP: 126/74, Pulse: 82, Resp: 16, Temp: 97.8, Pain: 0, O2 sat: 99 on RA. Time:

2/26/2011 23:06. (23:06 DEV)

BP: 117/71, Time: 2/27/2011 00:01. (Sun Feb 27, 2011 00:01 DEV)

Pulse: 81, Time: 2/26/2011 23:46. (23:46 DEV)

BP: 102/71, Time: 2/27/2011 00:31. (Sun Feb 27, 2011 00:31 DEV)

Pulse: 81, Resp: 21, O2 sat: 97, Time: 2/27/2011 00:06. (Sun Feb 27, 2011 00:06 DEV)

BP: 114/66, Time: 2/27/2011 00:16. (Sun Feb 27, 2011 00:16 DEV)

Pulse: 87, Resp: 19, O2 sat: 97, Time: 2/27/2011 00:21. (Sun Feb 27, 2011 00:21 DEV)

Pulse: 78, Resp: 19, O2 sat: 98, Time: 2/27/2011 00:36. (Sun Feb 27, 2011 00:36 DEV)

BP: 114/65, Time: 2/27/2011 01:31. (Sun Feb 27, 2011 01:31 DEV)

BP: 108/80, Time: 2/27/2011 02:01. (Sun Feb 27, 2011 02:01 DEV)

Pulse: 81, Resp: 26, O2 sat: 97, Time: 2/27/2011 02:31. (Sun Feb 27, 2011 02:31 DEV)

BP: 122/81, Time: 2/27/2011 03:01. (Sun Feb 27, 2011 03:01 DEV)

Pulse: 77, Resp: 23, O2 sat: 95, Time: 2/27/2011 03:24. (Sun Feb 27, 2011 03:24 DEV)

BP: 107/61, Time: 2/27/2011 01:01. (Sun Feb 27, 2011 01:01 DEV)

Pulse: 75, Resp: 25, O2 sat: 96, Time: 2/27/2011 01:06. (Sun Feb 27, 2011 01:06 DEV)

BP: 122/81, Time: 2/27/2011 03:13. (Sun Feb 27, 2011 03:13 DEV)

Pulse: 82, Resp: 25, O2 sat: 96, Time: 2/27/2011 03:29. (Sun Feb 27, 2011 03:29 DEV)

Pulse: 75, Resp: 25, Time: 2/27/2011 06:31. (Sun Feb 27, 2011 06:31 DEV)

BP: 110/73, Time: 2/27/2011 06:01. (Sun Feb 27, 2011 06:01 DEV)

BP: 120/78, Time: 2/27/2011 05:01. (Sun Feb 27, 2011 05:01 DEV)

Pulse: 73, Resp: 23, O2 sat: 95, Time: 2/27/2011 06:36. (Sun Feb 27, 2011 06:36 DEV)

BP: 123/88, Time: 2/27/2011 07:01. (Sun Feb 27, 2011 07:01 DEV)

Pulse: 81, Resp: 25, O2 sat: 95, Time: 2/27/2011 07:11. (Sun Feb 27, 2011 07:11 DEV)

Pulse: 79, Resp: 24, O2 sat: 96, Time: 2/27/2011 07:06. (Sun Feb 27, 2011 07:06 DSW)

Pulse: 78, Resp: 23, O2 sat: 95, Time: 2/27/2011 07:15. (Sun Feb 27, 2011 07:15 DSW)

Pulse: 73, Resp: 21, O2 sat: 96, Time: 2/27/2011 07:20. (Sun Feb 27, 2011 07:20 DSW)

Pulse: 74, Resp: 23, O2 sat: 95, Time: 2/27/2011 07:25. (Sun Feb 27, 2011 07:25 DSW)

Pulse: 78, Resp: 20, O2 sat: 95, Time: 2/27/2011 07:30. (Sun Feb 27, 2011 07:30 DSW)

Pulse: 100, Resp: 31, Time: 2/27/2011 07:42. (Sun Feb 27, 2011 07:42 DSW)

BP: 136/79, Time: 2/27/2011 07:45. (Sun Feb 27, 2011 07:45 DSW)

Pulse: 74, Resp: 24, O2 sat: 94, Time: 2/27/2011 07:50. (Sun Feb 27, 2011 07:50 DSW)

BP: 100/60, Time: 2/27/2011 12:01. (Sun Feb 27, 2011 12:01 MSF)

Pulse: 70, Resp: 24, O2 sat: 97, Time: 2/27/2011 12:11. (Sun Feb 27, 2011 12:11 MSF)

Pulse: 77, Resp: 23, O2 sat: 98, Time: 2/27/2011 16:26. (Sun Feb 27, 2011 16:26 MSF)

Pulse: 78, Resp: 20, O2 sat: 97, Time: 2/27/2011 16:36. (Sun Feb 27, 2011 16:36 MSF)

Pulse: 72, Resp: 22, Time: 2/27/2011 17:12. (Sun Feb 27, 2011 17:12 MSF)

Pulse: 77, Resp: 19, Time: 2/27/2011 17:27. (Sun Feb 27, 2011 17:27 MSF)

Pulse: 83, Resp: 24, Time: 2/27/2011 17:47. (Sun Feb 27, 2011 17:47 MSF)

BP: 119/67, Time: 2/28/2011 00:01. (Mon Feb 28, 2011 00:01 DEV)

BP: 110/69, Time: 2/27/2011 23:02. (Sun Feb 27, 2011 23:02 DEV)

Pulse: 74, Resp: 23, O2 sat: 95, Time: 2/27/2011 22:43. (Sun Feb 27, 2011 22:43 DEV)

BP: 116/71, Pulse: 79, Resp: 24, O2 sat: 97, Time: 2/27/2011 20:33. (Sun Feb 27, 2011 20:33

DEV)

BP: 95/63, Time: 2/28/2011 07:01. (Mon Feb 28, 2011 07:01 DEV)

BP: 104/59, Time: 2/28/2011 06:01. (Mon Feb 28, 2011 06:01 DEV)
BP: 101/68, Time: 2/28/2011 05:01. (Mon Feb 28, 2011 05:01 DEV)
Pulse: 59, Resp: 14, Time: 2/28/2011 06:37. (Mon Feb 28, 2011 06:37 DEV)
Pulse: 69, Resp: 19, O2 sat: 94, Time: 2/28/2011 05:37. (Mon Feb 28, 2011 05:37 DEV)
Pulse: 56, Resp: 10, Time: 2/28/2011 04:50. (Mon Feb 28, 2011 04:50 DEV)
Pulse: 65, Resp: 18, O2 sat: 98, Time: 2/28/2011 07:17. (Mon Feb 28, 2011 07:17 JFS2)
Pulse: 72, Resp: 17, O2 sat: 100, Time: 2/28/2011 07:12. (Mon Feb 28, 2011 07:12 JFS2)
(Mon Feb 28, 2011 07:20 JFS2)
Pulse: 63, Resp: 12, O2 sat: 93, Time: 2/28/2011 07:07. (Mon Feb 28, 2011 07:07 JFS2)
Pulse: 62, Resp: 15, O2 sat: 92, Time: 2/28/2011 06:57. (Mon Feb 28, 2011 06:57 JFS2)
Pulse: 61, Resp: 16, Time: 2/28/2011 06:52. (Mon Feb 28, 2011 06:52 JFS2)
Pulse: 56, Resp: 11, Time: 2/28/2011 07:21. (Mon Feb 28, 2011 07:21 JFS2)
Pulse: 66, Resp: 17, Time: 2/28/2011 06:47. (Mon Feb 28, 2011 06:47 JFS2)
Pulse: 58, Resp: 15, Time: 2/28/2011 06:42. (Mon Feb 28, 2011 06:42 JFS2)
Pulse: 57, Resp: 14, Time: 2/28/2011 06:32. (Mon Feb 28, 2011 06:32 JFS2)

PAST MEDICAL HISTORY

MEDICAL HISTORY: History of diabetes, That is currently treated with an oral medication, History of endocrine disease, including hypothyroidism. (Sat Feb 26,

2011 23:12 DEV)

as noted. (Sun Feb 27, 2011 00:57 LB01)

SURGICAL HISTORY: Patient has had no previous surgical history. (Sat Feb 26, 2011 23:12 DEV)

Patient's previous surgical history is not relevant to the case. (Sun Feb 27, 2011 00:57 LB01)

PSYCHIATRIC HISTORY: No previous psychiatric history. (Sat Feb 26, 2011 23:12 DEV)

No previous psychiatric history. (Sun Feb 27, 2011 00:57 LB01)

SOCIAL HISTORY: Denies smoking, Patient consumes alcohol socially, Lives at home with family. (Sat Feb 26, 2011 23:12 DEV)

Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives with others, Patient consumes alcohol socially. (Sun Feb 27, 2011 00:57 LB01)

FAMILY HISTORY: Family history is not contributory to this case. (Sat Feb 26, 2011 23:12 DEV)

Family history includes coronary artery disease, father with MI in his 40s, died at 54 of MI. (Sun Feb 27, 2011 00:57 LB01)

NOTES: Nursing records reviewed, Medication list reviewed, no old chart. (Sun Feb 27, 2011 00:57 LB01)

CURRENT MEDICATIONS

No recorded medications

HPI BLANK (Sun Feb 27, 2011 00:54 LB01)

CHIEF COMPLAINT: Pt presents with c/o chest pressure, diaphoresis, SOB, and generalized weakness after lifting a heavy pt today. Had the flu last week, and just came back to work. Had L shoulder pain also last week, thought was injury, altho XR did not indicate dislocation. No N/V, palpitations. Sx resolved by arrival. Took ASA 324 mg pta.

HISTORIAN: History obtained from patient, family.

TIME COURSE: Onset of symptoms reported as gradual, Onset was hours prior to arrival, Complaint is resolved, Complaint is constant.

SEVERITY: Maximum severity is moderate, Currently there are no symptoms.

CRITICAL CARE: Time: 40 minutes, Total number of minutes spent in direct and indirect care of this critically ill patient excluding procedure time.

ROS (Sun Feb 27, 2011 00:58 LB01)

GMMC
PRIMARY

Northen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

CARDIOVASCULAR: Historian reports dyspnea on exertion. Historian reports diaphoresis, chest pressure.

RESPIRATORY: Historian reports SOB.

NOTES: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM (Sun Feb 27, 2011 00:53 LB01)

CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed, Patient has normal pulse, Patient has normal blood pressure, Patient has normal respiratory rate, Well appearing. Patient appears comfortable, Alert and oriented X 3.

HEAD: Atraumatic, Normocephalic.

EYES: Eyes are normal to inspection. Pupils equal, round and reactive to light, No discharge from eyes. Extraocular muscles intact, Sclera are normal, Conjunctiva are normal.

NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine nontender.

RESPIRATORY CHEST: Chest is nontender, Breath sounds normal, No respiratory distress.

CARDIOVASCULAR: RRR, No murmurs, Normal S1 S2, No rub, No gallop, Pedal pulses present 4/4.

ABDOMEN: Abdomen is nontender, No masses, Bowel sounds normal, No distension, No peritoneal signs.

UPPER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, Normal pulses.

LOWER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema, Normal range of motion, No calf tenderness, Normal pulses.

NEURO: GCS is 15, No focal motor deficits, No focal sensory deficits, Speech normal, Memory normal.

SKIN: Skin is warm. Skin is dry, Skin is normal color.

PSYCHIATRIC: Oriented X 3.

DIAGNOSIS (Sun Feb 27, 2011 01:30 LB01)

FINAL: PRIMARY: ACS.

DOCTOR NOTES (Sun Feb 27, 2011 01:28 LB01)

TEXT: Family requests Upstate. Per Dr. Bittrick: Heparin bolus/gtt, Plavix.

PATIENT STATUS: Patient has stabilized since arrival to emergency department.

PATIENT PLAN: The patient will be admitted to the hospital.

ORDERS

BASIC METABOLIC PANEL by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 00:53

EKG STAT ((GMH ETC ONLY)) by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 00:08

CARDIAC PROFILE 1 (ADMISSION) by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 01:10

Troponin-i -- POC (GMH, GrMH only) by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by Velasquez, RN, Delia Sun Feb 27, 2011 00:14

Saline Lock by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by Velasquez, RN, Delia Sun Feb 27, 2011 00:14

CK-MB MASS by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 01:10

MAGNESIUM (MG) by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 00:53

CBC WITHOUT DIFF by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status: Done by System Sun Feb 27, 2011 00:37

DX CHEST SINGLE VIEW by Barr, MD, Lisa for Barr, MD, Lisa on Sat Feb 26, 2011 23:33
Status:

**GMMC
PRIMARY**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

Done by System Sun Feb 27, 2011 17:18
VENIPUNCTURE by Velasquez, RN, Delia for Barr, MD, Lisa on Sun Feb 27, 2011 00:14 Status: Active
Glucose – fingerstick – recheck by Barr, MD, Lisa for Barr, MD, Lisa on Sun Feb 27, 2011 01:05
Status: Done by Velasquez, RN, Delia Sun Feb 27, 2011 04:47
Troponin-i -- POC (GMH, GrMH only) by Barr, MD, Lisa for Barr, MD, Lisa on Sun Feb 27, 2011 01:27 Status: Done by Velasquez, RN, Delia Sun Feb 27, 2011 04:47
MD Consult at bedside by Velasquez, RN, Delia for Barr, MD, Lisa on Sun Feb 27, 2011 06:37
Status: Active
CARDIAC PROFILE 3 (8 HOUR) by Walton, HUC, Sandra for BITTRICK, JON M. on Sun Feb 27, 2011 08:13 Status: Cancelled by System Sun Feb 27, 2011 08:27
Reason: Laboratory credited
PTT 6 HR POST HEP (GMH ONLY) by Walton, HUC, Sandra for BITTRICK, JON M. on Sun Feb 27, 2011 08:13 Status: Done by System Sun Feb 27, 2011 08:50
PTT by Velasquez, RN, Delia for Barr, MD, Lisa on Mon Feb 28, 2011 03:22 Status: Done by System Mon Feb 28, 2011 04:00
IV SOLUTION-ED by Saitz, RN, Joe for Barr, MD, Lisa on Mon Feb 28, 2011 09:43 Status: Active

MEDICATION SERVICE

Heparin Sodium: Order: Heparin Sodium (Heparin) – Dose: 4000 Units : intravenous fluid

Ordered by: Lisa Barr, MD
Entered by: Lisa Barr, MD Sun Feb 27, 2011 01:27 ,
Acknowledged by: Delia Velasquez, RN Sun Feb 27, 2011 01:54
Documented as given by: Delia Velasquez, RN Sun Feb 27, 2011 01:57
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 4000 UNITS, IV SITE #1 IVP, initial medication, Connections checked prior to administration, Line traced prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Heparin Sodium: Order: Heparin Sodium (Heparin) – Dose: 1000 Units/hr : intravenous fluid

Ordered by: Lisa Barr, MD
Entered by: Lisa Barr, MD Sun Feb 27, 2011 01:28 ,
Acknowledged by: Delia Velasquez, RN Sun Feb 27, 2011 01:54
Documented as given by: Delia Velasquez, RN Sun Feb 27, 2011 01:58
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 1000UNITS/HOUR, IV SITE #1 IVPB or drip, initial infusion. Premixed, via primary tubing, Connections checked prior to administration, Line traced prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Humulin N: Order: Humulin N (Insulin Nph Human Recombinant) – Dose: 8 units : intravenous fluid

Ordered by: Lisa Barr, MD
Entered by: Lisa Barr, MD Sun Feb 27, 2011 01:04
Documented as given by: Delia Velasquez, RN Sun Feb 27, 2011 01:24
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 8 UNITS, IV SITE #1 IVP, initial medication, Connections checked prior to

**GMMC
PRIMARY**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

administration, Line traced prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Magnesium Oxide: Order: Magnesium Oxide – **Dose:** 400 mg : by mouth

Ordered by: Lisa Barr, MD

Entered by: Lisa Barr, MD Sun Feb 27, 2011 01:04

Documented as given by: Delia Velasquez, RN Sun Feb 27, 2011 01:17

Patient, Medication, Dose, Route and Time verified prior to administration.

, Amount given: 400MG, Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Plavix: Order: Plavix (Clopidogrel Bisulfate) – **Dose:** 600 mg : by mouth

Ordered by: Lisa Barr, MD

Entered by: Lisa Barr, MD Sun Feb 27, 2011 01:28 ,

Acknowledged by: Delia Velasquez, RN Sun Feb 27, 2011 01:54

Documented as given by: Delia Velasquez, RN Sun Feb 27, 2011 01:57

Patient, Medication, Dose, Route and Time verified prior to administration.

, Amount given: 600MG, Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

(CANCELLED) Aspirin Child Chewable: Order: Aspirin Child Chewable (Aspirin) –

Dose: 324 mg : by mouth

Ordered by: Lisa Barr, MD

Entered by: Lisa Barr, MD Sun Feb 27, 2011 00:23

Cancelled by: Delia Velasquez, RN, Sun Feb 27, 2011 00:34

, **Cancel reason:** HAD ASA 324MG PTA.

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Aspirin Child Chewable	324 mg	by mouth	Cancelled	00:34 2/27/2011
Heparin Sodium	1000 Units/hr	intravenous fluid	Given	01:58 2/27/2011
Heparin Sodium	4000 Units	intravenous fluid	Given	01:57 2/27/2011
Plavix	600 mg	by mouth	Given	01:57 2/27/2011
Humulin N	8 units	intravenous fluid	Given	01:24 2/27/2011
Magnesium Oxide	400 mg	by mouth	Given	01:17 2/27/2011

Detailed record available in Medication Service section.

PRESCRIPTION

No recorded prescriptions

EKG INTERPRETATION (Sun Feb 27, 2011 00:59 LB01)

12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, At: 2351, 12 Lead

EKG Interpretation shows rhythm is Normal Sinus, Rate is normal, Conduction is normal, Axis: right, **non-specific EKG**, Interpretation: **ant infarct, age indeterminate.**

LAB INTERPRETATION (Sun Feb 27, 2011 01:28 LB01)

INTERPRETATION: I reviewed the lab results.

RADIOLOGY INTERPRETATION (Sun Feb 27, 2011 01:23 LB01)

INTERPRETER: Preliminary review of x-rays by ED Physician.

CHEST: Interpretation of chest X-ray shows, **no acute process.**

**GMMC
PRIMARY**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

ATTENDING (Sun Feb 27, 2011 01:29 LB01)

HISTORY: The documented history was done by me personally.

PHYSICAL EXAM: The documented physical exam was done by me personally.

NURSING ASSESSMENT: CV WITH PROCEDURES (23:34 DEV)

NURSING DIAGNOSIS: SOB/CP.

CONSTITUTIONAL: History obtained from patient, Patient appears comfortable, Patient is cooperative, Patient is alert and oriented x 3, **History obtained from EMS.**

CARDIOVASCULAR: Normal sinus rhythm on monitor.

RESPIRATORY/CHEST: Breath sounds clear bilaterally, Equal chest expansion, No complaint of pain, No acute respiratory distress, Able to speak in full sentences.

CARDIAC MONITOR: Procedure was performed at 2335, Patient placed on cardiac monitor, Patient placed on non-invasive blood pressure monitor, Patient placed on continuous pulse Oximetry, Patient on cardiac monitor showing, Normal sinus, Disposable BP cuff applied, After procedure, alarms set and on.

EKG CHART: EKG was performed at 2335, 12 lead EKG Performed-left chest, EKG Number: 1.

SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING ASSESSMENT: NURSES NOTE

TIME ASSESSED: Time: 0035, Patient examined by MD. (Sun Feb 27, 2011 00:35 DEV)

Time: 0200, Patient up to bathroom with steady gait, Patient is Awaiting Disposition. (Sun Feb 27, 2011 02:19 DEV)

Time: 0230, Temporary care report given to heather s.m. (Sun Feb 27, 2011 03:58 DEV)

Patient is improving, Patient in no apparent distress, Patient resting quietly, Patient is Awaiting Disposition, **continue to monitor, Time: 0327.** (Sun Feb 27, 2011 03:27 DEV)

Time: 0637, Consulting physician at bedside, Physician consulted dr.bittrick. (Sun Feb 27, 2011 06:37 DEV)

Time: 0714, Shift change report given to matt f.m. **waiting on monitored bed.** (Sun Feb 27, 2011 07:14 DEV)

Time: 0945, **Dr. Bittrick paged to notify of troponin of 2.51.** (Sun Feb 27, 2011 09:46 MSF)

Time: 0951, **Dr. Bittrick returned paged and notified of 8 hour troponin of 2.51. No orders received.** (Sun Feb 27, 2011 09:51 MSF)

Time: 1042, **Ambulatory to bathroom without assistance.** (Sun Feb 27, 2011 10:42 MSF)

Time: 1200, Patient in no apparent distress, Patient resting quietly. (Sun Feb 27, 2011 12:38 MSF)

Time: 1508, Patient in no apparent distress, Patient resting quietly. (Sun Feb 27, 2011 15:08 MSF)

Time: 1742, Patient in no apparent distress, Patient resting quietly, Patient given meal tray. (Sun Feb 27, 2011 17:42 MSF)

Time: 2001, Patient given meal tray, c/o headache,tylenol given verbal order dr.Barr. (Sun Feb 27, 2011 20:01 DEV)

Time: 2100, Patient is Awaiting Disposition, **hung another bag of heparin.watching tv.** (Sun Feb 27, 2011 21:01 DEV)

Time: 2216, **ptt=64 no change in heparin drip at this time.** (Sun Feb 27, 2011 22:16 DEV)

Time: 0200, Patient is improving, Patient in no apparent distress, Patient resting quietly. **asleep.continue to monitor.** (Mon Feb 28, 2011 06:44 DEV)

Time: 0318, **am labs drawn.wanted to eat something.got mad because we woke him up to draw ptt.** (Mon Feb 28, 2011 07:07 DEV)

Time: 0600, Patient is improving, Patient in no apparent distress, Patient resting quietly, **cath permit signed.** (Mon Feb 28, 2011 07:12 DEV)

Time: 0620, Patient is improving, Patient in no apparent distress, Patient resting quietly, Patient is Awaiting Disposition, **heparin drip adjusted per ptt result.asleep, Time: 0620.** (Mon Feb 28, 2011 07:09 DEV)

GMMC
PRIMARY

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

Time: 0700, Shift change report given to joelrn. (Mon Feb 28, 2011 07:14 DEV)
SAFETY: Side rails up, Cart in lowest position, Call light within reach. (Mon Feb 28, 2011 07:09 DEV)

NURSING PROCEDURE: ADMISSION (Mon Feb 28, 2011 09:39 JFS2)

TIME: Patient admitted at 0935, Patient admitted to room Cath Lab, Patient acuity level was urgent, Patient admitted to, Admission orders received and completed, Report called/faxed to cath lab, Patient transported via, cart, Accompanied by, transport.

NURSING PROCEDURE: BEDSIDE RADIOLOGY (22:30 DEV)

TIME: Portable x-ray performed of chest.

NURSING PROCEDURE: BEDSIDE TESTING

FINGERSTICK GLUCOSE: Procedure was performed at 0445, Blood: Venous, Glucose results: 246. (Sun Feb 27, 2011 04:48 DEV)

Procedure was performed at 0905, Glucose results: 290. (Mon Feb 28, 2011 09:40 JFS2)

TROPONIN-I: Troponin-I performed at the bedside., Critical value Troponin-I given to Dr. BARR, and read back at 0035, BEDSIDE TROPONIN-I VALUE RANGE: 0.0-0.07 ng/mL -Negative for Acute Coronary Syndrome. 0.08-0.10 ng/mL -Diagnostic Significance Questionable. 0.11-0.40 ng/mL -Suggestive of Cardiac Injury (ACS). Greater than 0.40 ng/mL -Suggestive of AMI or Myocardial cell necrosis. CRITICAL VALUE: Greater than 0.40 ng/mL.-----TROPONIN-I RESULTS (ng/mL): **3.03**. (Sun Feb 27, 2011 00:35 DEV)

NURSING PROCEDURE: COMMUNICATIONS (Sun Feb 27, 2011 09:43 MMH)

PROCEDURE: Critical labs results received at 935, Critical labs results received from lab, Critical lab result troponin 2.51, Results read back and confirmed, Critical labs result given to Dr. bitrick, results given at 945.

NURSING PROCEDURE: EKG CHART (23:54 LCB1)

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, EKG was performed at 2351, 12 lead EKG Performed--left chest, Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: IV (Mon Feb 28, 2011 09:05 JFS2)

SITE 1: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, Procedure performed at 0905, IV established for venous access, 0.9NS 150ml hung, 1st bag hung, IV bolus of 300 ml established, via pump tubing, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab.

NURSING PROCEDURE: LAB DRAW

TIME: Labs drawn at 0010, Initial lab draw, Venipuncture performed/labs sent, Blood obtained from left AC and labs sent, in 1 attempt, Lab specimens labeled in the presence of the patient and sent to lab, Patient tolerated procedure well. (Sun Feb 27, 2011 00:13 DEV)

Labs drawn at 0445, Subsequent lab draw, Venipuncture performed/labs sent, Blood obtained from left AC and labs sent, in 1 attempt, Lab specimens labeled in the presence of the patient and sent to lab, Patient tolerated procedure well, **4hce drawn**. (Sun Feb 27, 2011 04:47 DEV)

Patient's identity verified by, patient stating name, patient stating birth date, Labs drawn at 0800, Subsequent lab draw, Blood obtained from left AC and labs sent, in 1 attempt, Lab specimens labeled in the presence of the patient and sent to lab, Patient tolerated procedure well, **8 hour PTT and CE drawn**. (Sun Feb 27, 2011 08:11 MSF)

Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, Labs drawn at 0318, Subsequent lab draw, Blood obtained from left AC and labs sent, in 1 attempt, Lab specimens labeled in the presence of the patient and sent to lab, After procedure, dressing applied to site, After procedure, no swelling, After procedure, no active bleeding, Patient tolerated

GMMC
PRIMARY

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

procedure well. (Mon Feb 28, 2011 03:23 LCB1)

SAFETY: Side rails up, Cart in lowest position, Call light within reach. (Mon Feb 28, 2011 03:23 LCB1)

NURSING PROCEDURE: MEDICATION (Sun Feb 27, 2011 20:02 DEV)

MEDICATION: TYLENOL, 1g, given PO, verbal order dr.barr.

DISPOSITION

PATIENT: Disposition Type: Admit, Condition: Stable. (Sun Feb 27, 2011 01:30 LB01)

Disposition: Admit to OR, Remove from ER. (Mon Feb 28, 2011 10:26 JFS2)

NOTES: Care transferred to Cardiology/Dr. Bittrick. (Sun Feb 27, 2011 01:30 LB01)

MEDICATION RECONCILIATION (Sun Feb 27, 2011 01:29 LB01)

ADDITIONAL NOTES: Reviewed with patient.

FORM (Mon Feb 28, 2011 07:23 JFS2)

GV_TRANSPORT.PDF

ADMIN

DIGITAL SIGNATURE: Burnett, NST, Lisa. (23:56 LCB1)

Han, RN, Maria. (Sun Feb 27, 2011 09:44 MMH)

Burnett, NST, Lisa. (Mon Feb 28, 2011 02:23 LCB1)

Key:

AWW=Wright, NST, Arthur BLB=Burden, HUC, Beverly DEV=Velasquez, RN, Delia DSW=Wesley, RN, Debra
JB17=BITTRICK, JON M. JFS2=Saitz, RN, Joe KDK=Koutsoukis, PPC, Kelly D. LB01=Barr, MD, Lisa
LCB1=Burnett, NST, Lisa MMH=Han, RN, Maria MSF=Farnham, RN, Matthew NNB=Braddock, NST, Nikki
SLJ1=Johnson, SEC, Sandy SMW=Walton, HUC, Sandra

GREENVILLE HOSPITAL SYSTEM

GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

PATIENT NAME: WORTHEN, MICHAEL
DOB: 1959
SEX: MALE
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 084F AM 4605
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: JON M. BITTRICK, MD
UPSTATE CARDIOLOGY
2 INNOVATION DRIVE, STE 400
GREENVILLE, SC, 29607

OP LOCATION:

0 ELECTRONIC SIGNATURE / GILPIN, MD,JOHN

RX410300 - CHEST PA AND LATERAL 3/1/2011 9:00 AM EXAM#: 11704382
ORDERED BY: Dr. JON M. BITTRICK, MD

REASON FOR EXAM: CAD, PREOP CABG-----

RESULT: MICHAEL WORTHEN

CHEST PA AND LATERAL 3/1/11:

PA and lateral chest films are provided to me. The heart and mediastinum appear normal. There is no evidence of consolidation. No pneumothorax is seen. Spondylosis is present.

IMPRESSION: NO EVIDENCE OF CONSOLIDATION.

TRANSCRIPTIONIST: TERESA, ENGEL
TRANSCRIBE TIME/DATE: 3/1/2011 2:25:00 PM
READ BY: JOHN GILPIN, MD,
SIGNED BY:

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: ()
SEX: Male
Reason for Exam: POST PACEMAKER

Medical Record#: 971366670
Pt. NS/Room: 082E / 2514
Corp. Act. No:
Patient Type: Inpatient

Account: 08011157521
Ordering MD: JOSEPH A, MANFREDI, MD
ARRHYTHMIA CONSULTANTS, PA
712 GROVE ROAD
GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 03/08/2011 10:56AM EXAM#: 11718368

IMPRESSION:
NO PNEUMOTHORAX NOTED STATUS POST DUAL LEAD PACER PLACEMENT. LEADS APPEAR
TO BE IN GOOD POSITION AND POSTSURGICAL CHANGE IN THE LEFT CHEST AND
PERSISTENT LEFT PLEURAL EFFUSION NOTED.

RESULT: WORTHEN, MICHAEL

CHEST SINGLE VIEW, 03/08/11:

COMPARISON: 03/05/11.

FINDINGS: Single view of the chest demonstrates dual lead pacing device
in place. Endotracheal tube and enteric tubes have been removed. Left
thoracostomy tube remains in place. Left sided pleural effusion and/or
volume loss on the left is again suggested.

TRANSCRIPTIONIST: JENNIFER, HOWANSKY
TRANSCRIBE TIME/DATE: 3/8/2011 5:49:00 PM
READ BY: B.F. "TRIPP" MASTERS, III, MD,
SIGNED BY:

GREENVILLE MEMORIAL HOSPITAL
GMH VASCULAR LAB
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL

DOB: [REDACTED]

SEX: male

Reason for Exam: CAROTID ARTERY STENOSIS, CABG

Medical Record#: 971366670

Pt. NS/Room: 084F / 4605

Corp. Act. No:

Patient Type: Inpatient

Account: 08011157521

Ordering MD: BARRY R., DAVIS, MD

UMG - CARDIOTHORACIC SURGERY

890 W. FARIS ROAD, STE 550

GREENVILLE, SC 29605

RV100100-VAS CAROTID DUPLEX COMPLETE 03/01/2011 09:00AM EXAM#: 11704265

IMPRESSION:

1. BILATERAL CLASS B ICA CAROTID STENOSIS, 1-15%.
2. THE VERTEBRAL ARTERIES ARE ANTEGRADE BILATERALLY.
3. THE BRACHIAL ARTERY PRESSURES ARE SYMMETRIC.

RESULT: WORTHEN, MICHAEL

CAROTID ARTERY DUPLEX, 03/01/11:

INDICATIONS FOR EXAMINATION: Preoperative CABG evaluation.

FINDINGS: The right brachial artery pressure is 116 mmHg. The left brachial artery pressure is 116 mmHg. The vertebral arteries are antegrade bilaterally.

RIGHT: The internal carotid artery peak systolic velocity is 75 cm/sec with an ICA/CCA ratio of 0.81. On B-mode imaging, the ICA has minimal disease.

LEFT: The internal carotid artery peak systolic velocity is 72 cm/sec with an ICA/CCA ratio of 0.69. On B-mode imaging, there is minimal to moderate disease within the ICA.

TRANSCRIPTIONIST: JENNIFER, HOWANSKY

TRANSCRIBE TIME/DATE: 3/3/2011 12:45:00 PM

READ BY: GINGER MANOS, MD,

SIGNED BY:

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: 03/05/1951
SEX: Male
Reason for Exam: RES. FAILURE, CABG

Medical Record#: 971366670
Pt. NS/Room: 082E / 2514
Corp. Act. No:
Patient Type: Inpatient

Account: 08011157521
Ordering MD: BARRY R., DAVIS, MD
UMG - CARDIOTHORACIC SURGERY
890 W. FARIS ROAD, STE 550
GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 03/05/2011 04:00AM EXAM#: 11713617

RESULT: WORTHEN, MICHAEL

CHEST, SINGLE VIEW - 3/5/2011

REFERENCE: 3/4/2011

HISTORY: CABG

FINDINGS: A single portable view of the chest again reveals features of coronary artery bypass graft surgery along with tubes, drains and catheters, as before. I do not appreciate a pneumothorax. There is the suggestion of some left perihilar interstitial infiltrate but actually the left lung appears better aerated than before. The right lung is grossly clear. No obvious effusions are seen. The cardiomedial silhouette is unremarkable.

TRANSCRIPTIONIST: PAM, PAGE
TRANSCRIBE TIME/DATE: 3/5/2011 12:48:00 PM
READ BY: S. ERIC FARNSWORTH, MD,
SIGNED BY: ELECTRONIC SIGNATURE / FARNSWORTH, MD, S. ERIC - 3/5/2011
1:14:02 PM

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL

DOB:

SEX: male

Reason for Exam: S/P CABG X 4, VENT ANEURYSM

REPAIR

Medical Record#: 971366670

Pt. NS/Room: 082E / 2514

Corp. Act. No:

Patient Type: Inpatient

Account: 08011157521

Ordering MD: BARRY R., DAVIS, MD

UMG - CARDIOTHORACIC SURGERY

890 W. FARIS ROAD, STE 550

GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 03/04/2011 04:00AM EXAM#: 11712010

IMPRESSION:

CARDIOMEGALY AND BILATERAL INFILTRATES SIMILAR TO PRIOR EXAM.

RESULT: MICHAEL WORTHEN

CHEST

Comparison with 3/3/11.

CLINICAL HISTORY: CABG.

Heart is enlarged. There are mild bilateral infiltrates present similar to prior exam. Bilateral midline chest tubes are in place. ET tube position is similar to prior exam. Swan-Ganz catheter over the right pulmonary artery. Median sternotomy wires are in place. There is an NG tube, tip difficult to see but at least in the stomach.

TRANSCRIPTIONIST: CINDY, CAMPBELL

TRANSCRIBE TIME/DATE: 3/4/2011 10:15:00 AM

READ BY: SYLVESTER LEE, MD,

SIGNED BY:

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL

DOB: ()

SEX: Male

Reason for Exam: CABG, VENT. ANEURYSM REPAIR

P/O DAY 1

Medical Record#: 971366670

Pt. NS/Room: 082E / 2514

Corp. Act. No:

Patient Type: Inpatient

Account: 08011157521

Ordering MD: BARRY R., DAVIS, MD

UMG - CARDIOTHORACIC SURGERY

890 W. FARIS ROAD, STE 550

GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 03/03/2011 04:00AM EXAM#: 11709211

IMPRESSION: 1. POSSIBLE SLIGHT WORSENING OF THE BILATERAL OPACITIES.

2. LIFE SUPPORT, AS DESCRIBED.

3. NO PNEUMOTHORAX.

RESULT:

P TIENT - MICHAEL P. WORTHEN

PROCEDURE: PORTABLE AP CHEST, 4:54 A.M. ON 3/3/11.

History: CABG, ventilation, aneurysm repair. Post-op day one.

Comparison is to 3/2/11.

Findings: The endotracheal tube tip and nasogastric tube are not appreciably changed in appearance. Bilateral chest tubes are again demonstrated. No definite evidence of pneumothorax is seen. The right internal jugular Swan-Ganz PA catheter tip is projected likely in the pulmonary out-flow tract. Bilateral opacities may be slightly worse. Left base opacification may be stable. The thoracic spine is suboptimally visualized.

TRANSCRIPTIONIST: GLORIA, PARKER

TRANSCRIBE TIME/DATE: 3/3/2011 10:33:00 AM

READ BY: LEWIS B. GILPIN, MD,

SIGNED BY:

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: 03-01-1950
SEX: Male
Reason for Exam: IABP PLACEMENT

Medical Record#: 971366670
Pt. NS/Room: 082E / 2514
Corp. Act. No:
Patient Type: Inpatient

Account: 08011157521
Ordering MD: BARRY R., DAVIS, MD
UMG - CARDIOTHORACIC SURGERY
890 W. FARIS ROAD, STE 550
GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 03/02/2011 15:19PM EXAM#: 11709302

RESULT:

MICHAEL WORTHEN

CLINICAL INFORMATION: Intra-aortic balloon pump placement.

FINDINGS: Portable chest, 03/02/2011 at 1550 hours. Comparison is made with previous study performed 03/01/2011 at 1019 hours.

Endotracheal tube is present with the tip at the level of the clavicles. Bilateral pleural tubes are present. Right internal jugular vein Swan-Ganz catheter tip projects over the proximal right pulmonary artery. The patient is status post median sternotomy. Mediastinal drains are present. There is no evidence of pneumothorax. The cardiac silhouette is enlarged. Evaluation of patient's intra-aortic balloon pump is limited due to presence of artifact. However, there is a radiopaque density present at approximately the T7 level and question whether this represents the aortic balloon pump. Repeat study may be helpful for further evaluation due to the limitations of this exam.

TRANSCRIPTIONIST: PATRICIA, COX
TRANSCRIBE TIME/DATE: 3/2/2011 9:12:00 PM
READ BY: A. MICHAEL DEVANE, MD,
SIGNED BY: ELECTRONIC SIGNATURE / DEVANE, MD, A. MICHAEL - 3/3/2011
7:51:45 AM

GREENVILLE MEMORIAL HOSPITAL
GMH ECHO LAB
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: _____
SEX: Male
Reason for Exam: NQWMI CPC BED 1

Medical Record#: 971366670
Pt. NS/Room: 08CP / CP00
Corp. Act. No:
Patient Type: Emergency

Account: 08011157521
Ordering MD: JON M., BITTRICK, MD
UPSTATE CARDIOLOGY
2 INNOVATION DRIVE, STE 400
GREENVILLE, SC 29607

FO000200-ECHO 2D W/SPEC/COLOR COMP ADULT 02/27/2011 09:00AM EXAM#: 11702671

Test Date: 02/27/2011
Physicians:
Referring: Bittrick, Jon MD
Reading: Upstate Cardiology
Reading: Freeman, Lawrence MD
Technician: Van, Vu H. BS, RDCS

Patient: WORTHENMICHAELPHILIP DOB: 09/08/1956 Age: 54
Med Rec#: 971366670 Gender: M Status: Inpatient
Hospital Loc: CPC1 Height (cm): 187.96 Weight (kg):
124.74 BSA: 2.49
Rhythm: HR BP
74 119/58

Study Type(s): Greenville Memorial Hospital
Indication(s): NQWMI
Study Quality:

Measurements	Value	Units

Measurements:		
IVSD	1.11	cm
LVIDd_2D	6.32	cm
LVIDs_2D	5.17	cm
LVPWD	1.2	cm
LADIAM	4.3	cm
AODIAM	3.8	cm
AVGRADP	4	mmHg
AVGRADM	2	mmHg
AVA_VTI	2.87	cm ²
AVA-(Vmax)	2.45	cm ²
MV_VTI	29.7	cm
MVA (Cont)	1.47	cm ²
MVA_PHT	3.79	cm ²
MVGDM	2	mmHg

Findings:
Technical Comments:
The study quality is fair.

Left Ventricle:
The left ventricular chamber size is moderately dilated. Mild
concentric left ventricular hypertrophy is observed. Severe global

Patient: WORTHEN, MICHAEL DOB: 09/08/1956 MRN: 971366670 Acct: 08011157521

h kinesis of the left ventricle is observed. The estimated ejection fraction is 30-35%. The left ventricular diastolic filling pattern is restrictive.

Left Atrium:

The left atrium is mildly dilated.

Right Atrium:

The right atrium appears normal.

Aortic Valve:

The aortic valve structure is normal. Mild aortic cusp sclerosis is present. There is no evidence of aortic stenosis. There is no evidence of aortic regurgitation.

Mitral Valve:

The mitral valve leaflets appear normal. There is a trace of mitral regurgitation.

Tricuspid Valve:

The tricuspid valve appears normal in structure and function.

Pulmonic Valve:

The pulmonic valve is not well visualized.

Pericardium:

There is no pericardial effusion.

Aorta:

The aortic root appears normal.

Impression:

Segmental wall motion abnormalities with decreased systolic performance indicative of CAD. There is left ventricular hypertrophy. Left ventricular diastolic dysfunction is present. The base of LV contracts normally. There is an extensive area of apical akinesis with what is likely a laminar apical thrombus. The remaining walls are mildly hypokinetic.

This report has been electronically signed by Lawrence Freeman MD
02/27/2011 15:26:03

GREENVILLE MEMORIAL HOSPITAL
GMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: 02/27/55
SEX: Male
Reason for Exam: CHEST PAIN

Medical Record#: 971366670
Pt. NS/Room: 08CP / CP00
Corp. Act. No:
Patient Type: Emergency

Account: 08011157521
Ordering MD: BONNIE LISA, BARR, MD
GMH INTERNAL MEDICINE
701 GROVE ROAD
GREENVILLE, SC 29605

RX410200-CHEST SINGLE VIEW 02/26/2011 23:33PM EXAM#: 11702557

IMPRESSION:
CARDIAC SILHOUETTE UPPER LIMITS OF NORMAL ALLOWING FOR AP PROJECTION.

RESULT: WORTHEN, MICHAEL

SINGLE VIEW CHEST

HISTORY:
Chest pain

FINDINGS:
Single view of the chest demonstrates the cardiac silhouette at the upper limits of normal in size. No definite acute airspace disease, pneumothorax or pleural effusion is present. Bony thorax appears intact.

TRANSCRIPTIONIST: MARY, SILAS
TRANSCRIBE TIME/DATE: 2/27/2011 10:36:00 AM
READ BY: B.F. "TRIPP" MASTERS, III, MD,
SIGNED BY:

GREENVILLE HOSPITAL SYSTEM
GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

PATIENT NAME: WORTHEN, MICHAEL
DOB:
SEX: MALE
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 084F AM 4605
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: BARRY R. DAVIS, MD
UMG - CARDIOTHORACIC SURGERY
890 W. FARIS ROAD, STE 550
GREENVILLE, SC, 29605

OP LOCATION:

RV100100 - VAS CAROTID DUPLEX COMPLETE 3/1/2011 9:00 AM
ORDERED BY: Dr. BARRY R. DAVIS, MD

EXAM#: 11704265

REASON FOR EXAM: CAROTID ARTERY STENOSIS, CABG----

RESULT: WORTHEN, MICHAEL

CAROTID ARTERY DUPLEX, 03/01/11:

INDICATIONS FOR EXAMINATION: Preoperative CABG evaluation.

FINDINGS: The right brachial artery pressure is 116 mmHg. The left brachial artery pressure is 116 mmHg. The vertebral arteries are antegrade bilaterally.

RIGHT: The internal carotid artery peak systolic velocity is 75 cm/sec with an ICA/CCA ratio of 0.81. On B-mode imaging, the ICA has minimal disease.

LEFT: The internal carotid artery peak systolic velocity is 72 cm/sec with an ICA/CCA ratio of 0.69. On B-mode imaging, there is minimal to moderate disease within the ICA.

IMPRESSION:

1. BILATERAL CLASS B ICA CAROTID STENOSIS, 1-15%.
2. THE VERTEBRAL ARTERIES ARE ANTEGRADE BILATERALLY.
3. THE BRACHIAL ARTERY PRESSURES ARE SYMMETRIC.

TRANSCRIPTIONIST: JENNIFER, HOWANSKY
TRANSCRIBE TIME/DATE: 3/3/2011 12:45:00 PM
READ BY: GINGER MANOS, MD,
SIGNED BY:

Appellant's APA Submission #3



GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER

Greenville Hospital System
Echocardiographic Report
Greenville, South Carolina



Patient: WORTHEN, MICHAEL PHILIP	Date: 02/27/2011	Referring: Bittrick, Jon MD
DOB: 09/08/1956	Type: Inpatient	Reading: Upstate Cardiology
Sex: M	Room#: CPC1	Reading: Freeman, Lawrence MD
Height: 187.96 cm	Location: Greenville Memorial Hospital	Technician: Van, Vu H. BS, RDCS
Weight: 124.74 kg		
Med:		
Rec#: 971366670		

Indication: NQWMI

Study Quality:

HR 74

BP 119/58

Measurements		
Name	Value	Units
IVSD	1.11	(0.3 - 1.1) cm
LVIDd_2D	6.32	cm
LVIDs_2D	5.17	cm
LVPWD	1.2	(0.7 - 1.1) cm
LADIAM	4.3	cm
AODIAM	3.8	cm
AVGRADP	4	(<36) mmHg
AVGRADM	2	(<20) mmHg
AVA_VTI	2.87	cm ²
AVA (Vmax)	2.45	cm ²
MV_VTI	29.7	cm
MVA (Cont)	1.47	cm ²
MVA_PHT	3.79	cm ²
MVGDM	2	mmHg

Findings

Technical Comments

The study quality is fair.

Left Ventricle

The left ventricular chamber size is moderately dilated. Mild concentric left ventricular hypertrophy is observed. Severe global hypokinesis of the left ventricle is observed. The estimated ejection fraction is 30-35%. The left ventricular diastolic filling pattern is restrictive.

Left Atrium

The left atrium is mildly dilated.

Right Atrium

The right atrium appears normal.

Aortic Valve

The aortic valve structure is normal. Mild aortic cusp sclerosis is present. There is no

evidence of aortic stenosis. There is no evidence of aortic regurgitation.
Mitral Valve The mitral valve leaflets appear normal. There is a trace of mitral regurgitation.
Tricuspid Valve The tricuspid valve appears normal in structure and function.
Pulmonic Valve The pulmonic valve is not well visualized.
Pericardium There is no pericardial effusion.
Aorta The aortic root appears normal.
Impression Segmental wall motion abnormalities with decreased systolic performance indicative of CAD. There is left ventricular hypertrophy. Left ventricular diastolic dysfunction is present. The base of LV contracts normally. There is an extensive area of apical akinesis with what is likely a laminar apical thrombus. The remaining walls are mildly hypokinetic.

This report has been electronically signed by:

Lawrence Freeman MD
02/27/2011 15:26:03

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

DATE OF ADMISSION: 02/27/2011

DATE OF DISCHARGE: 03/14/2011

REASON FOR ADMISSION: Angina and coronary artery disease

FINAL DIAGNOSIS:

1. Hypothyroidism.
2. Hypertension.
3. Hyperlipidemia.
4. Type 2 diabetes mellitus.
5. Non-Q-wave myocardial infarction (MI)
6. Postop ventricular fibrillation, arrest, requiring implantable cardioverter-defibrillator (ICD) placement.

PROCEDURES.

1. Left heart catheterization on 02/28/2011.
2. Coronary artery bypass grafting (CABG) x 4 with left internal mammary artery to the diagonal artery (D1), saphenous vein graft to the left anterior descending (LAD), saphenous vein graft to the obtuse marginal (OM) 1, saphenous vein graft to the right coronary artery, left ventricular (LV) aneurysmectomy and left ventricular (LV) thrombectomy on 03/02/2011 by Dr. Barry Davis.
3. Implantable cardioverter-defibrillator (ICD) placement on 03/08/2011 by Dr. Manfredi.

CONSULTING PHYSICIANS:

1. Dr. Manfredi, EP.
2. Dr. Horton, endocrinology.
3. Dr. Treece, pulmonary medicine.

REFERRING PHYSICIAN: Dr. Ross, Upstate Cardiology.

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: Patient is a 54-year-old white male who presented with acute myocardial infarction on 02/27/2011. Patient had a troponin that peaked at 2.6. He did have a non-Q-wave MI. He was taken to the cath lab 48 hours after admission where his cardiac catheterization showed severe, multivessel coronary artery disease with totally occluded LAD that filled by collaterals and totally occluded circumflex system and right system, filled via collaterals as well. EF was estimated at 30% with inferior apical hypokinesis. The echo showed a questionable mural thrombus with ejection fraction of 30%. It was felt that CABG, LV aneurysmorrhaphy were indicated. A MRI was recommended, however due to the patient's claustrophobia, this could not be done. The patient did have an

DISCHARGE SUMMARY

Page 1 of 3

COPY TO: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

echocardiogram, again that demonstrated LV thrombus. As part of the preoperative evaluation for CABG, Dr. Horton from endocrinology, was consulted secondary to uncontrolled hyperglycemia, diabetes mellitus. Dr. Treece from pulmonary medicine was also consulted for preoperative clearance. The patient had a carotid duplex preoperatively, demonstrated bilateral 1:15% stenosis with antegrade vertebral flow. It was felt that the patient had sleep apnea but was cleared from a pulmonary standpoint. He was taken to the OR on 03/02/2011 where he underwent CABG x 4. Left internal mammary artery was used to the diagonal, saphenous vein graft to distal LAD, saphenous vein graft to the OM and saphenous vein graft to right coronary artery. Intraaortic balloon pump was placed at the time of surgery. LV aneurysmorrhaphy with LV thrombectomy was performed by Dr. Barry Davis. At the time of surgery, the patient had a subacute inferior MI with large amount of edematous as well as the inferior wall. Ejection fraction was 25% prior to cardiopulmonary bypass. The patient had a large amount of laminate clot as well as free floating clot in the left ventricle. The patient tolerated procedure and was transferred to the CV ICU. In the CV ICU Dr. Treece, from pulmonary medicine, continued followup for critical care management. The patient was hemodynamically stable with a hematocrit of 24, BUN and creatinine were stable at 15 and 1.3. He remained intubated and sedated on pressure support. Dr. Horton, from endocrinology, continued to follow the patient. He was placed on an insulin drip for hyperglycemia control. On postoperative day 2, the patient's intraaortic balloon pump was removed without difficulty. Upstate Cardiology continued to follow the patient. Again, he was intubated and sedated. He was weaned off all pressor support. Patient was scheduled to be transferred to 4D telemetry bed, however the patient developed V-fib arrest requiring CPR and defibrillation. This time, Dr. Manfredi from EP was consulted. The patient had an ICD placed on 03/08/2011 by Dr. Manfredi. The patient was also continued on IV Amio. Patient was subsequently transferred to 4D telemetry bed. From here, his hospital course has been fairly uneventful. His pacing wires and XL tubes were removed without difficulty. He has been ambulating with the assistance of physical therapy and Heart Life. He was started on Coumadin for his LV aneurysm thrombus. He was weaned off all oxygen. His blood sugars were under good control with the help of endocrinology. He will be discharged to home on 03/14/2011. On the day of discharge, the patient's vital signs included temperature 97.7, heart rate 66 and regular, blood pressure 122/74, 98% on room air. His lab values on the chart include white blood cell count is 12.3, hemoglobin 10.3, hematocrit 30.8, platelets are 333, potassium is 4, BUN is 12, creatinine 1.1.

MEDICATIONS ON DISCHARGE:

1. Enteric coated aspirin 81 mg 1 p.o. daily.
2. Coreg 3.125 mg 1 p.o. twice daily.
3. Quinapril 5 mg 1 p.o. daily.
4. Pravachol 80 mg 1 p.o. daily.
5. Ultracet 1 to 2 p.o. q. 4 to 6 hours p.r.n. for pain.
6. Coumadin 4 mg 1 p.o. daily.

DISCHARGE SUMMARY

Page 2 of 3

COPY TO: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP

PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

7. Levothyroxine 250 mcg 1 p.o. daily.
8. Prilosec OTC as taken at home.
9. Spiriva HandiHaler 1 inhalation daily.
10. Amiodarone taper 200 mg 1 p.o. b.i.d. x 1 week then decrease to 1 p.o. daily.
11. Novolin N 30 units subcutaneously q a.m. and q p.m.
12. NovoLog sliding scale as directed by Dr. Horton.

The patient's level of activity is restricted to no heavy lifting, no pushing or pulling with arms for 8 to 10 weeks, no driving for 4 weeks. He is instructed to wash all incisions daily with warm soapy water and keep clean and dry. He is encouraged to abstain from smoking and to attend cardiac rehab. If he has problems or questions prior to seeing Dr. Davis in 2 weeks, he is instructed to call 455-6800. The patient also has follow up appointment with Dr. Ross in 1 month and with Upstate Coumadin Clinic on 03/17/2011 at 10:30 a.m. for PT INR check. Again, the patient is on 4 mg tablets. His INR range needs to be between 2 and 3. He is on it for LV aneurysm repair with LV thrombus at the time of surgery and ventricular arrhythmias postoperatively. The patient, again, is encouraged to abstain from smoking, to attend cardiac rehab.

DICTATED BY: Sarah K. Miller, PA-C.

On Hold

Barry R. Davis, MD

cc: Barry R. Davis, MD
Charles D. Ross, MD

D: 03/14/2011 02:49 P T 03/14/2011 04:04 P zhj DVI 287163 C/S#: 3308480

DISCHARGE SUMMARY

Page 3 of 3

COPY TO: Charles D. Ross, MD

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/12/2011

CHIEF COMPLAINT: Michael Worthen is a 54 year old patient seen today following coronary artery bypass grafting, AICD implantation, had IM and CABG with subsequent ICD placement.

HISTORY:

414.01-ASCAD - OF THE NATIVE VESSEL

V45.81-STATUS POST CABG LIMA to Diag, SV to LAD, SV to OM, SV to RCA with aneurysectomy and thrombectomy done 2/28/2011

V45.02-1X OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR Dual chamber St jude ICD 3/8/2011

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE EF 30%

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

MEDICATION INFORMATION SOURCE: Medication information source comes from the hospital discharge summary. Pt did not bring Rx bottles or med. list today Nurse's initials:mp

CURRENT MEDICATION LIST:

ASPIRIN LOW DOSE ORAL TABLET 81 MG, 1 Every Day

COREG ORAL TABLET 3.125 MG, 1 Two Times A Day

QUINAPRIL HCL ORAL TABLET 5 MG, 1 Every Day

PRAVACHOL ORAL TABLET 80 MG, 1 Every Day

COUMADIN ORAL TABLET 4 MG, AS DIRECTED

SYNTHROID 2MG, 250mcg 1qd

PRILOSEC OTC ORAL TABLET ENTERIC COATED 20 MG, 1 Every Day

NOVOLIN, bid

NOVOLOG 2, sl scale

SPIRIVA, qd

AMIODARONE HCL ORAL TABLET 200 MG, 1 Every Day

FAMILY HISTORY:

FAMILY HISTORY OF CAD: There is a family history of coronary artery disease.

SOCIAL HISTORY:

1799

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/12/2011

TOBACCO: Does not give any significant history of tobacco usage.

ALCOHOL: Does not give any significant history of alcohol usage.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies history of fever, unexplained weight loss or new fatigue.

EYES: No history of blurred vision or glaucoma.

EARS/NOSE/MOUTH/ THROAT: No history of hearing changes or epistaxis.

RESPIRATORY: No cough, hemoptysis or wheezing.

CARDIAC: See HPI.

GI: No history of pain, melena, hematochezia or ulcers.

GU: No history of renal failure, stones or recent infections.

MUSCULOSKELETAL: No history of inflammation, claudication or edema.

NEUROLOGICAL: No history of stroke or TIA.

SKIN: No history of rash or non-healing wounds.

PSYCHIATRIC: No history of depression.

ENDOCRINE: No history of diabetes or thyroid disease.

HEMATOLOGIC: No history of bleeding diathesis, clotting disorder or prior DVT/Pulmonary embolus.

PHYSICAL EXAM:

VITAL SIGNS:

VS-PULSE: 76 Right Radial, Regular

VS-BLOOD PRESSURE: 124/80 Left Arm Sitting

VS-HEIGHT: 6ft2in

VS-WEIGHT: 265lbs

CONSTITUTIONAL:

GENERAL APPEARANCE: Well developed, well nourished individual in no acute distress.

EYES: Sclera clear and pupils are round and equal.

EARS/NOSE/MOUTH/THROAT: Hearing grossly normal.

NECK: Supple. No JVD. No Carotid Bruits.

CARDIOVASCULAR:

Heart rate and rhythm are regular. Normal S1, S2, no murmur.

CHEST: Equal bilateral expansion. The lungs are clear to anterior and posterior auscultation.

ABDOMEN: Soft, non-tender, without pulsatile masses, no organomegaly or bruit noted. Bowel sounds are active.

1799

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/12/2011

EXTREMITIES No varicosities of the extremities or edema. pulses are full and symmetrical.
MUSCULOSKELETAL EXAM:

EXAM: No peripheral clubbing, cyanosis or edema is present.

SKIN: Skin is warm and dry.

NEUROLOGICAL: No motor weakness noted. Gait normal.

MENTAL STATUS: Normal mood and affect.

ASSESSMENT/PLAN:

414.01-ASCAD - OF THE NATIVE VESSEL

ASSESSMENT: No angina present.

MEDICATIONS: Continue medications as prescribed.

V45.81-STATUS POST CABG

ASSESSMENT: Status Post CABG.

MEDICATIONS: Continue medications as prescribed.

V45.02-11X OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR

MEDICATIONS: Continue medications as prescribed.

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE

MEDICATIONS: Continue medications as prescribed.

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

MEDICATIONS: Continue medications as prescribed.

RETURN VISIT: Patient instructed to return in 2 months. after echo.

FAX TO REFERRING DOCTOR: Phone: ima

Electronically Signed by: Jon M. Bitnick, MD on Tuesday, April 12, 2011 9:24 am

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth:

Date of Service: 04/14/2011

Nurses Notes: Mr. Worthen needs DR Bittrick to send a letter to Colonial Life for his short term disability explaining that he has been under our care since 2/27/2011; he is still under our care, we are re-evaluating him 5/16/2011 and we are projecting that he will be able to return to work approximately the end of June. The letter needs to be FAXed to Colonial Life 800-880-9325 - claim # 040486863000I0 987539825. Reference Laurens County E98695040000.

DR Bittrick evaluated Mr. Worthen 4/12/2011, he is scheduled for echocardiogram 5/11/2011, f/u OV 5/16/2011. We sent disability form to Mr. Worthen 3/29/2011. He underwent CABG and subsequent ICD implant in February./smb

Will d/w DR Bittrick for further instruction./smb

PHYSICIANS RESPONSE: OK to write letter, end of June is reasonable return time, possibly later, last echo showed EF still only 30%.

Letter written, forwarded to DR Bittrick for review and signature./smb

4/19/2011 Letter FAXed to Colonial Life. DR Bittrick signed letter 4/14/2011 and it has been scanned into chart. It is not clear if copy already sent to Colonial Life so re-FAXed today./smb

Electronically Signed by: Scott Boileau, LPN on Tuesday, April 19, 2011 10:13 am

1799

UPSTATE CARDIOLOGY

William P. Algary, M.D., F.A.C.C.,
Retired

Charles D. Ross, M.D., F.A.C.C.

Morris E. Williams, Jr., M.D., F.A.C.C.

Lawrence W. Freeman, M.D., F.A.C.C.

Michael W. Payne, M.D., F.A.C.C.

Gregory W. San, M.D., F.A.C.C.

Brad M. Simpson, M.D., F.A.C.C.

Ned D. Freeman, M.D., F.A.C.C.

John E. Cebe, M.D., F.A.C.C.

Steven D. Johnson, M.D., F.A.C.C.

Jon M. Bittrick, M.D., F.A.C.C.

Barbara A. Morán-Faile, M.D., F.A.C.C.

A. Thomas Siachos, M.D., F.A.C.C.

Christopher H. Smith, M.D., F.A.C.C.

Mark A. Grabarczyk, M.D., F.A.C.C.

Matthew G. Nessmith, M.D., F.A.C.C.

Craig J. McCotter, M.D., F.A.C.C.

Forrest A. Stewart, D.O.

Kathryn M. McFadden, PA-C

Amy M. York, PA-C

Michael D. Cade, RN, MSN, FNP-C

Gail Kirby, FNP-C

Vishali Chand, MS, PA-C

Lara Hoshko, MS, PA-C

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Ronald E. Eskew, Administrator

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114-A Hospital Drive

Simpsonville, SC 29681

(864) 235-7665 • Fax (864) 233-5971

702 North A Street

Easley, SC 29640

(864) 859-9855 • Fax (864) 859-9807

www.upstatecardiology.com

Thursday, April 14, 2011

Colonial Life

Claim #: 0404868630010 987539825

Michael Worthen, DOB: 9/8/1956

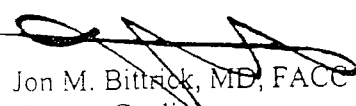
REF: Laurens County E98695040000

FAX: 800-880-9325

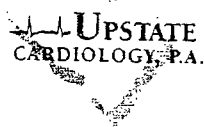
To Whom It May Concern:

I am writing to update you regarding my patient, Mr. Worthen. He has been under my care since February 27, 2011 when he suffered a myocardial infarction and underwent coronary artery bypass surgery and subsequent implantation of an AICD. I saw him in my office April 12, 2011. At that point his ejection fraction was still only 30%. We scheduled a repeat echocardiogram May 11, 2011 and I will see him again to re-assess his condition May 16, 2011. He is motivated to return to work, but given his current ejection fraction he may not be able to return until the end of June. We will assess his progress when he follow up in May; at that point we will be able to provide a more accurate projection for his return to work.

Sincerely,


Jon M. Bittrick, MD, FACC
Upstate Cardiology

FAXed
4/14/11
053154



VidiStar

Echocardiogram Report

Patient name: **WORTHEN, MICHAEL**

DOB: 09/08/1956	Chart#: 103961	Referred by: DR. GERIAO
Age: 54Y	Inpt/Outpt:	Bittrick
Sex: M	Equipment: iE33A	Sonographer: LW
Weight: 265 lbs	B/P: /	Interpreting physician: Ned D. Freeman, M.D., F.A.C.C.
Height: 74 in	HR:	Location:
BSA: 2.51 m2	Rhythm:	Examination date: 05/11/2011

Indications/History: s/p CABG, MI. Congestive heart failure.

Study quality: Fair

Comments:

Diagnosis/CPT Transthoracic echocardiogram report with Definity contrast (000411), Saline (J7050).

Echo dimensions

	M-Mode	2D	Range
Aorta	3.6 cm		(2.0-3.7)
LA	5 cm	4.5 cm	(1.9-4.0)
IVS (D)	1.24 cm	1.19 cm	(0.6-1.1)
LVPW (D)	1.29 cm	1.27 cm	(0.6-1.1)
LV (D)	5.4 cm	4.71 cm	(3.5-5.6)
LV (S)	3.38 cm	3.22 cm	(2.1-4.0)
LA Vol			<29

	M-Mode	2D	Range
Asc Ao			<39
RV (D)		2.61 cm	(2.2-4.4)
LVOT		2.5 cm	(1.8-2.2)
AV opening	2.1 cm		(1.5-2.6)
EF	66.8		(50-90)
Fractional Shortening		31.6	(25-46)
RVSP (Doppler)		31 mmHg	(15-30)

Findings

Left Ventricle	LV chamber size is normal. LV Wall Thickness is mildly increased. LV systolic function is mildly reduced. There is a segmental wall motion abnormality. The estimated LV ejection fraction is 45-50% (abnormal). There is a pseudonormal pattern of diastolic dysfunction. Diastolic filling demonstrates a pseudonormal pattern. Elevated mean left atrial pressure (LAP). There is anteroseptal hypokinesis.
Right Ventricle	RV size is normal.
Left Atrium	LA chamber is mildly dilated.
Right Atrium	RA chamber size is normal.
Aortic Valve	There is aortic valve sclerosis. There is no aortic stenosis.
Mitral Valve	There is mitral valve prolapse, posterior leaflet. There is mild central mitral regurgitation.
Tricuspid Valve	Tricuspid valve is structurally normal. There is mild tricuspid regurgitation. Estimated RVSP is 31 mmHg.
Pulmonary Valve	The pulmonic valve structurally is normal.
Pericardium	There is no pericardial effusion present.
Aorta	Aortic root dimensions are normal.
Thrombus/Mass	There is no intracardiac mass or thrombus identified.

Impressions

LVEF: 45-50%. Mild LV systolic dysfunction. Segmental wall motion abnormality indicating coronary artery disease. Pseudonormal pattern of LV diastolic dysfunction. Dilated left atrium. Aortic valve sclerosis. Mild mitral regurgitation. Mitral valve prolapse. Mild tricuspid regurgitation.

Electronically signed by: Ned D. Freeman, M.D., F.A.C.C.
05/11/2011 7:00 PM

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 05/16/2011

CHIEF COMPLAINT: Michael Worthen is a 54 year old patient seen today for a follow-up of current cardiac condition. pt doing well. no significant complaints. EF now 45-50%

HISTORY:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

414.01-ASCAD - OF THE NATIVE VESSEL

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE EF 30%. EF now 45-50%

V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR Dual chamber St jude ICD
3/8/2011

V45.81-STATUS POST CABG LIMA to Diag, SV to LAD, SV to OM, SV to RCA with aneurysectomy
and thrombectomy done 2/28/2011

CURRENT ALLERGY LIST:

LANTUS INSULIN

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory.
Nurse's initials:ag

CURRENT MEDICATION LIST:

ASPIRIN LOW DOSE ORAL TABLET 81 MG, 1 Every Day

COREG ORAL TABLET 3.125 MG, 1 Two Times A Day

QUINAPRIL HCL ORAL TABLET 5 MG, 1 Every Day

PRAVACHOL ORAL TABLET 80 MG, 1 Every Day

COUMADIN ORAL TABLET 4 MG, AS DIRECTED

PRILOSEC OTC ORAL TABLET ENTERIC COATED 20 MG, 1 Every Day

NOVOLIN, bid

NOVOLOG ?, sl scale

SPIRIVA, qd

AMIODARONE HCL ORAL TABLET 200 MG, 1 Every Day

SYNTHROID ORAL TABLET 200 MCG, 250mcg qd

FAMILY HISTORY:

1799

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 05/16/2011

FAMILY HISTORY OF CAD: There is a family history of coronary artery disease.

SOCIAL HISTORY:

TOBACCO: Does not give any significant history of tobacco usage.

ALCOHOL: Does not give any significant history of alcohol usage.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies history of fever, unexplained weight loss or new fatigue.

EYES: No history of blurred vision or glaucoma.

EARS/NOSE/MOUTH/THROAT: No history of hearing changes or epistaxis.

RESPIRATORY: No cough, hemoptysis or wheezing.

CARDIAC: See HPI.

GI: No history of pain, melena, hematochezia or ulcers.

GU: No history of renal failure, stones or recent infections.

MUSCULOSKELETAL: No history of inflammation, claudication or edema.

NEUROLOGICAL: No history of stroke or TIA.

SKIN: No history of rash or non-healing wounds.

PSYCHIATRIC: No history of depression.

ENDOCRINE: No history of diabetes or thyroid disease.

HEMATOLOGIC: No history of bleeding diathesis, clotting disorder or prior DVT/Pulmonary embolus.

PHYSICAL EXAM:

VITAL SIGNS:

VS-PULSE: 72 Right Radial, Regular

VS-BLOOD PRESSURE: 122/76 Left Arm Sitting

VS-HEIGHT: 6ft2in

VS-WEIGHT: 265lbs

ASSESSMENT/PLAN:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

ASSESSMENT: The patient's hyperlipidemia is stable.

MEDICATIONS: Continue medications as prescribed.

414.01-ASCAD - OF THE NATIVE VESSEL

ASSESSMENT: No angina present.

1799

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 05/16/2011

MEDICATIONS: Continue medications as prescribed.
428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE
ASSESSMENT: The chronic systolic heart failure remains satisfactory.
MEDICATIONS: Continue medications as prescribed.
V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR
MEDICATIONS: Continue medications as prescribed.
V45.81-STATUS POST CABG
MEDICATIONS: Continue medications as prescribed.

RETURN VISIT: Patient instructed to return in 3 months.

FAX TO REFERRING DOCTOR: DAVID GUIRAO MD Phone: 242-4683

Electronically Signed by: Jon M. Bittrick, MD on Monday, May 16, 2011 2:15 pm

**UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 05/19/2011

Nurses Notes: Received follow up form for Mr. Worthen's short term disability. Completed as much of form as possible 5/19/11. FAXed to Easley office for DR Bittrick to review and sign (he will be out of town all next week)/snib

Completed form FAXed back to our office, Mr. Worthen picked up forms today 5/20/11./smb

Electronically Signed by: Scott Boileau, LPN on Friday, May 20, 2011 4:53 pm

UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN
Date of Birth: 09/08/1956

Date of Service: 06/29/2011

CHIEF COMPLAINT: Michael Worthen is a 54 year old patient seen today for a follow-up of current cardiac condition. pt doing ok. pt had initial injury while working lifting a 400 pound pt. pt now able to go back to work

HISTORY:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

414.01-ASCAD - OF THE NATIVE VESSEL

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE EF 30%. EF now 45-50%

V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR Dual chamber St jude ICD

3/8/2011

V45.81-STATUS POST CABG LIMA to Diag, SV to LAD, SV to OM, SV to RCA with aneurysectomy and thrombectomy done 2/28/2011

CURRENT ALLERGY LIST:
LANTUS INSULIN

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory,
Nurse's initials:jd

CURRENT MEDICATION LIST:

ASPIRIN LOW DOSE ORAL TABLET 81 MG, 1 Every Day

COREG ORAL TABLET 3.125 MG, 1 Two Times A Day

QUINAPRIL HCL ORAL TABLET 5 MG, 1 Every Day

PRAVACHOL ORAL TABLET 80 MG, 1 Every Day

COUMADIN ORAL TABLET 4 MG, AS DIRECTED

PRILOSEC OTC ORAL TABLET ENTERIC COATED 20 MG, 1 Every Day

SPIRIVA, qd

AMIODARONE HCL ORAL TABLET 200 MG, 1 Every Day

SYNTHROID ORAL TABLET 200 MCG, 250mcg qd

NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML, twice daily as directed

NOVOLOG SUBCUTANEOUS SOLUTION 100 UNIT/ML, sliding scale

SOCIAL HISTORY:

1799

UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 06/29/2011

TOBACCO: Does not give any significant history of tobacco usage.
ALCOHOL: Does not give any significant history of alcohol usage.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies history of fever, unexplained weight loss or new fatigue.
EYES: No history of blurred vision or glaucoma.
EARS/NOSE/MOUTH/ THROAT: No history of hearing changes or epistaxis.
RESPIRATORY: No cough, hemoptysis or wheezing.
CARDIAC: See HPI.
GI: No history of pain, melena, hematochezia or ulcers.
GU: No history of renal failure, stones or recent infections.
MUSCULOSKELETAL: No history of inflammation, claudication or edema.
NEUROLOGICAL: No history of stroke or TIA.
SKIN: No history of rash or non-healing wounds.
PSYCHIATRIC: No history of depression.
ENDOCRINE: No history of diabetes or thyroid disease.
HEMATOLOGIC: No history of bleeding diathesis, clotting disorder or prior DVT/Pulmonary embolus.

PHYSICAL EXAM:

VITAL SIGNS:

VS-PULSE: 66 Right Radial, Regular
VS-BLOOD PRESSURE: 120/76 Left Arm Sitting
VS-HEIGHT: 6ft2in
VS-WEIGHT: 270lbs
BMI: 34.66

CONSTITUTIONAL:

GENERAL APPEARANCE: Well developed, well nourished individual in no acute distress.
EYES: Sclera clear and pupils are round and equal.
EARS/NOSE/MOUTH/THROAT: Hearing grossly normal.
NECK: Supple. No JVD. No Carotid Bruits.
CARDIOVASCULAR:
Heart rate and rhythm are regular. Normal S1, S2, no murmur.
CHEST: Equal bilateral expansion. The lungs are clear to anterior and posterior auscultation.
ABDOMEN: Soft, non-tender, without pulsatile masses, no organomegaly or bruit noted. Bowel sounds

1799

UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN
Date of Birth: 09/08/1956

Date of Service: 06/29/2011

are active.

EXTREMITIES No varicosities of the extremities or edema, pulses are full and symmetrical.

MUSCULOSKELETAL EXAM:

EXAM: No peripheral clubbing, cyanosis or edema is present.

SKIN: Skin is warm and dry.

NEUROLOGICAL: No motor weakness noted. Gait normal.

MENTAL STATUS: Normal mood and affect.

ASSESSMENT/PLAN:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

ASSESSMENT: The patient's hyperlipidemia is stable.

MEDICATIONS: Continue medications as prescribed.

414.01-ASCAD - OF THE NATIVE VESSEL

ASSESSMENT: No angina present.

MEDICATIONS: Continue medications as prescribed.

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE

ASSESSMENT: The chronic systolic heart failure remains satisfactory.

MEDICATIONS: Continue medications as prescribed.

V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR

MEDICATIONS: Continue medications as prescribed. due for ICD check in July

V45.81-STATUS POST CABG

MEDICATIONS: Continue medications as prescribed.

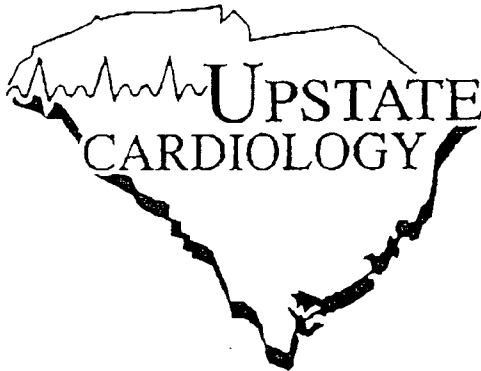
RETURN VISIT: Patient instructed to return in 6 months.

FAX TO REFERRING DOCTOR: DAVID GUIRAO MD Phone: 242-4683

Electronically Signed by: Jon M. Bittrick, MD on Wednesday, June 29, 2011 1:18 pm

1799

Charles D. Ross, M.D., F.A.C.C.
 Morris E. Williams, M.D., F.A.C.C.
 Lawrence W. Freeman, M.D., F.A.C.C.
 Michael W. Payne, M.D., F.A.C.C.
 Gregory W. Sio, M.D., F.A.C.C.
 Fred M. Simpson, M.D., F.A.C.C.
 Ned D. Freeman, M.D., F.A.C.C.
 John E. Cobe, M.D., F.A.C.C.
 Steven D. Johnson, M.D., F.A.C.C.
 Jon M. Butrick, M.D., F.A.C.C.
 Barbara A. Moran-Taille, M.D., F.A.C.C.
 A. Thomas Naches, M.D., F.A.C.C.
 Christopher H. Smith, M.D., F.A.C.C.



www.upstatecardiology.com

Mark A. Grabarczyk, M.D., F.A.C.C.
 Matthew G. Nossuth, M.D., F.A.C.C.
 Craig J. McConter, M.D., F.A.C.C.
 Edward A. Stewart, D.O.
 Kathryn M. McFadden, PA-C
 Amy M. York, PA-C
 Michael D. Cade, RN, MSN, FNP-C
 Gail Kirby, FNP-C
 Vishali Chand, PA-C
 Lara Hoshko, FNP-C
 Caroline Klossam, RN, Director of Research
 Ronald E. Eskew, Administrator

1 Intermountain Drive, Suite 400 - Greenville, SC 29607
 Phone 864-235-7665 - Fax 864-282-2090

114-A Hospital Drive - Simpsonville, SC 29681
 Phone 864-235-7665 - Fax 864-282-2090

702 North A Street -asley, SC 29640
 Phone 864-859-9855 - Fax 864-859-9807

REMOTE IN OFFICE ICD FOLLOW UP

Name: Michael Wirthner Chart: 103961 Date: 7/18/11
 M.D.: Butrick / McConter Model: Stg Fortify MR Implant Date: 3/8/11
 Lead Implant/Date & Type: A Stg 2088 TC/52 RV Stg 7120 Q/58 LV
 Configuration: 1 Zone 166-APX1, 36, 40 2 Zone 3 Zone
 Mode: DDI LRL/URL: 60 PAV/SAV: 250
 A 2.5 v @ .9 ms RV 2.5 v @ .5 ms LV v @ ms
 Intrinsic Rhythm: Sinus bradycardia Pacer Dependent: NO ☒ YES ☐
 Battery Status: Voltage: 93% volts Charge Date/Time: 8.4 seconds
 Defib/Shock Impedance: 39 ERI Voltage: 6.5 - 7.9 Jts.
 A Imped 460 ohms RV Imped 360 ohms LV Imped ohms
 P Waves 35 mV R Waves >12.0 mV R waves mV
 A-Thresh .5 v @ .9 ms RV Thresh .75 v @ .5 ms LV Thresh v @ ms
 Site Check:

AP% 50 VP% 23

Events: Sustained ☒ Non-Sustained ☒ Mode Switch/ATR ☒

none

Changes/Comments: no change made

pt has no complaints

in office - 3 mo. + xpt card given

Physician Signature

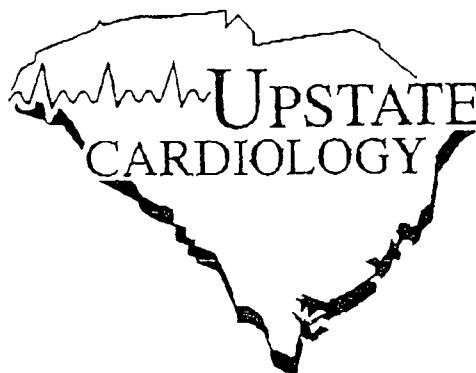
Jon M Butrick, MD

Tech Signature

Craig J 260 ter, MD

000103

Charles D. Ross, M.D., F.A.C.C.
 Morris E. Williams, M.D., F.A.C.C.
 Lawrence W. Freeman, M.D., F.A.C.C.
 Michael W. Payne, M.D., F.A.C.C.
 Gregory W. San, M.D., F.A.C.C.
 Brad M. Simpson, M.D., F.A.C.C.
 Ned D. Freeman, M.D., F.A.C.C.
 John E. Cebal, M.D., F.A.C.C.
 Steven D. Johnson, M.D., F.A.C.C.
 Jon M. Bittrick, M.D., F.A.C.C.
 Barbara A. Moran-Faile, M.D., F.A.C.C.
 A. Thomas Siachos, M.D., F.A.C.C.
 Christopher H. Smith, M.D., F.A.C.C.



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 Matthew G. Nezmith, M.D., F.A.C.C.
 Craig J. McCotter, M.D., F.A.C.C.
 Edward A. Stewart, D.O.
 Richard N. Vest III, M.D.
 Kathryn M. McFadden, PA-C
 Amy M. York, PA-C
 Michael D. Cade, RN, MSN, FNP-C
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REMOTE IN OFFICE ICD FOLLOW UP

Name: Michael Worthen Chart: 103961 Date: 10.17.2011
 M.D.: Bittrick / McCotter Model: Sim Fortify DR 2231-400 Implant Date: 03.08.2011
 Lead Implant/Date & Type: A 2088tc/52 RV 7120Q/58 LV
 Configuration: 1 Zone VF 116 bpm 2 Zone 3 Zone
 Mode: DDI LRL/URL: 160/120 PAV/SAV: 250
 A 2.50 v @ 0.90 ms RV 2.50 v @ 0.50 ms LV v @ ms
 Intrinsic Rhythm: SB@50bpm Pacer Dependent: NO ☒ YES ☐
 Battery Status: Voltage: 91% volts Charge Date/Time: 07.08.2011/8.4 seconds
 Defib/Shock Impedance: 40 ERI Voltage: ~6.4-6.7 yrs
 A Imped 480 ohms RV Imped 360 ohms LV Imped ohms
 P Waves 5.0 mV R Waves >12.0 mV R waves mV
 A-Thresh 0.50 v @ 0.90 ms RV Thresh 1.0 v @ 0.50 ms LV Thresh v @ ms
 Site Check:

AP% 80% VP% 50% PVCs: <1% 4.4K
 Events: Sustained 0 Non-Sustained 0 Mode Switch/ATR 0
0 Events

Changes / Comments: 0 A's made. 0 pt complaints related to device
Normal device function. Pt came in complaining of "buzzing" noise from "his
Clinic in 3 mos — 0 Remotes. device" 100 times/day for
one day. No episodes/therapy
problems indicated at
device interrogation.

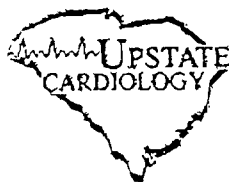
Physician Signature Jon M. Bittrick, MD

Tech Signature Craig J. McCotter, MD

Craig J. McCotter, MD
 261

000164

Charles D. Ross, M.D., F.A.C.C.
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 Michael W. Payne, M.D., F.A.C.C.
 Gregory W. San, M.D., F.A.C.C.
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 Phone 864-859-9855 Fax 864-859-9807

REMOTE IN OFFICE ICD FOLLOWUP

Name: Worthen, Michael Chart: 103961 Date: 01.17.2012
 M.D. Bittrick/McCotter Model: SJM-Fortify DR CD2231-40Q Implant Date: 03.08.2011
 Lead Type: A: 2088TC-52 RV: 7120Q-58 LV: n/a
 Lead Date: A: 03.08.2011 RV: 03.08.2011 LV: n/a
 Configuration: 1 Zone: VF 166bpm 2 Zone: n/a 3 Zone: n/a
 Mode: DDI LRL/URL: 60 PAV/SAV: 250
 A: 2.5 V @ 0.9 ms RV: 2.5 V @ 0.5 ms LV: n/a V @ n/a ms n/a
 Intrinsic Rhythm: SB 57 Pacer Dependent: NO ☒ YES ☐
 Battery Status: Voltage: 88% Charge Date/Time: 11.07.2011/8.6 seconds
 Defib/Shock Impedance: 39 ohms ERI Voltage: ~6.2-6.4yrs remaining
 A Imped: 460 ohms RV Imped: 360 ohms LV Imped: n/a ohms
 P waves: >5.0 mV R Waves: >12.0 mV R waves: n/a mV
 A-Thresh: 0.5 V @ 0.5 ms RV Thresh: 1.0 V @ 0.5 ms LV Thresh: n/a V @ n/a ms

SITE CHECK:

AP%: 78 VP%: 57

EVENTS: Sustained: 0 Nonsustained: 0 Mode Switch/ATR: 0

CHANGES/COMMENTS: Normal ICD fx. Pt on Coumadin. Pt c/o DOE & SOB ==> changed to DDIR.
 Increased PAV to 300ms to decrease Vp. MSR at 115bpm due to programmer conflict. Decreased A/RV
 output to 2.0V/0.5ms to increase battery longevity. In office 3mos/noR/30 also.

Physician Signature: _____

Jon M. Bittrick, MD

Tech Signature: _____

Craig J. McCotter, MD

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000165

UPSTATE CARDIOLOGY, PA
UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/26/2012

CHIEF COMPLAINT: Michael Worthen is a 55 year old patient seen today for a follow-up. 10 months and med refills. doing well. no chest pain or SOB. follow up of cad, htn

HISTORY:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA The patient's hyperlipidemia is stable. The medication is well tolerated.

414.01-ASCAD - OF THE NATIVE VESSEL The angina has not changed with no episodes of chest pain since the last visit. No complications noted from the medication presently being used.

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE No complications noted from the medication presently being used. EF 30%. EF now 45-50%

V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR Dual chamber St jude ICD
3/8/2011

V45.81-STATUS POST CABG LIMA to Diag, SV to LAD, SV to OM, SV to RCA with aneurysectomy and thrombectomy done 2/28/2011

CURRENT ALLERGY LIST:

LANTUS INSULIN

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory, Nurse's initials:wc

CURRENT MEDICATION LIST:

ASPIRIN LOW DOSE ORAL TABLET 81 MG, 1 Every Day

QUINAPRIL HCL ORAL TABLET 5 MG, 1 Every Day

PRIOSEC OTC ORAL TABLET ENTERIC COATED 20 MG, 1 Every Day

AMIODARONE HCL ORAL TABLET 200 MG, 1 Every Day

SYNTHROID ORAL TABLET 200 MCG, 250mcg qd

NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML, twice daily as directed

NOVOLOG SUBCUTANEOUS SOLUTION 100 UNIT/ML, sliding scale

PRAVASTATIN SODIUM ORAL TABLET 80 MG, 1 Every Day

COUMADIN ORAL TABLET 4 MG, Take 1-1 1/2 tablets daily or as directed

1799

UPSTATE CARDIOLOGY, PA
UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/26/2012

CARVEDILOL ORAL TABLET 3.125 MG, 1 Two Times A Day

SPIRIVA, qd prn

E-PRESCRIBED: One prescription or more was created during the patients encounter using e-Prescribe (G8553)

SOCIAL HISTORY:

TOBACCO: Does not give any significant history of tobacco usage.

ALCOHOL: Does not give any significant history of alcohol usage.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies history of fever, unexplained weight loss or new fatigue.

EYES: No history of blurred vision or glaucoma.

EARS/NOSE/MOUTH/ THROAT: No history of hearing changes or epistaxis.

RESPIRATORY: No cough, hemoptysis or wheezing.

CARDIAC: See HPI.

GI: No history of pain, melena, hematochezia or ulcers.

GU: No history of renal failure, stones or recent infections.

MUSCULOSKELETAL: No history of inflammation, claudication or edema.

NEUROLOGICAL: No history of stroke or TIA.

SKIN: No history of rash or non-healing wounds.

PSYCHIATRIC: No history of depression.

ENDOCRINE: No history of diabetes or thyroid disease.

HEMATOLOGIC: No history of bleeding diathesis, clotting disorder or prior DVT/Pulmonary embolus.

PHYSICAL EXAM:

VITAL SIGNS:

VS-PULSE: 58 Right Radial, Regular

VS-BLOOD PRESSURE: 130/70 Left Arm Sitting

VS-HEIGHT: 6ft2in

VS-WEIGHT: 284lbs8oz

BMI: 36.52

CONSTITUTIONAL:

GENERAL APPEARANCE: Well developed, well nourished individual in no acute distress.

1799

UPSTATE CARDIOLOGY, PA
UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN
Date of Birth: 09/08/1956

Date of Service: 04/26/2012

EYES: Sclera clear and pupils are round and equal.

EARS/NOSE/MOUTH/THROAT: Hearing grossly normal.

NECK: Supple. No JVD. No Carotid Bruits.

CARDIOVASCULAR:

Heart rate and rhythm are regular. Normal S1, S2, no murmur.

CHEST: Equal bilateral expansion. The lungs are clear to anterior and posterior auscultation.

ABDOMEN: Soft, non-tender, without pulsatile masses, no organomegaly or bruit noted. Bowel sounds are active.

EXTREMITIES No varicosities of the extremities or edema, pulses are full and symmetrical.

MUSCULOSKELETAL EXAM:

EXAM: No peripheral clubbing, cyanosis or edema is present.

SKIN: Skin is warm and dry.

NEUROLOGICAL: No motor weakness noted. Gait normal.

MENTAL STATUS: Normal mood and affect.

ASSESSMENT/PLAN:

272.4-DYSLIPIDEMIA/HYPERLIPIDEMIA

ASSESSMENT: The patient's hyperlipidemia is stable.

MEDICATIONS: Continue medications as prescribed.

414.01-ASCAD - OF THE NATIVE VESSEL

ASSESSMENT: No angina present.

MEDICATIONS: Continue medications as prescribed.

428.22-CHF - CHRONIC SYSTOLIC HEART FAILURE

ASSESSMENT: The chronic systolic heart failure remains satisfactory. The chronic systolic heart failure is New York Class II.

MEDICATIONS: Continue medications as prescribed.

V45.02-HX OF AICD-IMPLANTED CARDIAC DEFIBRILLATOR

ASSESSMENT:

MEDICATIONS: Continue medications as prescribed.

V45.81-STATUS POST CABG

MEDICATIONS: Continue medications as prescribed.

RETURN VISIT: Patient instructed to return in 3 months, to 6 months.

1799

**UPSTATE CARDIOLOGY, PA
UPSTATE CARDIOLOGY, PA
2 INNOVATION DR.
SUITE 400
GREENVILLE, SC 29607
864-235-7665**

PatientID: 103961MW

Patient Name: MICHAEL P WORTHEN

Date of Birth: 09/08/1956

Date of Service: 04/26/2012

FAX TO REFERRING DOCTOR: DAVID GUIRAO MD Phone: 242-4683

Electronically Signed by: Jon M. Bittrick, MD on Thursday, April 26, 2012 3:27 pm

Appellant's APA Submission #4

JUL/18/2012/WED 03:26 PM

FAX No. 864 312 4447

P. 002

RE: Michael Worthen
DOB: 09/08/56
DOA: 02/26/11

1. In your medical opinion, do you believe Mr. Worthen's myocardial infarction was caused or is an aggravation of his 02/26/11 work related injury?

☒ Yes☐ No

Please explain the reason for your opinion:

MI occurred while moving 500 pound patient. Due to strain of dealing with a patient this size

2. In your medical opinion, do you believe Mr. Worthen has reached maximum medical improvement from his 02/26/11 work related injury?

☒ Yes☐ No

3. In your medical opinion, do you believe Mr. Worthen has any permanent work restrictions due to his 02/26/11 work injury?

☒ Yes☐ No

Please explain the work restrictions:

Bending/Squatting _____

Standing _____

Lifting _____

Reaching _____

Pushing/Pulling _____

Other Suggest formal testing but he will not
have the stamina to perform strenuous
tasks.

JUL/18/2012/WED 03:26 PM

FAX No 864 312 4447

P.003

4. In your medical opinion, do you believe Mr. Worthen will need any future medical treatment from his 02/26/11 work related injury?

☒ Yes☐ No

Please describe the future medical treatment he will require.

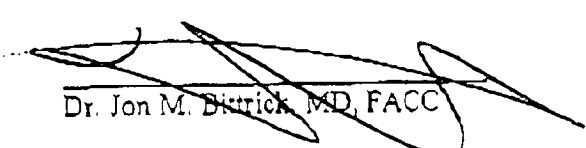
Q 6 months visits with me

Q 3 months ICD checks

Is now on several heart failure and rhythm management meds.

5. Do you hold all of these opinions to a reasonable degree of medical certainty?

☒ Yes☐ No


Dr. Jon M. Districk, MD, FACC

2-27-11

Date

Respondents' APA Submission #7



Spartanburg Regional

PHYSICIAN GROUP

at PELHAM

August 8, 2011

Mr. Richard B. Kale, Jr.
Willson Jones Carter & Baxley, P.A.
Attorneys at Law
872 S. Pleasantburg Drive
Greenville, SC 29607

RE: Michael Worthen vs. Laurens County
WCC File No.: 11036404 DOI: 2/27/2011
Claim No.: 58-232221
WJC&B File No.: 0560.00425

Dear Mr. Kale:

I have reviewed the deposition of Mr. Michael Worthen, records from Greenville Memorial Hospital, records from Dr. Jon M. Bettrick, and records from Dr. David Guirao as requested in reference to the above noted case. As noted in the records Mr. Worthen had advanced coronary disease, which led to his myocardial infarction and subsequent coronary artery bypass surgery. The cause of the coronary artery disease was his diabetes mellitus, hyperlipidemia, and possible hypertension. It is noteworthy that Mr. Worthen was remarkably functional and asymptomatic given the very advanced degree of his disease - all three main coronary arteries occluded with most of the heart muscle being perfused by collaterals. It is also noteworthy that Mr. Worthen had at least one significant prior myocardial infarction or several smaller events as indicated by his left ventricular aneurysm which was repaired at surgery.

Given the above noted facts, it is my medical opinion that his myocardial infarction could have occurred at any time. It is very fortunate for Mr. Worthen that because of his medical training, he recognized his symptoms as being possibly cardiac related and that he was able to get such excellent medical care so promptly.

If I may be of further assistance, please let me know.

Very truly yours,

W. Travis Ellison, M.D.

Internal Medicine of Greer

Respondents' APA Submission #8

GREENVILLE HOSPITAL SYSTEM
GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

4429

PATIENT NAME: WORTHEN, MICHAEL
DOB: 09/08/1956
SEX: MALE
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 082E AM 2514
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: JOSEPH A MANFREDI, MD
ARRHYTHMIA CONSULTANTS, PA
712 GROVE ROAD
GREENVILLE, SC, 29605

OP LOCATION:

RX410200 - CHEST SINGLE VIEW 3/8/2011 10:56 AM EXAM#: 11718368
ORDERED BY: Dr. JOSEPH A MANFREDI, MD

REASON FOR EXAM: POST PACEMAKER-----

RESULT: WORTHEN, MICHAEL

CHEST SINGLE VIEW, 03/08/11:

COMPARISON: 03/05/11.

FINDINGS: Single view of the chest demonstrates dual lead pacing device in place. Endotracheal tube and enteric tubes have been removed. Left thoracostomy tube remains in place. Left sided pleural effusion and/or volume loss on the left is again suggested.

IMPRESSION:

NO PNEUMOTHORAX NOTED STATUS POST DUAL LEAD PACER PLACEMENT. LEADS APPEAR TO BE IN GOOD POSITION AND POSTSURGICAL CHANGE IN THE LEFT CHEST AND PERSISTENT LEFT PLEURAL EFFUSION NOTED.

TRANSCRIPTIONIST: JENNIFER, HOWANSKY
TRANSCRIBE TIME/DATE: 3/8/2011 5:49:00 PM
READ BY: B.F. "TRIPP" MASTERS, III, MD.
SIGNED BY:

0 ELECTRONIC SIGNATURE / MASTERS, III, MD, B.F. "TRIPP"

GREENVILLE HOSPITAL SYSTEM
GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

PATIENT NAME: WORTHEN, MICHAEL
DOB:
SEX: ~~MALE~~
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 082E AM 2514
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: BARRY R. DAVIS, MD
UMG - CARDIOTHORACIC SURGERY
890 W. FARIS ROAD, STE 550
GREENVILLE, SC, 29605

OP LOCATION:

0 ELECTRONIC SIGNATURE / GILPIN, MD, LEWIS B.

RX410200 - CHEST SINGLE VIEW 3/3/2011 4:00 AM EXAM#: 11709211
ORDERED BY: Dr. BARRY R. DAVIS, MD

REASON FOR EXAM: CABG, VENT. ANEURYSM REPAIR---P/O DAY 1 ---

RESULT:

PATIENT - MICHAEL P. WORTHEN

PROCEDURE: PORTABLE AP CHEST, 4:54 A.M. ON 3/3/11.

History: CABG, ventilation, aneurysm repair. Post-op day one. Comparison is to 3/2/11.

Findings: The endotracheal tube tip and nasogastric tube are not appreciably changed in appearance. Bilateral chest tubes are again demonstrated. No definite evidence of pneumothorax is seen. The right internal jugular Swan-Ganz PA catheter tip is projected likely in the pulmonary out-flow tract. Bilateral opacities may be slightly worse. Left base opacification may be stable. The thoracic spine is suboptimally visualized.

IMPRESSION:

1. POSSIBLE SLIGHT WORSENING OF THE BILATERAL OPACITIES.
2. LIFE SUPPORT, AS DESCRIBED.
3. NO PNEUMOTHORAX

TRANSCRIPTIONIST: GLORIA, PARKER
TRANSCRIBE TIME/DATE: 3/3/2011 10:33:00 AM
READ BY: LEWIS B. GILPIN, MD,
SIGNED BY:

GREENVILLE HOSPITAL SYSTEM

Circle one: Allen Bennett Hospital, Cross Creek Surgery Center,
Patewood Medical Campus, Greenville Memorial Hospital,
Hillcrest Hospital

8011157521 971366670
WORTHEN, MICHAEL PHILIP
BITTRICK, JON M
CAR Admit Date - 02/27/11
Date of Birth - 09/08/1956

LBA
1100

PRE-ANESTHETIC ASSESSMENT AND ORDER SHEET

NAME: <u>Northen, Michael</u>		☐ OSC <u>David</u> ☐ AM ADMIT ☐ ROOM# <u>4605</u>	
PROCEDURE <u>CABG</u> SURGEON		DAY <u>Wed.</u> DATE <u>3/2/11</u> TIME <u>0900</u>	
AGE: <u>54</u> WT: <u>275</u> HT: <u>6'2"</u>		2/27 Cath → EFN 4590.	
BP <u>133/86</u> P <u>68</u> RR <u>18</u> T <u>97.2</u> SAT <u>97%</u>		3V CAD ± 3V occlusion after the	
PRE-OP MEDS <u>Am med x Zestral/20u NPH R/A</u>		prox 3rd of the LAD, of the 2nd and	
ALLERGIES: <u>AKDA Lantus</u>		primary Marg. Branch of Circ, and prox	
MEDICATIONS: <u>amiodarone Novolog Pen</u> <u>Ambien Solate Provacel</u> <u>Vit.C mag. Sulfate Protonix</u> <u>ASA Zofenol Synthroid</u> <u>Bactrim Novolin N Zestral</u>		PREOPERATIVE DIAGNOSIS <u>CAD</u> LVA	
NPO STATUS <u>NPO - N/A</u>		COMMENTS <u>Discussed -</u> <u>Cardiac Mx</u> <u>Coatid up</u> <u>Ph. is ENT</u> <u>Contact Pucard</u>	
PREVIOUS ANESTHETICS/SURGERIES <u>1/6A @ 3rd Jax Gmp, Back Surg.</u>		RN SIGNATURE <u>Shirley Busby, RN</u> DATE: <u>3/1/11</u> TIME: <u>1345</u>	
C-V DISEASE <u>@ C/P → NSTEMI</u> <u>@ HLD, PVD, HTN</u> <u>Ricet SOB & exertion</u> <u>2/27 EFN → EF 30-35%, SINMA</u>		☐ GENERAL ☐ SPINAL ☐ IV REGIONAL ☐ EPIDURAL ☐ MON/CARE ☐ OTHER	
PULMONARY DISEASE <u>@ Smoker</u> <u>3/1 PFT's @</u>		PATIENT ASSESSED - RISKS, BENEFITS, ANESTHETIC DISCUSSED WITH ☒ PATIENT ☐ OTHER ANESTHETISTS SIGNATURE <u>Mash</u> DATE/TIME <u>3/1/11</u>	
RENAL DISEASE <u>@</u>		ASA STATUS P1 P2 P3 <u>P4</u> P5 P6 E <u>1710</u>	
HEPATIC DISEASE <u>@</u>		PROGRESS NOTE: TRANSPORTED TO ☐ RR ☒ ICU TRANSPORT MONITORING ☒ OBSERVATION ☐ EKG ☐ ART AIRWAY DURING TRANSPORT ☐ EXTUBATED ☐ INTUBATED RESP ☐ ASSIST/CONTROL ☐ SPONT. ☐ O2 ON ARRIVAL BP <u>101/70</u> P <u>107</u> R <u>15</u> CONDITION ☒ STABLE ☐ UNSTABLE ☒ REACTIVE <u>100</u> % O2 SAT	
CNS DISEASE, SEIZURES <u>@</u>		☐ REPORT GIVEN TO RECEIVING PERSON ☒ NO APPARENT ANESTHETIC COMPLICATIONS ☐ SEE CHART PROGRESS NOTES TRANSPORTING ANESTHETISTS SIGNATURE <u>mshoud</u> <u>CRNA</u> DATE <u>3-2-11</u>	
GASTRO INTESTINAL <u>@</u>		ANESTHESIA PLAN REVIEWED AND PT. ASSESSED IMMEDIATELY PRIOR TO INDUCTION. CONTROLLED DRUGS ORDERED AND INTRA-OP CARE PROVIDED BY:	
DIABETES <u>DM ~ 10 yrs</u>		<u>Intubated</u> <u>mshoud</u> CRNA	
BLEEDING DISORDER <u>2/28 Rec'd 1 APC</u>		<u>versed</u> <u>1/minute</u> MD	
AIRWAY ☐ DENTURES ☐ PARTIALS ☒ NORMAL		<u>3/2/11</u> DATE <u>0800</u> TIME	
LABORATORY EKG <u>2/26 SR</u> <u>anterior infarct 7 age</u>		POST ANESTHESIA VISIT PATIENT HAS NO ANESTHESIA RELATED COMPLICATIONS ☐ OTHER:	
CXR <u>3/1</u>	BHCG + ☐ - ☐ <u>3/1</u>	SIGNATURE _____ DATE/TIME _____	
H/H <u>14.6/42.2</u>	CHEMISTRY <u>136/99/115/4.0/31/1.2/248</u>	OTHER <u>PT 13.9</u> <u>DT 275</u> <u>ENK LNY</u>	

9.9
A2 020 (8/02)
42.2

2/28 7.46/37/79
21

3/2 3085
0600

GREENVILLE HOSPITAL SYSTEM
GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

PATIENT NAME: WORTHEN, MICHAEL
DOB: 09/08/1956
SEX: MALE
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 084F AM 4605
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: BARRY R. DAVIS, MD
UMG - CARDIOTHORACIC SURGERY
890 W. FARIS ROAD, STE 550
GREENVILLE, SC, 29605

OP LOCATION:

RV100100 - VAS CAROTID DUPLEX COMPLETE 3/1/2011 9:00 AM
ORDERED BY: Dr. BARRY R. DAVIS, MD

EXAM#: 11704265

REASON FOR EXAM: CAROTID ARTERY STENOSIS, CABG-----

RESULT: WORTHEN, MICHAEL

CAROTID ARTERY DUPLEX, 03/01/11:

INDICATIONS FOR EXAMINATION: Preoperative CABG evaluation.

FINDINGS: The right brachial artery pressure is 116 mmHg. The left brachial artery pressure is 116 mmHg. The vertebral arteries are antegrade bilaterally.

RIGHT: The internal carotid artery peak systolic velocity is 75 cm/sec with an ICA/CCA ratio of 0.81. On B-mode imaging, the ICA has minimal disease.

LEFT: The internal carotid artery peak systolic velocity is 72 cm/sec with an ICA/CCA ratio of 0.69. On B-mode imaging, there is minimal to moderate disease within the ICA.

IMPRESSION:

1. BILATERAL CLASS B ICA CAROTID STENOSIS, 1-15%.
2. THE VERTEBRAL ARTERIES ARE ANTEGRADE BILATERALLY
3. THE BRACHIAL ARTERY PRESSURES ARE SYMMETRIC

TRANSCRIPTIONIST: JENNIFER, HOWANSKY
TRANSCRIBE TIME/DATE: 3/3/2011 12:45:00 PM
READ BY: GINGER MANOS, MD,
SIGNED BY:

Inpatient History & Physical Form

Internal Medicine
Greenville Hospital System

() Initial Visit (X) Consult requested by: DANS

Date: 2/20/11

1° MD:

Service: PPT

Attending: TRECE

Ident Stamp

8011157521 971366670

WORTHEN, MICHAEL PHILIP

BITTRICK, JON M

CAR Admit Date - 02/27/11

Date of Birth - 09/08/1956

NAM:

MRN:

AGE:

ROOM#:

Chief Complaint/Reason for Consult:

Preop CABG

Allergies:

Lantus

History of Present Illness:

54 yr m 2 hx HTN, hypothyroid, HLD, DM
2 hx shoulder pain, musculoskeletal pain, & flu-
like symptoms x 2 weeks. He works for EMS &
dev. CP & lifting 80 lb pt. to ED 2/12/11
Initial troponin 93.03 c/w NQWMI. He was
admitted by cardiologist given ACEI, BB, ASA, statin,
Plavix, HCP gt.

① SOB on Saturday, usually only gets SOB & exertion
② cough 2° sinus, & acute bronchitis
③ asthma/COPD/chronic bronchitis
④ PNA larynx as outpt, ⑤ bronchitis
⑥ GERD - PPIs, ⑦ sinus - Alka Seltzer
⑧ DVT/PE

⑨ smoking, ⑩ apnea, wakes himself @ night
frequent awakenings, nap during

Medications and Dosages:

Home

Otiapride
Novolin 71/30
Simvastatin
lisinapi
Levofloxacin = 250

Hosp

Ambien 10 qhs
Asa 325
Cephradine 250 q8h
Novolog 70/30 BID
Novolog SS
Pravastatin 80 qhs
Lisinopril 5 qd

Past Medical/Surgical History:

HTN
HLD
DM
hypothyroidism

Amputation @ toe
Dissection

Social History:

Married
works EMS x 24 yrs. here in Greenville
① tobacco 1 1/2 pps x 12 yrs. but has
put 70s
occasional 2th
drugs
Navy 6 yrs
Army 6 yrs
been 2 EMS/fireman in
② lab @ home

③ asbestos/TB, reg. PPD yearly

Family History:

Father - CAD

GREENVILLE HOSPITAL SYSTEM
GREENVILLE MEMORIAL HOSPITAL
GREENVILLE, SOUTH CAROLINA

PATIENT NAME: WORTHEN, MICHAEL
DOB: 09/08/1956
SEX: MALE
PT. CLASS: INPATIENT

MED. REC. NO.: 971366670
PT. NS./ROOM: 084F AM 4605
CORP. ACCOUNT NO.:
ADMISSION NO.: 08011157521

ORDERING MD: JON M. BITTRICK, MD
UPSTATE CARDIOLOGY
2 INNOVATION DRIVE, STE 400
GREENVILLE, SC, 29607

OP LOCATION:

0 ELECTRONIC SIGNATURE / GILPIN, MD, JOHN

RX410300 - CHEST PA AND LATERAL 3/1/2011 9:00 AM EXAM#: 11704382
ORDERED BY: Dr. JON M. BITTRICK, MD

REASON FOR EXAM: CAD, PREOP CABG-----

RESULT: MICHAEL WORTHEN

CHEST PA AND LATERAL 3/1/11:

PA and lateral chest films are provided to me. The heart and mediastinum appear normal. There is no evidence of consolidation. No pneumothorax is seen. Spondylosis is present.

IMPRESSION: NO EVIDENCE OF CONSOLIDATION.

TRANSCRIPTIONIST: TERESA, ENGEL
TRANSCRIBE TIME/DATE: 3/1/2011 2:25:00 PM
READ BY: JOHN GILPIN, MD,
SIGNED BY:

Patient Stamp

8011157521 971366670
 WORTHEN, MICHAEL PHILIP
 BITTRICK, JON M
 CAR Admit Date - 02/27/11
 Date of Birth - 09/08/1956

Assessment:

- ① Dyspnea
- ② Pncop
- ③ ROSA
- ④ tobacco
- ⑤ CAD

- ⑥ Hypothyroid
- ⑦ DM
- ⑧ HTN
- ⑨ NAWHL
- ⑩ HLD
- ⑪ Prophylaxis

Plan:

- ① Multifactorial
- ② low to mod. risk
- ③ CPAP / BIPAP pncop, P50 & d/c
- ④ quit 720 yrs. ago
- ⑤ CABG

- ⑥ Synthroid 20
- ⑦ SS1
- ⑧ Lopressor / Lisinopril
- ⑨ Heparin, Loprin, Lisinopril, Paracetamol
- ⑩ Paracetamol
- ⑪ Protinix

Attending HPI: Pt seen & examined. Agree & above documented H&P by Jennifer Lashley, PA. Briefly, 54yo ♂ with DM, HTN, HLD, hypothy, presented w/ c/o chest pain on exertion while working as paramedic. Accompanying shoulder pain, SOB. Ruled in for MI & enzymes. H/o remote tobacco abuse. Chronic cough & post-nasal catarrh & multivessel CAD requiring CABG.

Attending PE:

54yo obese ♂, A+ox, Mallampati III-IV
 large neck, 3 mild wheezes
 CR: RR 12, CTAB, NTM
 Resp: Ate 5 Ext & d/c

H/O GERD.

Labst Imaging personally reviewed.

Attending Assessment and Plan:

CAD - multivessel dz (RCA, LCA, LAD) requiring CABG

Good surgical candidate. Low to mod risk for complication post-op. No known h/o lung dz but does have symptoms of sleep apnea. May need CPAP qhs post-op.

Resident signature:

MD

PGY1, PGY2, PGY3 Date: 2/20/11

out pt sleep 1143

Resident name printed:

Dictated by:

VPAT given Intern Pager: h/o 11872

Attending signature:

Date: 2/28/11

Rest per above

Attending: Ansari Atkisson Bowers Bruch Call Chang Cochrane Curran Ferraro Fuller Gilroy Hayes Kelly Knight Latham McCraw McFarland Meyer North-Coombes Schrank Sinopoli Smith Surka Von Hofe Wagstaff Watson Weber Weems White

Greenville Hospital System

CONSULTATION REQUEST

8011157521 971366670
 WORTHEN, MICHAEL PHILIP
 BITTRICK, JON M
 CAR Admit Date - 02/27/11
 Date of Birth - 09/08/1956

Consulting Physician and/or Service Endocrine
 Reason for Request Preop Eval, for CABG 3/2/11

(Check one or more suitable blanks)

☐ At convenience of consultant
☐ Urgent, today if possible
☐ Opinion and recommendation only
☐ Write diagnostic orders and
 re-evaluate as indicated

☐ Evaluate and manage condition
 in your specialty
☐ Accept in transfer, if you
 will

Date 2/28/11 Signed Dr. Barry Davis
 Attending Physician

Date and Time Consultant Notified 2/28/11 Signed Don J. Evans
Spoke in Dr. Weber's Office @ 11:30

Report: # 278436 TSH 1.94

Home: 70/30 54 am 152 lb
Glipizide 5 mg TID

- Imp/
- ① T2DM uncontrolled
 - ② Primary hyperthyroidism
 - ③ CABG 5/1 AMI
 - ④ Obesity
 - ⑤ Hypertension

Plan/

- NPIT 40/30
- N. 12 AC + 3/10 7:00 AM
- ✓ AC
- LT4 200 AD

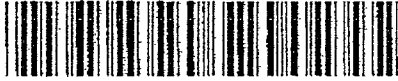
Date 2/28/11 Signed [Signature]
 Consultant



X-ray
Greenville Hospital System

8011157521 971366670
WORTHEN, MICHAEL
BITTRICK, JON M
CAR 0037 BLB10B 02/27/11
S W M 54 09/08/1956
264178874

**MAGNETIC RESONANCE IMAGING (MRI)
PATIENT SCREENING FORM**



Exam number: _____

Name Worthen Michael
Last name First name Middle initial

Date 2/20/11 Time 1415

☐ Female ☒ Male Age 54 Date of Birth _____ Height 62 Weight 270 lb

1. Reason for exam? Explain your medical problems in detail. (What is the problem? Where is the problem? How long have you had this problem?) Eval for Heart Surgery

2. ☒ YES ☐ NO.... Have you had any prior diagnostic study (MRI, CT, Ultrasound, X-ray, etc)?

If yes, list:

Body Part

Date/Facility

MARK ON THE FIGURE(S) BELOW THE
LOCATION OF WHERE YOUR PAIN IS
ON YOUR BODY

MRI

Back

1984

Crossroads

CT

X-RAY

back, arms, legs, chest 2003 / Chiropractor / GHS

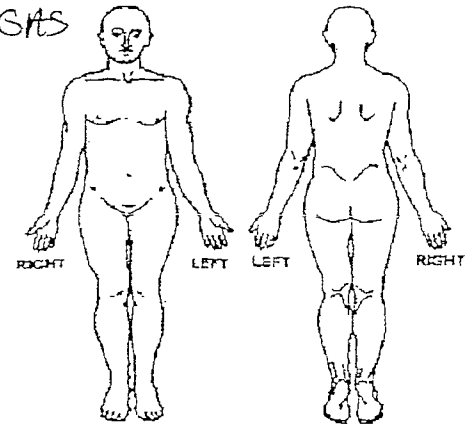
Ultrasound

Nuclear Medicine

Cardiac

2006 / Greer

Other



3. ☒ YES ☐ NO Are you a diabetic?
4. ☐ YES ☒ NO Do you have liver disease?
5. ☐ YES ☒ NO Do you have a history of High Blood Pressure?
6. ☐ YES ☒ NO Are you claustrophobic?
7. ☐ YES ☒ NO Are you about to have a renal transplant or have you had a renal transplant?
8. ☐ YES ☒ NO Do you have a history of renal failure, kidney disease, renal tumor or abnormal kidney function?
9. ☐ YES ☒ NO Are you about to have a liver transplant or have you had a recent liver transplant?
10. ☐ YES ☒ NO Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination?
11. ☒ YES ☐ NO Do you have any drug allergies? If yes, describe: Latex
12. ☐ YES ☒ NO Do you have a history of cancer? If yes, give type, treatments and date:

13. ☒ YES ☐ NO Have you ever had a surgical operation or procedure of any kind? If yes, tell us what you had done.

Back Surgery Left foot toe amputation, C

14. ☐ YES ☒ NO Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, and other metal object)? If yes, describe:

FOR FEMALE PATIENTS

15. DATE OF LAST MENSTRUAL PERIOD: _____

16. ☐ YES ☒ NO Are you pregnant or suspect you may be pregnant?

Post menopausal? ☐ YES ☐ NO

17. ☐ YES ☒ NO Are you breast feeding?

Form completed by: ☐ Patient ☐ Relative ☒ Nurse Amy McIsaac Other: _____

Patient Signature: Michael P. Worthen Date: 2/20/11

Person Authorized to Sign for Patient: _____ Date: _____

Form information reviewed by: _____ Date: _____

Please fax to 455-3013 and place the original copy under the x-ray tab on the patient's Medical record.



X-ray
Greenville Hospital System

8011157521 971366670
WORTHEN, MICHAEL
BITTRICK, JON M
CAR 0037 BLB10B 02/27/11
S W M 54 09/08/1956
264178874

MAGNETIC RESONANCE IMAGING (MRI) PATIENT SCREENING FORM



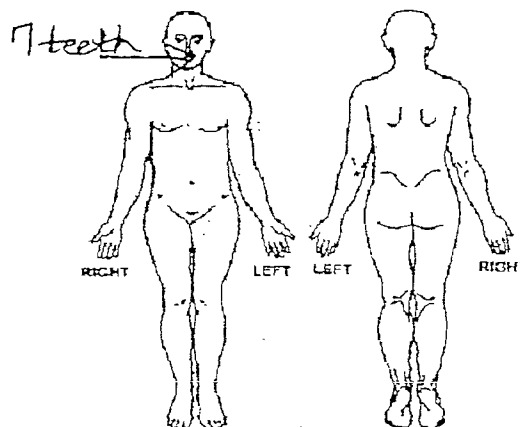
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. **Do not enter** the MRI room if you have any questions or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MRI room.

The MRI is **ALWAYS** on.

Please indicate if you have any of the following:

☐ YES ☒ NO	Aneurysm clip(s)
☐ YES ☒ NO	Cardiac pacemaker
☐ YES ☒ NO	Implanted cardioverter defibrillator (ICD)
☐ YES ☒ NO	Electronic implant or device
☐ YES ☒ NO	Magnetically-activated implant or device
☐ YES ☒ NO	Neurostimulator or biostimulator system
☐ YES ☒ NO	Internal electrodes or wires
☐ YES ☒ NO	Bone growth/bone fusion
☐ YES ☒ NO	Cochlear, otologic, or other ear implant
☐ YES ☒ NO	Insulin or other infusion pump
☐ YES ☒ NO	Implanted drug infusion device
☐ YES ☒ NO	Any type of prosthesis (eye, penile, etc.)
☐ YES ☒ NO	Heart valve prosthesis
☐ YES ☒ NO	Eyelid spring or wire
☐ YES ☒ NO	Artificial or prosthetic limb/joint
☐ YES ☒ NO	Metallic stent, filter, coil

MARK THE FIGURE BELOW OF ANY
METAL OR STENTS IN YOUR BODY



Maker/Model Name: _____

Date: _____

☐ YES ☒ NO	Any metallic fragment or foreign body (bullet, BB, shrapnel, metal shavings, metal slivers)
☐ YES ☒ NO	Vascular access port and/or catheter
☐ YES ☒ NO	Radiation seeds or implants
☐ YES ☒ NO	Swan-Ganz or thermodilution catheter
☐ YES ☒ NO	Medication patches (all patches must be removed before MRI)
☐ YES ☒ NO	Shunt (spinal or intraventricular)
☐ YES ☒ NO	Wire mesh or mesh implant
☐ YES ☒ NO	Tissue expander (e.g. breast)
☐ YES ☒ NO	Surgical staples, clips, or metallic sutures
☐ YES ☒ NO	Joint replacement (hip, knee, etc.)
☐ YES ☒ NO	Bone/joint pin, screws, nail, wire, plate, etc.
☐ YES ☒ NO	IUD, diaphragm, or pessary
☐ YES ☒ NO	Dentures or partial plate or false teeth
☐ YES ☒ NO	Tattoo or permanent makeup
☐ YES ☒ NO	Body piercing
☐ YES ☒ NO	Hearing aid
☒ YES ☐ NO	Other implant <i>7 teeth implanted w metal posts</i>
☐ YES ☒ NO	Breathing problems or motion disorder
☐ YES ☒ NO	Endotracheal or Tracheotomy tubes

Important Instructions

Before entering the MRI room, you must remove **ALL** metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watches, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads!

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

Form completed by: ☐ Patient ☐ Relative ☒ Nurse *Amy Williams* Other: _____

Patient Signature: *Michael P. Worthen*

Date: *2/28/11*

Person Authorized to Sign for Patient: _____

Date: _____

Form information reviewed by: */*

Date: _____

Please fax to 455-3013 and place the original copy **282** e x-ray tab on the patient's Medical record.

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084F4605.AM
Billing NO: 080011157521

GREENVILLE MEMORIAL CARDIAC CATHETERIZATION:

DATE OF CATHETERIZATION: 02/27/2011

HISTORY: This 54-year-old gentleman has diabetes. He reported to the emergency room with chest pain and unusual shortness of breath. He had had an essentially normal electrocardiogram 6 or 8 months ago. His EKG in the emergency room appeared to show anterior wall infarction and poor inferior forces. His troponin has risen to 3. Cardiac cath and possible intervention was discussed this morning in detail with the patient. Hemodynamics and rhythm have remained stable.

PROCEDURE: The area over the right femoral artery was infiltrated with lidocaine. There were 6-French right and left Judkins coronary catheters used. The patient had extreme coronary disease and I thought surgical consultation was in order. There had been suspicion of an apical thrombus but I felt we should still have a left ventricular angiogram to supplement the echocardiogram in this 275 pound gentleman. A straight guidewire was carefully placed across the aortic valve and the pigtail catheter was specifically positioned at the base of the heart, just at the mitral inflow. The thrombus is said to be in the left ventricular apex. An angiogram was filmed using 20 mL of contrast over 2 seconds. Images were reviewed. Catheter and sheath were sutured in place, to be removed with ACT falls to an acceptable range.

CONTRAST: Oxilan

CONTRAST VOLUME: 75 mL

HEMODYNAMICS: Left ventricular pressure 111/pre-A-wave 15, post-A-wave 22. Pullback revealed no aortic valve systolic gradient.

ANGIOGRAPHIC DATA: The left main coronary artery is intact. The left anterior descending has 70% to 80% stenosis just beyond the first septal. Then, at the bifurcation into the diagonal branch and the distal left anterior descending, the LAD is completely occluded. Filling of the LAD distally is by left collateral, I think septal collaterals and possibly from the first circumflex marginal. The distal LAD is visualized in its entirety along with the diagonal branch, but the mid segment of the vessel, I think, may have some narrowing. It is very difficult to evaluate by septal collateral filling. The diagonal appears to be an average sized diagonal branch and intact. First circumflex marginal is patent. The second circumflex marginal is a large, marginal system and fills very promptly by left coronary collateral. It is a very large system and intact. The right coronary artery is occluded proximally. There is some filling into the distal right coronary system

CARDIAC CATHETER.

Page 1 of 2

COPY FOR: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084F4605AM
Billing NO: 080011157521

from left coronary collaterals and there is fairly good flow into the distal right coronary artery by a Kugel's collateral. The distal right coronary artery appears intact and consists of a posterior descending and 2 posterolateral branches. The larger posterolateral branch appears to be a significant vessel. I suspect there is good continuity between all 3 of these branches, through the conduit segment. The left ventricle appears mildly dilated but when corrected for body habitus, is probably normal volume. The apex is akinetic and in light of his echo findings, the apex does appear to be squared. There is no obvious apical filling defect but it does not have the usual rounded appearance of a left ventricular apex. The anterior apical segment is akinetic. The inferior segment is hypokinetic. I think ejection fraction is better than estimated on echocardiogram, at least in the single RAO view. I would estimate ejection fraction in this view to be approaching 45%. There is no significant mitral insufficiency.

IMPRESSION:

1. Three vessel coronary disease with 3 vessel total occlusion after the proximal 3rd of the left anterior descending of the second and primary marginal branch of the circumflex and of the proximal right coronary artery.
2. Left ventricular dysfunction.

Charles D. Ross, MD

cc: Charles D. Ross, MD

D 02/28/2011 11:27 A T 02/28/2011 04:34 P zhj/C DVI 278323 C/S#: 3396484



GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER

Greenville Hospital System
Echocardiographic Report
Greenville, South Carolina



Patient: WORTHEN, MICHAEL
PHILIP
DOB: 09/08/1956
Sex: M
Height: 187.96 cm
Weight: 124.74 kg
Med
Rec#: 971366670

Date: 02/27/2011
Type: Inpatient
Room#: CPC1
Location: Greenville Memorial
Hospital

Referring: Bittrick, Jon MD
Reading: Upstate Cardiology
Reading: Freeman, Lawrence
MD
Technician: Van, Vu H. BS,
RDCS

Indication: NQWMI

Study Quality:

HR 74

BP 119/58

Measurements		
Name	Value	Units
IVSD	1.11	(0.3 - 1.1) cm
LVIDd_2D	6.32	cm
LVIDs_2D	5.17	cm
LVPWD	1.2	(0.7 - 1.1) cm
LADIAM	4.3	cm
AODIAM	3.8	cm
AVGRADP	4	(<36) mmHg
AVGRADM	2	(<20) mmHg
AVA_VTI	2.87	cm2
AVA (Vmax)	2.45	cm2
MV VTI	29.7	cm
MVA (Cont)	1.47	cm2
MVA_PHT	3.79	cm2
MVGDM	2	mmHg

Findings

Technical Comments

The study quality is fair.

Left Ventricle

The left ventricular chamber size is moderately dilated. Mild concentric left ventricular hypertrophy is observed. Severe global hypokinesis of the left ventricle is observed. The estimated ejection fraction is 30-35%. The left ventricular diastolic filling pattern is restrictive.

Left Atrium

The left atrium is mildly dilated.

Right Atrium

The right atrium appears normal.

Aortic Valve

The aortic valve structure is normal. Mild aortic cusp sclerosis is present. There is no

evidence of aortic stenosis. There is no evidence of aortic regurgitation.
Mitral Valve The mitral valve leaflets appear normal. There is a trace of mitral regurgitation.
Tricuspid Valve The tricuspid valve appears normal in structure and function.
Pulmonic Valve The pulmonic valve is not well visualized.
Pericardium There is no pericardial effusion.
Aorta The aortic root appears normal.
Impression Segmental wall motion abnormalities with decreased systolic performance indicative of CAD. There is left ventricular hypertrophy. Left ventricular diastolic dysfunction is present. The base of LV contracts normally. There is an extensive area of apical akinesis with what is likely a laminar apical thrombus. The remaining walls are mildly hypokinetic.

This report has been electronically signed by

Lawrence Freeman MD

02/27/2011 15:26:03

6'2
275

**GMMC
TRIAGE RECORD**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

Patient Data

Complaint: Respiratory — shortness of breath
Triage Time: Sat Feb 26, 2011 23:12
Urgency: 3—Urgent
Bed: ED CPC 01
Initial Vital Signs: 2/26/2011 23:06
BP: 126/74
P: 82
O2 sat: 99 on RA

ED Attending:
Primary RN: Velasquez, RN, Delia

R: 16
T: 97.8
Pain: 0

KNOWN ALLERGIES

Lantus

PRESENTING PROBLEM (23:12 DEV)

Presenting problems: Dyspnea — Adult. Chest Pain — Adult.

TRIAGE (Sat Feb 26, 2011 23:12 DEV)

PATIENT: NAME: Worthen, Michael P. AGE: 54. GENDER: male, DOB: Sat Sep 08, 1956.

TIME OF GREET: Sat Feb 26, 2011 23:05. Infectious Disease: Not Applicable, Travel History: No foreign travel in past 10 days, Poss. H1N1 Flu: No contact with person with flu. Homicidal/Suicidal:

Denies homicidal tendencies / history. Smoking Cessation: Denies smoking in past 12 months,

SSN: 264178874. MEDICAL RECORD NUMBER: 971366670, ACCOUNT NUMBER: 08011157521.

PERSON ID: 971366670. (Sat Feb 26, 2011 23:12 DEV)

ADMISSION: URGENCY 3—Urgent, ADMISSION SOURCE: work, TRANSPORT: Laurens

County EMS — ALS. DEPT: Emergency. BED: CPC 01. (Sat Feb 26, 2011 23:12 DEV)

VITAL SIGNS: BP 126/74, Pulse 82, Resp 16, Temp 97.8, Pain 0, O2 Sat 99, on RA, Time

2/26/2011 23:06. (23:06 DEV)

COMPLAINT: Respiratory — shortness of breath. (Sat Feb 26, 2011 23:12 DEV)

HISTORY OF PRESENT COMPLAINT: C/O SOB STARTED AFTER ANSWERING AN
EMS CALL ASSOCIATED WITH CHEST PRESSURE. (Sat Feb 26, 2011 23:12 DEV)

ASSESSMENT (Sat Feb 26, 2011 23:12 DEV)

TREATMENTS PRIOR TO ARRIVAL: Oxygen, IV: .9NS, IV KVO, Site: R arm. Gauge:

18. Labs/X—Rays. BGL=222DL. (Sat Feb 26, 2011 23:12 DEV)

MEDICATIONS PRIOR TO ARRIVAL: Aspirin, dosage taken: 324MG. (Sat Feb 26, 2011

23:12 DEV)

TREATMENTS IN TRIAGE: No treatment. (Sat Feb 26, 2011 23:12 DEV)

PROVIDERS: TRIAGE NURSE: Delia Velasquez, RN, PRIMARY NURSE: Delia Velasquez,

RN. (Sat Feb 26, 2011 23:12 DEV)

PAST MEDICAL HISTORY (Sat Feb 26, 2011 23:12 DEV)

MEDICAL HISTORY: History of diabetes. That is currently treated with an oral medication. History of endocrine disease, including hypothyroidism.

SURGICAL HISTORY: Patient has had no previous surgical history.

PSYCHIATRIC HISTORY: No previous psychiatric history.

SOCIAL HISTORY: Denies smoking. Patient consumes alcohol socially. Lives at home with family.

FAMILY HISTORY: Family history is not contributory to this case.

CURRENT MEDICATIONS

No recorded medications

*unusual
admission
last few days
had been out
1 wk ago
affect
HA
chest pain
upstate
Trop 3.03
last few days
weakness
heavy
ps.*

*PT EMT
Lifted PT 75*

*Nov 10/30-
5A/5Z
glipizide
gen floro 301
lisinpril 6mg
levothyroxine*

**GMMC
TRIAGE RECORD**

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 971366670
AcctNum: 08011157521

VITAL SIGNS (23:06 DEV)

VITAL SIGNS: BP: 126/74, Pulse: 82, Resp: 16, Temp: 97.8, Pain: 0, O2 sat: 99 on RA, Time:
2/26/2011 23:06.

PRESCRIPTION

No recorded prescriptions

Key:

DEV=Velasquez, RN, Delia

Respondents' APA Submission #9



UNIVERSITY MEDICAL GROUP

WORTHEN, MICHAEL PHILIP

54 Y old Male, DOB: 09/08/1956
104 ARBORDALE LANE, SIMPSONVILLE, SC-29680

Home: 864-915-0039

Guarantor: WORTHEN, MICHAEL PHILIP

Insurance: BCBS STATE EMP HEAL PLAN

PCP: David P Guirao (GHS-UMG), MD External Visit

ID: 117867606

Appointment Facility: Pulmonary Disease (PTWD) Associates -Patewood (PULE)

06/23/2011

Progress Notes: Catherine Chang, MD

Current Medications

Allegra 180 mg tablet 180 mg 1 tab(s) once a day
Spiriva Inhaler 1 puff QD
Coumadin tablet 4 mg 1 tab(s) once a day
Coreg 3.125 mg 1 tab 2 times a day
Pravachol tablet 80 mg 1 tab(s) once a day (at bedtime)
ASA capsule 81 1 CAPS daily
Novolin 70/30 injection human recombinant 70 u-30 u/ml 34 units AM/35 units PM twice a day
glipizide tablet, extended release 10 mg 1 tab(s) once a day
Metformin tablet, extended release 500 mg 1 tab(s) once a day
quinapril tablet 5 mg 1 tab(s) once a day
Prilosec 20 mg 1 tab once a day
levothyroxine tablet 25 mcg (0.025 mg) 1 tab(s) once a day
gemfibrozil tablet 600 mg 1 tab(s) 2 times a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
Hyperthyroidism
Diabetes
High Cholesterol
Coronary artery disease
Congestive heart failure

Surgical History

No Surgical History documented.

Family History

Family: hypertension, heart disease, diabetes, cancer
Brother: elevated triglycerides
Father: deceased 60s yrs colon cancer
diabetes heart attack
Mother: deceased 78 yrs cancer, unknown cause of death
1 brother(s), 1 sister(s), 1 daughter(s) - healthy.

Reason for Appointment

1. 8 wk f/u

History of Present Illness

General:

Today I had the pleasure of seeing Mr. Worthen in follow-up after his hospitalization for coronary artery bypass grafting surgery. His pulmonary function studies indicated mild COPD, no is also the suggestion of obstructive sleep apnea, and therefore he was referred for sleep apnea at his last visit. He had a difficult time falling asleep during the study. He is very pleased as he has maintained his 30-pound weight loss from his hospital stay. He also has been cleared to begin work as of July 2, and he is very pleased.

With regards to COPD, he has been using Spiriva but does not feel that it has caused any improvement in his exertional shortness of breath. Overall, he feels that his level of functioning is improved farther out from his cardiac surgery.

Pain Assessment:

Denies : Pain.

Vital Signs

Temp (F) 98.2, Ht 74, Wt lbs 271.8, Wt kg 123.29, BMI 34.89, HR 63, BP 130/80, RR 18, O2 Sat 97% ra.

Examination

FOLLOWUP:

General normal general appearance. ENT nasal mucosa normal, septum midline, oropharynx benign, no thrush, Narrow airway in the oropharynx, large thick uvula and a low soft palate, large tonsils. Respiratory chest symmetric, normal expansion and effort, normal auscultation, no wheezing. Cardiovascular regular rate and rhythm, no murmurs, gallops or rubs, peripheral vascular normal by observation and palpation. Abdomen soft, nontender, normal bowel sounds, no hepatosplenomegaly. Extremities no clubbing, cyanosis or edema. Neuro/Psych alert and oriented, normal mood and affect.

PULM-7:

I personally reviewed the results of his sleep study. He demonstrated severe obstructive sleep apnea with an AHI of 35.7 and desaturation to 74%, with 28 minutes of desaturation between 50 and

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang, MD 06/23/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Married.
Lives With: spouse.
Occupation: Disabled short term.
no Alcohol .
no Smoking chewing tobacco quit x 1 year.
no Recreational drug use.
Caffeine: yes, 2 servings/day.

Allergies

unknown insulin: rash
Lantus

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems

GENERAL:

Negative for change in appetite, fever, chills, sweats. Positive for weight loss.

NOSE:

Negative for epistaxis, sinusitis, postnasal drip.

RESPIRATORY:

Negative for shortness of breath, hemoptysis, chest congestion.
Cough yes.

CARDIOVASCULAR:

Negative for chest pain, palpitations, orthopnea.

GASTROINTESTINAL:

Negative for nausea, vomiting, diarrhea, reflux.

PULM SKIN:

Negative for skin rashes.

90%..

Assessments

1. Obstructive sleep apnea - 327.23 (Primary)
2. Chronic airway obstruction NEC - 496
3. DYSPNEA - 786.09
4. CAD - 414.00
5. Allergic rhinitis - 477.9

Treatment

1. Obstructive sleep apnea

Diagnostic Imaging: Polysomnography (Sleep study), Titration (Ordered for 06/30/2011)

He has been set up for positive pressure titration. He reports he does occasionally take an over-the-counter sleep aid, and I have given him permission to do this at his positive pressure titration to improve sleep latency. Asked him to notify the technician upon his arrival of the name of this drug for documentation purposes.

2. Chronic airway obstruction NEC

Stop Spiriva Inhaler, 1 puff, QD

He was surprised to learn of his diagnosis of COPD. I reviewed his pulmonary function studies with him. Spirometry is more consistent with a combined obstructive and restrictive ventilatory defect. We discussed the restriction may be related to body habitus. There is a small component of obstruction present, however and this is reversible with bronchodilator. I have told him that his disease is likely very mild, and that he did not wish to continue with Spiriva he could stop it and determine if the shortness of breath worsens. If not, he may remain off of medication.

3. Allergic rhinitis

Start Flonase spray, 0.05 mg/inh, 1 spray(s), intranasally, once a day, 30 day(s), 1, Refills 6

Start Allegra 180 mg tablet, 180 mg, 1 tab(s), orally, once a day, 30 day(s), 30

4. Others

We discussed the pathophysiology of obstructive sleep apnea, treatment options including CPAP mask, surgery, dental appliances, positional therapy and what to expect from treatment. Explanation of natural course of disease and associated disorders. The detrimental effects of untreated obstructive sleep apnea were relayed including stroke, HTN, arrhythmias, and pulmonary hypertension. Drowsy driving/sleepiness counseling. We also discussed central apneas and restless leg syndrome. We discussed risk factor identification, explanation of exacerbating factors, and risk factor modification. The importance of diet, exercise, and particularly weight loss were discussed. We reviewed simple strategies to reach this goal, including patient's role in treatment, address their concerns and set goals. Handouts on obstructive sleep apnea and CPAP were provided. We will check PSG to evaluate for possible OSA and start CPAP if indicated.

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang, MD 06/23/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Labs

Lab: PFT Full Study (Lung volumes & DLCO) PFT good effort

FVC-Pre (Liters)	3.59
FVC%-Pre	64%
FEV1-Pre (Liters)	2.48
FEV1%-Pre	57%
FEV1/FVC%-Pre	69%
FEF25-75%-Pre (L/sec)	1.54
FVC-Post (Liters)	3.63
FVC%-Post	64%
FEV1-Post (Liters)	2.46
FEV1%-Post	57%
FEV1/FVC%-Post	68%
FEF25-75%-Post (L/sec)	1.25

Chang, Catherine 06/23/2011 04:21:59 PM EDT > Impression:
There is a suggestion of a combined obstructive and restrictive ventilatory defect. There is no significant improvement after inhaled bronchodilator. As compared to previous study done April 27, 2011, there has been slight improvement in the forced vital capacity and significant improvement in the FEV1. The ratio has also improved but does remain slightly reduced

Follow Up

2 Months

Electronically signed by Catherine Chang on 06/23/2011 at 04:22 PM EDT

Sign off status: Completed

Pulmonary Disease (PTWD) Associates -Patewood (PULE)
200 Patewood Blvd.
Greenville, SC 29615
Tel: 864-454-4200
Fax: 864-454-4205

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang,
MD 06/23/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Montage: Recorded parameters: EEG, eye movements (EOG), chin EMG, ECG, intercostal EMG, anterior tibialis EMG, respiratory effort at the chest and abdomen, nasal pressure, airflow at the nose & mouth via thermocouple, sound, body position, limb movements, oximetry and CPAP levels when applicable. Collected in 10mm/sec format, 30 sec epochs. Scoring Standard: reference: 2007 AASM Manual for Scoring of Sleep & Associated Events. 10 second minimum for apnea events, 10 second minimum for hypopnea events with $\geq 30\%$ decrease in nasal pressure amplitude, desaturations of 4%, RDI calculation includes obstructive apneas, central apneas, hypopneas, & RERAs, Arousals ≥ 3 seconds, limb movements with minimum 0.5 second duration, PLMs: series of ≥ 4 within 90 seconds.

Sleep Disorders Centers
Greenville Hospital System
P: 864 455 7743
F: 864 455 7748

Hillcrest Memorial Hospital Sleep Lab

PATIENT'S NAME: Worthen, Michael
DOB: 9/8/1956
SS#: 264-17-8874
REFERRING M.D.: CHANG

DATE OF RECORDING: 5/4/2011
DATE OF SCORING: 05/09/2011
DATE INTERPRETED:

Study Performed: Nocturnal Polysomnography (SLEEP STUDY W/ TV ON)

SUMMARY:

Worthen, Michael is a 54 year old Male. Weight is 257 pounds, Height is 6'2". The patient was referred for the evaluation of obstructive sleep apnea, and for possible causes of excessive daytime somnolence

The patient was studied from 22:44:35 to 05:19:53. Total recording time was 395.3 minutes, with a total sleep time of 244.0 minutes and a sleep efficiency of 63.1%. The patient's sleep latency was 93.0 minutes with a REM latency of 141.0 minutes. With regards to sleep staging, Stage 1N sleep = 9.4%, Stage 2N = 76.4%, Stage 3N sleep = 1.8%, and REM sleep = 12.3%. Overall sleep is fragmented and shallow.

Patient's snoring was noted by technologist as mild to moderate in sound level.

Respiratory analysis demonstrated 12 obstructive apneas and 0 mixed apneas with a total of 12 apneas and an apnea index of 3.0. There were 133 hypopneas, with an APNEA/HYPOPNIA INDEX (AHI) of 35.7. The patient also had 24 respiratory event related arousals (RERA) with a RESPIRATORY DISTURBANCE INDEX (RDI) of 41.6 per hour of sleep. The patient spent 83.6% of total sleep time in the supine position, with a supine RDI of 41.8, versus a non-supine RDI of 4.5. The REM RDI was 62.0, versus a non-REM RDI of 38.7. The lowest desaturation was 74, with 28.3 minutes of desaturations between 50% and 90%.

The patient had a Periodic Limb Movement (PLM) index of 0.0. The Limb Arousal Index was 0.5

The total arousal index was 30.0. The Respiratory Arousal Index was 22.6, and the Spontaneous Arousal Index was 1.0.

ECG showed a sinus rhythm with no cardio graphic abnormalities.

DIAGNOSTIC IMPRESSION:

1. This study shows Severe Obstructive Sleep Apnea Syndrome (327.23) with significant sleep fragmentation and severe hypoxemia.
2. Poor sleep hygiene. Patient sleeps with television on.

RECOMMENDATION:

1. A CPAP Titration study is recommended.
- 2.

John Kudlak, D.O.
Medical Director Greer Sleep Lab
GHS Sleep Disorders Centers

CC:



UNIVERSITY MEDICAL GROUP

WORTHEN, MICHAEL PHILIP
 54 Y old Male, DOB: 09/08/1956
 104 ARBORDALE LANE, SIMPSONVILLE, SC-29680
 Home: 864-915-0039
 Guarantor: WORTHEN, MICHAEL PHILIP
 Insurance: BCBS STATE EMP HEAL PLAN
 PCP: David P Guirao (GHS-UMG), MD External Visit ID: 112615596
 Appointment Facility: Pulmonary Disease (PTWD) Associates -Patewood (PULE)

04/27/2011

Progress Notes: Catherine Chang, MD

Current Medications

gemfibrozil tablet 600 mg 1 tab(s) 2 times a day
 levothyroxine tablet 25 mcg (0.025 mg) 1 tab(s) once a day
 Prilosec 20 mg 1 tab once a day
 quinapril tablet 5 mg 1 tab(s) once a day
 Metformin tablet, extended release 500 mg 1 tab(s) once a day
 glipizide tablet, extended release 10 mg 1 tab(s) once a day
 Novolin 70/30 injection human recombinant 70 u-30 u/ml 34 units AM/35 units PM twice a day
 ASA capsule 81 1 CAPS daily
 Pravachol tablet 80 mg 1 tab(s) once a day (at bedtime)
 Coreg 3.125 mg 1 tab 2 times a day
 amiodarone tablet 200 mg 2 tabs twice a day
 Coumadin tablet 4 mg 1 tab(s) once a day
 Spiriva Inhaler 1 puff QD
 Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
 Hyperthyroidism
 Diabetes
 High Cholesterol
 Coronary artery disease
 Congestive heart failure

Surgical History

heart surgery March 2011
 Back Surgery
 Foot Surgery

Family History

Family: hypertension, heart disease, diabetes, cancer
 Brother: elevated triglycerides
 Father: deceased 60s yrs colon cancer diabetes heart attack
 Mother: deceased 78 yrs cancer, unknown cause of death
 1 brother(s), 1 sister(s), 1 daughter(s) - healthy.

Reason for Appointment

1. HOSP FU

History of Present Illness

Pain Assessment:

Denies : Pain.

General:

Today I had the pleasure of seeing Mr. Worthen in follow-up after his hospitalization for coronary artery bypass grafting surgery. His hospital stay is briefly summarized: He was admitted on February 27 with an acute MI. Left heart catheter revealed multivessel disease with an ejection fraction of 30% and a possible mural thrombus. He underwent a 4-vessel bypass and LV aneurysmorrhaphy and thrombectomy on March 2. He did have some vasopressor dependence as well as an intra-aortic balloon pump, which was discontinued on the second postoperative day. He was then transferred to a monitored bed, then suffered a ventricular fibrillation arrest. ICD was placed on March 8. He was discharged home on amiodarone and Coumadin. He was discharged home on March 14. He is followed by Upstate Cardiology.

He was seen in preoperative consultation, by Dr. Treece, as well, and found to have COPD on the basis of his pulmonary function studies. He was discharged home on Spiriva which he has not been using for the last week. He has been trying to be active, and is walking in the woods with his friend who is turkey hunting. He has not yet been cleared to participate in cardiac rehab, but is anticipating this within the next several weeks. There was also significant suspicion that he has obstructive sleep apnea. He is employed by EMS, and is required to stay overnight. His coworkers frequently complained about his loud snoring. He has never had a sleep study.

He also has diabetes, and this is much better controlled since his discharge from the hospital as he has lost nearly 30 pounds.

Vital Signs

Temp (F) 99.1, Ht 74, Wt lbs 257.0, Wt kg 116.57, BMI 32.99, HR 66, BP 130/54, RR 16, O2 Sat 97%ra
 neh.

Past Orders

PFT Full Study (Lung volumes & DLCO) (Order

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang, MD 04/27/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Married.
Lives With: spouse.
Occupation: Disabled short term.
no Alcohol .
no Smoking chewing tobacco quit x 1 year.
no Recreational drug use.
Caffeine: yes, 2 servings/day.

Allergies

unknown insulin: rash
Lantus

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

GENERAL:

Negative for change in appetite,
weight loss, fever, chills, sweats.

EYES:

Eye irritation yes.

NOSE:

Negative for epistaxis, sinusitis.
Postnasal drip yes.

RESPIRATORY:

Negative for shortness of breath,
cough, hemoptysis, chest
congestion.

CARDIOVASCULAR:

Negative for chest pain,
palpitations, orthopnea.

GASTROINTESTINAL:

Negative for nausea, vomiting,
diarrhea, reflux.

NEUROLOGIC:

Headache yes.

OTHER:

Snoring yes.

PULM SKIN:

Negative for skin rashes.

Date - 04/27/2011) (Collection Date -
04/27/2011)

Result: Pt. unable to give good effort due to
pain.

FVC-Pre (Liters)	3.26
FVC%-Pre	58%
FEV1-Pre (Liters)	1.71
FEV1%-Pre	40%
FEV1/FVC%-Pre	52%
FEF25-75%-Pre (L/sec)	1.04

Examination

FOLLOWUP:

General normal general appearance. ENT nasal mucosa normal, septum midline, oropharynx benign, Nasal mucosa congested and edematous, Narrow airway in the oropharynx, large tongue and a low soft palate, , no thrush. Respiratory chest symmetric, normal expansion and effort, few crackles at the right base, no wheezing slightly reduced breath sounds. Cardiovascular regular rate and rhythm, no murmurs, gallops or rubs, peripheral vascular normal by observation and palpation. Abdomen soft, nontender, normal bowel sounds, no hepatosplenomegaly. Extremities no clubbing, cyanosis or edema. Neuro/Psych alert and oriented, normal mood and affect.

PULM-Chest X-rays:

Chest x-ray, PA and lateral was done in the office today and person reviewed by me. There is cardiomegaly, cardiac device in the left chest, and sternal wires. There is blunting of the right costophrenic angle, however I do not appreciate a pleural effusion on the lateral view. No obvious bony abnormality. X-ray is free of chest compared to previous film done March 8, 2011.

Assessments

1. Chronic airway obstruction NEC - 496 (Primary)
2. DYSPNEA - 786.09
3. CAD - 414.00
4. Allergic rhinitis - 477.9
5. Snoring - 786.09

Treatment

1. Chronic airway obstruction NEC

Continue Spiriva Inhaler, 1 puff, QD

I've asked him to continue using Spiriva on a daily basis, especially as he is due to begin cardiac rehab, and I would not want a pulmonary limitation to prevent him from exercising to capacity. I will repeat his forearm entry at his return appointment. It should be noted that his preoperative pulmonary function studies did reveal moderate obstruction, but also a reduction in forced vital capacity, which was also seen on pulmonary function studies done today.

2. Allergic rhinitis

Start Flonase spray, 0.05 mg/inh, 1 spray(s), intranasally, once a day, 30 day(s), 1, Refills 6

Start Allegra 180 mg tablet, 180 mg, 1 tab(s), orally, once a day, 30 day

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang,
MD 04/27/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

(s), 30

3. Snoring

Diagnostic Imaging: Polysomnography (Sleep study), Baseline (Ordered for 05/04/2011)

We discussed the pathophysiology of obstructive sleep apnea, treatment options including CPAP mask, surgery, dental appliances, positional therapy and what to expect from treatment. Explanation of natural course of disease and associated disorders. The detrimental effects of untreated obstructive sleep apnea were relayed including stroke, HTN, arrhythmias, and pulmonary hypertension. Drowsy driving/sleepiness counseling. We also discussed central apneas and restless leg syndrome. We discussed risk factor identification, explanation of exacerbating factors, and risk factor modification. The importance of diet, exercise, and particularly weight loss were discussed. We reviewed simple strategies to reach this goal, including patient's role in treatment, address their concerns and set goals. Handouts on obstructive sleep apnea and CPAP were provided. We will check PSG to evaluate for possible OSA and start CPAP if indicated.

Labs

Lab: PFT Full Study (Lung volumes & DLCO) Pt. unable to give good effort due to pain.

FVC-Pre (Liters)	3.26
FVC%-Pre	58%
FEV1-Pre (Liters)	1.71
FEV1%-Pre	40%
FEV1/FVC%-Pre	52%
FEF25-75%-Pre (L/sec)	1.04

Chang, Catherine 04/27/2011 10:29:02 AM EDT > Impression: There is the suggestion of a combined obstructive and restrictive ventilatory defect. Chang, Catherine 04/27/2011 11:12:11 AM EDT > Review of flow volume loop is borderline suspicious for a fixed airway obstruction. The expiratory limb is not completely flat.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt.. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

2 Months (Reason: spirome Epworth sleepiness scale)

Electronically signed by Catherine Chang on 04/27/2011 at 11:16 AM EDT

Sign off status: Completed

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang, MD 04/27/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Pulmonary Disease (PTWD) Associates -Patewood (PULE)
200 Patewood Blvd.
Greenville, SC 29615
Tel: 864-454-4200
Fax: 864-454-4205

Patient: WORTHEN, MICHAEL PHILIP DOB: 09/08/1956 Progress Note: Catherine Chang,
MD 04/27/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Lung Center
200 Patewood Dr. B 300
Greenville, SC 29615
864-454-4200

Reference values have been changed! Comparison to prior studies should use actual number not percent predicted.

PFT Lab Report

ID: 971366670

Name: WORTHEN, MICHAEL

Age: 54 Height(in): 74.0

Weight(lb): 272 Gender: Male

Race: Caucasian

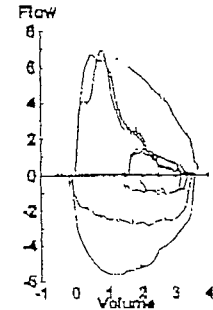
Date: 06/23/11

Technician: TMJ

Physician: DR. CHANG

Diagnosis:

		Ref		Pre	% Ref	Post	% Ref	% Chg
Spirometry								
FVC	Liters	5.65	(4.6 - 6.7)	(3.59)	(64)	(3.63)	(64)	1
FEV1	Liters	4.33	(3.5 - 5.2)	(2.48)	(57)	(2.46)	(57)	-1
FEV1/FVC	%	77	(67.2 - 86.6)	69		68		
FEF25-75%	L/sec	3.66	(1.9 - 5.4)	(1.54)	(42)	(1.25)	(34)	-18
PEF	L/sec	10.55	(8.0 - 13.1)	(6.68)	(63)	(6.91)	(65)	3
FVL ECode				000010		000100		



Comments:

PFT B/A PT GIVEN 4 PUFFS OF ALBUTEROL.TMJ

Intepretation:

CALIBRATION: Pred Volume: 3.00 Expire Avg: 3.00

Inspire Avg: 3.00

Flow Cal Date: 06/23/11

() = OUTSIDE 95% CONFIDENCE INTERVAL

PF Reference: NHANES III - Caucasian

Version: IVS-0101-20-5B

Lung Center
200 Patewood Dr. B 300
Greenville, SC 29615
864-454-4200



ID: 264178874
 Name: WORTHEN, MICHAEL
 Race: Caucasian Weight(lb): 256 Height(in): 74.0
 Date: 04/27/11 Gender: Male Age: 54

Reference values have changed! Comparison to prior studies should use actual number not percent predicted.

Technician: SKS

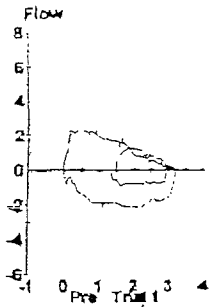
Physician: DR. CHANG

Diagnosis:

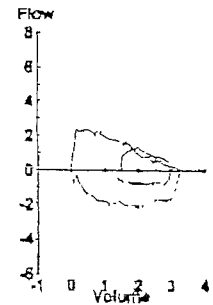
PFT Lab Report

		Ref		Pre	% Ref	Post	% Ref	% Chg
Spirometry								
FVC	Liters	5.65	(4.6 - 6.7)	(3.26)	(58)			
FEV1	Liters	4.33	(3.5 - 5.2)	(1.71)	(40)			
FEV1/FVC	%	77	(67.2 - 86.6)	(52)				
FEF25-75%	L/sec	3.66	(1.9 - 5.4)	(1.04)	(28)			
PEF	L/sec	10.55	(8.0 - 13.1)	(2.31)	(22)			
FVL ECode				111010				

	Pre	Trial 1	Trial 2	Trial 3	Trial 4	Trial 5	Trial 6	Trial 7	Trial 8
Spirometry									
FVC	Liters	(3.26)							
FEV1	Liters	(1.71)							



BEST GRAPH



Comments:

PT HAVING A LOT OF PAIN TODAY FROM HIS SURGERY AND UNABLE TO GIVE GOOD EFFORT FOR THE TEST. SKS

Interpretation:

CALIBRATION: Pred Volume: 3.00 Expire Avg: 2.99

Inspire Avg: 3.01

Flow Cal Date: 04/27/11

() = OUTSIDE 95% CONFIDENCE INTERVAL

PF Reference: NHANES III - Caucasian

Version: IVS-0101-20-5B

Lung Center
200 Patwood Dr. B 300
Greenville, SC 29615
864-454-4200



ID: 264178874
 Name: WORTHEN, MICHAEL
 Race: Caucasian Weight(lb): 256 Height(in): 74.0
 Date: 04/27/11 Gender: Male Age: 54

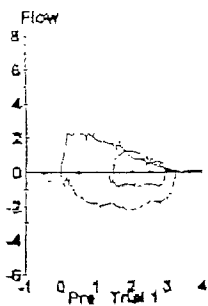
Reference values have changed! Comparison to prior studies should use actual number not percent predicted.

Technician: SKS
 Physician: DR. CHANG

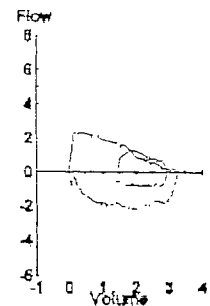
PFT Lab Report

		Ref		Pre	% Ref	Post	% Ref	% Chg
Spirometry								
FVC	Liters	5.65	(4.6 - 6.7)	(3.26)	(58)			
FEV1	Liters	4.33	(3.5 - 5.2)	(1.71)	(40)			
FEV1/FVC	%	77	(67.2 - 86.6)	(52)				
FEF25-75%	L/sec	3.66	(1.9 - 5.4)	(1.04)	(28)			
PEF	L/sec	10.55	(8.0 - 13.1)	(2.31)	(22)			
FVL ECode				111010				

	Pre	Trial 1	Trial 2	Trial 3	Trial 4	Trial 5	Trial 6	Trial 7	Trial 8
Spirometry									
FVC	Liters	(3.26)							
FEV1	Liters	(1.71)							



BEST GRAPH



Comments:

PT HAVING A LOT OF PAIN TODAY FROM HIS SURGERY AND UNABLE TO GIVE GOOD EFFORT FOR THE TEST. SKS

Interpretation:

CALIBRATION: Pred Volume: 3.00 Expire Avg: 2.99

Inspire Avg: 3.01

Flow Cal Date: 04/27/11

() = OUTSIDE 95% CONFIDENCE INTERVAL

PF Reference: NHANES III - Caucasian

Version: IVS-0101-20-5B

Respondents' APA Submission #10

HMH
ER PATIENT RECORD

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 264178874
AcctNum: 03006915933

Patient Data

Complaint: Shoulder — pain (specify)
Triage Time: Fri Feb 18, 2011 23:21
Urgency: 3—Urgent
Bed: ED ED

ED Attending: Clardy, MD, Alan
Primary RN: Alexander, RN, Katina A.

Initial Vital Signs: 2/18/2011 23:15

BP: 157/104

R: 18

O2 sat: 97 on ra

P: 86

T: 98.2

Pain: 10

PRESENTING PROBLEM (Fri Feb 18, 2011 23:21 SB00)

Presenting problems: Shoulder Injury—Pain—Swelling.

TRIAGE (Fri Feb 18, 2011 23:21 SB00)

PATIENT: NAME: Michael P Worthen, AGE: 54, GENDER: male, DOB: Sat Sep 08, 1956, TIME OF GREET: Fri Feb 18, 2011 23:07, LANGUAGE: English, RACE: Caucasian, Infectious Disease: Not Applicable, Travel History: No foreign travel in past 10 days, Poss. H1N1 Flu: No contact with person with flu, Homicidal/Suicidal: Denies homicidal tendencies / history, Smoking Cessation: Denies smoking in past 12 months, SSN: 264178874, MEDICAL RECORD NUMBER: 264178874, ACCOUNT NUMBER: 03006915933, PERSON ID: 264178874.

ADMISSION: URGENCY: 3—Urgent. ADMISSION SOURCE: HOME, TRANSPORT: private vehicle, DEPT: Emergency, BED: WAITING.

VITAL SIGNS: BP 157/104, Pulse 86, Resp 18, Temp 98.2, Pain 10, O2 Sat 97, on ra, Time 2/18/2011 23:15.

COMPLAINT: COMPLAINT: Shoulder — pain (specify).

HISTORY OF PRESENT COMPLAINT: Pt c/o left shoulder pain that started this afternoon. States he was in bed and must have rolled on it wrong. Pt states he cannot lift his arm.

ASSESSMENT: Pain level 10, using numeric pain scoring.

TREATMENTS PRIOR TO ARRIVAL: No treatment.

TREATMENTS IN TRIAGE: No treatment.

PROVIDERS: TRIAGE NURSE: Shelly L. Brown, RN.

ES LEVEL: ES level 3.

ADMIN

PATIENT DATA CHANGE: Primary Nurse changed from (none) to Katina A. Alexander, RN. (Sat Feb 19, 2011 00:10 KAA)

Attending changed from (none) to Alan Clardy, MD. (Sat Feb 19, 2011 00:23 ARC)

Extender changed from (none) to Heather L. Evon, PCT. (Sat Feb 19, 2011 00:33 HLE)

A08 CHPFQP02 by Interface, Zip code: 29680, Phone number: (864)915-0039. (Sat Feb 19, 2011 01:36)

KNOWN ALLERGIES

Type of insulin.

VITAL SIGNS

VITAL SIGNS: BP: 157/104, Pulse: 86, Resp: 18, Temp: 98.2, Pain: 10, O2 sat: 97 on ra, Time: 2/18/2011 23:15.

(23:15 SB00)

BP: 142/86, Pulse: 90, Resp: 16, Pain: 4, O2 sat: 98, Time: 2/19/2011 02:04. (Sat Feb 19, 2011 02:04 ACG)

PAST MEDICAL HISTORY

MEDICAL HISTORY: History of diabetes, type II, That is currently treated with insulin, History of endocrine disease, including hyperthyroidism, History of hyperlipidemia, including high cholesterol, which has been treated, History of hypertension, which has been treated. (Fri Feb 18, 2011 23:21 SB00)

SURGICAL HISTORY: History of spinal surgery, eye, . (Fri Feb 18, 2011 23:21 SB00)

PSYCHIATRIC HISTORY: No previous psychiatric history. (Fri Feb 18, 2011 23:21 SB00)

SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives with others, Denies smoking. (Fri Feb 18, 2011 23:21 SB00)

FAMILY HISTORY: Family history is not contributory to this case. (Fri Feb 18, 2011 23:21 SB00)

NOTES: Nursing records reviewed, Agree with nursing records, Old chart reviewed, Medication list reviewed.

HMH
ER PATIENT RECORD

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 264178874
AccNum: 03006915933

(Sat Feb 19, 2011 00:42 ARC)

CURRENT MEDICATIONS

Novolin 70/30 (23:22 SB00)

Lisinopril (23:22 SB00)

GlipizIDE (23:23 SB00)

HPI SHOULDER (Sat Feb 19, 2011 00:41 ARC)

CHIEF COMPLAINT: Patient presents for the evaluation of **left, shoulder pain, shoulder decreased ROM, shoulder tenderness, shoulder decreased use.**

HISTORIAN: History obtained from patient.

MECHANISM: Complaint occurred by **No trauma by history.**

OCCURRED: Onset was this afternoon, Patient currently has symptoms, Complaint is persistent.

LOCATION: Pain in shoulder, diffusely, Radiation is proximal, Radiation is distal.

QUALITY: Patient describes pain as sharp, Patient describes pain as stabbing, Patient describes pain as aching, Patient describes pain as cramping.

ASSOCIATED WITH: Patient denies clavicle pain, Patient denies elbow pain, Patient denies wrist pain, Patient denies hand pain, Patient denies finger pain, Patient denies distal neuro c/o.

SEVERITY: Maximum severity is severe, Currently symptoms are severe.

EXACERBATED BY: Patient's condition exacerbated by movement.

RELIEVED BY: Patient's condition relieved by nothing.

NOTES: Pt took a nap and woke with shoulder pain, thinks he slept on it wrong, Pt states it feels like when he dislocated his shoulder.

ROS (Sat Feb 19, 2011 00:42 ARC)

NOTES: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM (Sat Feb 19, 2011 00:42 ARC)

CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed, Patient has normal pulse, Patient has normal respiratory rate, Well appearing, Patient appears comfortable, Alert and oriented X 3, **Hypertensive.**

HEAD: Atraumatic, Normocephalic.

EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal, Conjunctiva are normal.

ENT: Ears normal to inspection, Nose examination normal, Posterior pharynx normal, Mouth normal to inspection.

NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine nontender.

RESPIRATORY CHEST: Chest is nontender. Breath sounds normal, No respiratory distress.

CARDIOVASCULAR: RRR, No murmurs, Normal S1 S2, No rub, No gallop.

ABDOMEN: Abdomen is nontender, No masses, Bowel sounds normal, No distension, No peritoneal signs.

BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.

UPPER EXTREMITY: No cyanosis. No clubbing, No edema, **Left shoulder range of motion is limited**, Shoulder exam shows, **LEFT** shoulder to have, no deformity, no ecchymosis, no swelling, no hematoma, no erythema, no warmth, no muscle atrophy, distal pulse intact, capillary refill less than 2 seconds, distal motor intact, distal sensory intact, **Tenderness to palpation, of scapula, of glenohumeral joint, Active range of motion:, limited, causes pain, Passive range of motion, limited, causes pain.**

NEURO: GCS is 15, No focal motor deficits, No focal sensory deficits.

SKIN: Skin is warm, Skin is dry, Skin is normal color.

PSYCHIATRIC: Oriented X 3, Normal affect.

DIAGNOSIS (Sat Feb 19, 2011 01:37 ARC)

FINAL: PRIMARY: Shoulder strain , ADDITIONAL: Muscle spasms .

DOCTOR NOTES (Sat Feb 19, 2011 00:44 ARC)

TEXT: pt may have slipped shoulder out of joint and spontaneously relocated, now with spasms.

HMH
ER PATIENT RECORD

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 264178874
AcctNum: 03006915933

ORDERS

DX SHOULDER AP/LAT/AXILARY by JMB for BJT9 on Fri Feb 18, 2011 23:50

Status: Active.

Sling (specify site) by ARC for ARC on Sat Feb 19, 2011 00:34 Status: Done by KAA Sat Feb 19, 2011 00:43.

ER THER PROPH/DX INJ,SQ/IM by KAA for ARC on Sat Feb 19, 2011 00:58 Status:

Active.

ER THER PROPH/DX INJ,SQ/IM by KAA for ARC on Sat Feb 19, 2011 00:59 Status:

Active.

ER THER PROPH/DX INJ,SQ/IM by KAA for ARC on Sat Feb 19, 2011 00:59 Status:

Active.

ER THER PROPH/DX INJ,SQ/IM by ACG for ARC on Sat Feb 19, 2011 01:39 Status:

Active.

MEDICATION SERVICE

Dilaudid: Order: Dilaudid (Hydromorphone Hydrochloride) – Dose: 1mg : intramuscular injection

Time: now

POTENTIAL MODERATE INTERACTION: Lisinopril

Ordered by: Alan Clardy, MD

Entered by: Alan Clardy, MD Sat Feb 19, 2011 00:34 ,

Acknowledged by: Katina A. Alexander, RN Sat Feb 19, 2011 00:43

Documented as given by: Katina A. Alexander, RN Sat Feb 19, 2011 00:59

Patient, Medication, Dose, Route and Time verified prior to administration.

Time given: 0058, IM medication, Amount given: 1mg, Medication administered to right buttock.

Dilaudid: Order: Dilaudid (Hydromorphone Hydrochloride) – Dose: 1mg : intramuscular injection

Time: now

POTENTIAL MODERATE INTERACTION: Lisinopril

POTENTIAL MODERATE INTERACTION: Valium (Diazepam)

Ordered by: Alan Clardy, MD

Entered by: Alan Clardy, MD Sat Feb 19, 2011 01:32 ,

Acknowledged by: Aimee C. Goss, RN Sat Feb 19, 2011 01:36

Documented as given by: Aimee C. Goss, RN Sat Feb 19, 2011 01:39

Patient, Medication, Dose, Route and Time verified prior to administration.

IM medication, given in amount and via route as prescribed, Medication administered to right buttock, Correct

patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and

side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Ketorolac Tromethamine: Order: Ketorolac Tromethamine – Dose: 30mg : intramuscular injection

Time: now

POTENTIAL MODERATE INTERACTION: GlipiZIDE

POTENTIAL MODERATE INTERACTION: Lisinopril

Ordered by: Alan Clardy, MD

Entered by: Alan Clardy, MD Sat Feb 19, 2011 00:35 ,

Acknowledged by: Katina A. Alexander, RN Sat Feb 19, 2011 00:43

Documented as given by: Katina A. Alexander, RN Sat Feb 19, 2011 00:59

Patient, Medication, Dose, Route and Time verified prior to administration.

Time given: 0058, IM medication, Amount given: 30mg, Medication administered to left buttock, Correct patient,

time, route, dose and medication confirmed prior to administration, Patient advised of actions and

side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Valium: Order: Valium (Diazepam) – Dose: 5 mg : intramuscular injection

Time: now

POTENTIAL MODERATE INTERACTION: Dilaudid (Hydromorphone Hydrochloride)

POTENTIAL MODERATE INTERACTION: Lisinopril

Ordered by: Alan Clardy, MD

Entered by: Alan Clardy, MD Sat Feb 19, 2011 00:35 ,

Acknowledged by: Katina A. Alexander, RN Sat Feb 19, 2011 00:43

HMH ER PATIENT RECORD

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 264178874
AcctNum: 03006915933

Documented as given by: Katina A. Alexander, RN Sat Feb 19, 2011 00:58
Patient, Medication, Dose, Route and Time verified prior to administration.
Time given: 0058, IM medication, Amount given: 5mg, Medication administered to right deltoid, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

MEDICATION ADMINISTRATION SUMMARY (Sat Feb 19, 2011 02:13)

Drug Name	Dose	Route	Status	Time
Dilaudid	1mg	intramuscular injection	Given	01:39 2/19/2011
Dilaudid	1mg	intramuscular injection	Given	00:59 2/19/2011
Ketorolac Tromethamine	30mg	intramuscular injection	Given	00:59 2/19/2011
Valium	5 mg	intramuscular injection	Given	00:58 2/19/2011

Detailed record available in Medication Service section.

PRESCRIPTION (Sat Feb 19, 2011 01:35 ARC)

Flexeril: Tablet : 10 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: three times daily

Dispense: *** 21 ***

POTENTIAL MODERATE INTERACTION: Dilaudid (Hydromorphone Hydrochloride)

POTENTIAL MODERATE INTERACTION: Valium (Diazepam).

NOTES: for spasms

DEA: BC5930638

NPI: 1265533947

MLN: 22664

Naprosyn: Tablet : 500 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: twice daily Dispense: *** 14 ***

POTENTIAL SEVERE INTERACTION: Ketorolac Tromethamine

POTENTIAL MODERATE INTERACTION: Lisinopril

POTENTIAL MODERATE INTERACTION: GlipizIDE.

NOTES: with food

DEA: BC5930638

NPI: 1265533947

MLN: 22664

Roxicodone: Tablet : 5 mg : Oral : Quantity: *** 1-2 *** Unit: tab Route: Oral Schedule: every six hours

Dispense: *** 20 ***

POTENTIAL MODERATE INTERACTION: Lisinopril

POTENTIAL MODERATE INTERACTION: Valium (Diazepam).

NOTES:

DEA: BC5930638

NPI: 1265533947

MLN: 22664

NURSING ASSESSMENT: EXTREMITY UPPER (Sat Feb 19, 2011 01:00 KAA)

CONSTITUTIONAL: Patient arrives ambulatory with steady gait to treatment area. History obtained from patient.

Patient is cooperative, Patient is alert and oriented x 3, Patient appears in no acute distress, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink.

LEFT UPPER EXTREMITY: Area of assessment is shoulder. Pain described as throbbing, Pain is continuous, On a scale 0-10 patient rates pain as 10, Pain non-radiating, no deformity noted.

RIGHT UPPER EXTREMITY: No complaint of pain.

SAFETY: Side rails up, Cart in lowest position. Family at bedside.

NURSING PROCEDURE: TRANSPORT TO TESTS (Sat Feb 19, 2011 00:09 JMB)

HMH
ER PATIENT RECORD

Worthen, Michael P
DOB: 9/8/1956 M54
Wt/Ht:
MedRec: 264178874
AcctNum: 03006915933

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for test:
facilitate diagnosis, Procedure was performed at 2355, Patient transported to, X-ray, Patient transported via,
wheelchair, After procedure, patient returned to ED at 0010, Patient tolerated procedure with difficulty.

NURSING PROCEDURE: NURSE NOTES (Sat Feb 19, 2011 00:13 JMB)

TIME: Time: 0017, pt told me in quick reg that this injury and pain was acute and onset was tonight. pt told
rad tech that the pain had been present for 3 days. pt misinformed me of his situation for unknown reason. .

NURSING PROCEDURE: SPLINTING (Sat Feb 19, 2011 00:17 JMB)

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for procedure:
pain control, Sling applied, sling applied in quick reg upon arrival, pt reluctant to wear sling and states
"won't do any good". sling applied regardless with good cap refill.

NURSING PROCEDURE: DISCHARGE NOTE (Sat Feb 19, 2011 02:04 ACG)

TIME: Patient discharged to, home, Patient, ambulates without assistance, Transported via friend/family
driving, Accompanied by family member, Patient instructed not to drive home, Discharge instructions given to,
patient, Simple/moderate discharge teaching performed, Prescription given and additional instructions on side
effects of same given, Medication reconciliation form given to patient, Above Person(s) verbalized
understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician.

VITAL SIGNS: BP: 142, / 86, Pulse: 90, Resp: 16, Pain: 4, O2 sat: 98.

INSTRUCTION (Sat Feb 19, 2011 01:39 ARC)

DISCHARGE: MUSCLE STRAIN.

SPECIAL: Advance activity as tolerated

- Encourage fluids
- Follow up with primary care physician
- Ice and elevate
- Light duty-injured area
- Return if worse, or if new problems develop
- Take medication as prescribed
- Tylenol for Pain.

DISPOSITION

PATIENT: Disposition: Discharge home, Condition: Stable. (Sat Feb 19, 2011 01:37 ARC)

Remove from ER. (Sat Feb 19, 2011 02:11 ACG)

MEDICATION RECONCILIATION (Sat Feb 19, 2011 01:36 ARC)

GlipiZIDE – Continue as previously prescribed: (No Reconciliation Information).

Lisinopril – Continue as previously prescribed: (No Reconciliation Information).

Novolin 70/30 – Continue as previously prescribed: (No Reconciliation Information).

ADDITIONAL NOTES: Reviewed with patient.

Key:

ACG=Goss, RN, Aimee C. ARC=Clardy, MD, Alan HLE=Evon, PCT, Heather L. JMB=Bauguess, NST, Michael
KAA=Alexander, RN, Katina A. SB00=Brown, RN, Shelly L.

HILLCREST MEMORIAL HOSPITAL
HMH RADIOLOGY
GREENVILLE, SC

Patient Name: WORTHEN, MICHAEL
DOB: 09/08/1956
SEX: Male
Reason for Exam: PAIN (SHOULDER)

Medical Record#: 264178874
Pt. NS/Room: 03ER / 03ER
Corp. Act. No:
Patient Type: Emergency

Account: 03006915933
Ordering MD: B. JASON, THEILING, MD
GHS - EMERGENCY SERVICES
701 GROVE ROAD
GREENVILLE, SC 29605

RX495577L-LEFT SHOULDER AP/LAT/AXILARY 02/18/2011 23:51PM EXAM#: 11689493

IMPRESSION:
NO DEFINITE FRACTURE.

RESULT: WORTHEN, MICHAEL

LEFT SHOULDER AP, INTERNAL AND EXTERNALLY ROTATED AND Y-VIEW.

CLINICAL: The patient's age is 54 and he has pain in the shoulder after a left shoulder injury.

FINDINGS: I see no definite scapular, distal clavicular or humeral fracture or dislocation.

TRANSCRIPTIONIST: WARRENIA, STEWART
TRANSCRIBE TIME/DATE: 2/19/2011 3:11:00 PM
READ BY: A. RONALD COWLEY, MD,
SIGNED BY: ELECTRONIC SIGNATURE / COWLEY, MD, A. RONALD - 2/19/2011
4:28:09 PM



Name: Worthen, Michael P
Age: 54Y DOB: Sep 08, 1956
Gender: M
MedRec: 264178874
AcctNum: 03006915933
Attending: ARC
Primary RN: KAA
Bed: ED ED 06

HMH DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS

Shoulder strain

ADDITIONAL DIAGNOSIS

Muscle spasms

FOLLOWUP CONTACTS

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN

Advance activity as tolerated
Encourage fluids
Follow up with primary care physician
Ice and elevate
Light duty-injured area
Return if worse, or if new problems develop
Take medication as prescribed
Tylenol for Pain

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN

MUSCLE STRAIN

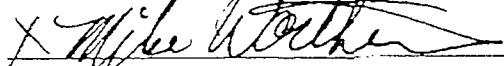
THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Roxicodone : Tablet : 5 mg : Oral
Dispense: 20, Quantity: 1-2, Unit: tab, Route: Oral, Schedule: every six hours

Naprosyn : Tablet : 500 mg : Oral
Dispense: 14, Quantity: 1, Unit: tab, Route: Oral, Schedule: twice daily

Flexeril : Tablet : 10 mg : Oral
Dispense: 21, Quantity: 1, Unit: tab, Route: Oral, Schedule: three times daily

"I Understand the written and discussed instructions. My questions have been answered."



Patient or responsible person

Physician or Nurse

0211

HMH

EMERGENCY FLOW SHEET RECORD

Name: Worthen, Michael Age: 54Y MR: 264178874 Acct: 03006915933

VITAL SIGNS

User	Date/Time	BP	PULSE	RESP	TEMP	PAIN	O2 SAT	TIME
ACG	Sat Feb 19, 2011 02:05	142/86	90	16		4	98	2/19/2011 02:04
SB00	Fri Feb 18, 2011 23:21	157/104	86	18	98.2	10	97 on ra	2/18/2011 23:15

309
275

Name: Worthen, Michael Age: 54Y MR: 264178874 Acct: 03006915933

Prepared: Sat Feb 19 02:13:57 2011 by Page: 1

Respondents' APA Submission #11

Internal Medicine Associates of Greenville, P.A.
1025 Verdae Blvd, Suite A
Greenville, South Carolina 29607

Telephone (864)242-4683
Fax (864)240-8104

CHIEF COMPLAINT:

Body aches, fever, & chills

HISTORY OF PRESENT ILLNESS:

On 02/17/2011, Michael Worthen, a 54 year old male presented with:

sudden onset fevers, chills, severe body aches. also with headache, mild nausea and loose stools. started yesterday. works as an EMT. did not get his flu shot. has likely exposure to the flu with patient transport. Feels some congestion in his chest with some burning pressure in chest only when laying back. no productive sputum

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. fenofibrate 160 mg Tab, 1 PO Q Day
3. glipizide 10 mg Tab, 1 po bid
4. levothyroxine 200 mcg Tab, 1 po qd
5. levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
6. quinapril 5 mg Tab, 1 po qd
7. One Touch Ultra Test Strips, AND LANCETS 2 TIMES PER DAY
8. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 54U @ BKFT AND 52U @ SUPPER
9. Insulin Syringe 1 mL 30 x 5/16", USE BID WITH INSLIN
10. Prilosec OTC 20 mg Tab, 1 po qd
11. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
12. Multivitamin Tab, 1 po qd

ALLERGIES: Insulin that he can't remember name of- Hives

EXAMINATION:

VITAL SIGNS: B/P - 130/90, Sitting, Right arm, large cuff;

Pulse - 76: Regular, Respiration - 20, Temperature - 99.8: Taken Orally
O2SAT 98

CONSTITUTIONAL - appears ill

SKIN - no rash

HEAD - Normal. No trauma.

EYE - conjunctiva injected

ENT - mucosa pink and moist and TM's intact

NECK - no nodes

CHEST - clear to auscultation, no wheezing and no crackles

CARDIAC - regular rhythm

EXTREMITIES - no edema

NEUROLOGICAL - Alert, oriented, no focal signs.

ASSESSMENT:

1. Influenza-like Disease - New

PLAN: check rapid flu. no work for 3 311 - least. start tamiflu. rest, push

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued fluids. call if any SOB or worsening pulmonary symptoms. he is an EMT and is aware of what symptoms to watch for

DRUG RX:

1. Tamiflu 75 mg, Oral Cap, #10, 1 po bid, Refills: 0

Entered by: AMY Z WELCOME MD

~

Electronically signed by AMY Z WELCOME MD 2/17/2011 16:26:43

CHIEF COMPLAINT:

follow up of multiple medical problems

HISTORY OF PRESENT ILLNESS:

On 01/20/2011, Michael Worthen, a 54 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as above normal levels of Triglycerides, below normal levels of HDL and elevated TG GREATER THAN 150. The patient is on a low fat diet. The patient reports the following complications: HTN, DM and obesity. Since taking the medication, the patient has improving. Side effects reported by the patient are as follows: none. The patient denies the following: chest pain, abdominal pain, focal weakness. There is family history of hyperlipidemia.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance patient has been more compliant with diet and has started to exercise. Since taking the prescribed medication, the severity has been Alc is 9.5. Side effects reported by the patient are none. Glucose levels were reported by the patient to be 150-208. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Patient states for the past 3 weeks, his FSGs have been a lot better than they have been as compared to the past 3 months.

hypothyroidism, which began 9 years ago. Severity was described as well controlled. It is aggravated by non-compliance with medication and relieved by Synthroid. An associated sign and symptom is none. The patient denies the following: changes in bowel habits, changes in hair texture, changes in skin texture, cold intolerance, constipation, diarrhea, dry hair, goiter, nervousness and palpitations.

-- Hypertension, which began recent diagnosis. Severity was described as well controlled. It is relieved by medication (ACE inhibitors).

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Fenofibrate 160 mg Tab, 1 PO Q Day
3. glipizide 10 mg Tab, 1 po bid
4. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 46 units q am and 46 units q pm
5. levothyroxine 200 mcg Tab, 1 po qd
6. levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
7. Prilosec OTC 20 mg Tab, 1 po qd
8. Quinapril 5 mg Tab, 1 po qd
9. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
10. Multivitamin Tab, 1 po qd

ALLERGIES: Insulin that he can't remember name of- Hives

HEALTH MAINTENANCE HISTORY:

Tetanus Shot: 03/20/05

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
 Cholesterol: 01/19/11
 Colonoscopy: 06/20/05 normal
 Dilated Eye Exam: 05/20/07
 HgbA1c: 04/20/11
 Physical Exam: 04/28/10
 Urinalysis: 04/28/10
 HGBA1C: 01/19/11

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago and L 3rd toe amputation. Other Physicians - New Horizon

EXAMINATION:

VITAL SIGNS: B/P - 128/74, Sitting, Right arm, large cuff;

Pulse - 80: Regular, Respiration - 18

Height: 72 inches

Weight: 288.60 lbs. BMI 39.14

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

LOWER EXTREMITIES -

LEG/ANKLE : Inspection - no erythema, no edema and no deformity;

all Observation Details			Value	Ref_
Range	Abnrm1	Site		
=====				
01/19/11	*Creatine Kinase (CPK), Total/CPK		118 IU/L	
40 - 186	POLYTECH			
01/19/11	*Hepatic Panel/ALT(SGPT)		31 IU/L	
9 - 44	POLYTECH			
01/19/11	*Hepatic Panel/AST(SGOT)		24 IU/L	
12 - 38	POLYTECH			
01/19/11	*Hepatic Panel/Total Protein		7.1 g/dL	
6.0 - 8.0	POLYTECH			
01/19/11	*Hepatic Panel/Alkaline Phosphatase		84 IU/L	
35 - 117	POLYTECH			
01/19/11	*Hepatic Panel/Albumin		4.1 g/dL	
3.2 - 4.6	POLYTECH			
01/19/11	*Hepatic Panel/Total Bilirubin		0.8 mg/dL	
0.0 - 1.5	POLYTECH			
01/19/11	*Hepatic Panel/Direct Bilirubin		0.1 mg/dL	
0.0 - 0.40	POLYTECH			
01/19/11	*Hepatic Panel/INDIRECT BILIRUBIN		0.7 mg/dL	
	POLYTECH			
01/19/11	*HgbA1C/HGBA1C		9.5 %	
3.2 - 7.0 H	POLYTECH			

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

01/19/11 *Lipid Panel/Cholesterol	130 mg/dL
<200 POLYTECH	
01/19/11 *Lipid Panel/Triglyceride	444 mg/dL
<150 H POLYTECH	
01/19/11 *Lipid Panel/HDL CHOLESTEROL	24.4 mg/dL
39 L POLYTECH	
01/19/11 *Lipid Panel/VLDL	89 mg/dL
POLYTECH	
01/19/11 *Lipid Panel/LDL CHOLESTEROL	16.8 mg/dL
<130 POLYTECH	
01/19/11 *Lipid Panel/LDL/HDL RATIO	0.7 RATIO
POLYTECH	
01/19/11 *Lipid Panel/TOTAL CHOLESTEROL HDL RATIO	5.3 %
POLYTECH	
01/19/11 *TSH/TSH	0.64 UIU/ml
0.30 - 5.00 POLYTECH	

ASSESSMENT:

1. Diabetes Mellitus Type II - Uncontrolled Insulin Dependent
2. Hyperlipidemia, Nos - Improving
3. Hypertension - Controlled
4. Hypothyroidism Nos - Controlled

PLAN:

1. *Follow up visit 3 months - physical - Diabetes Mellitus Type II

FUTURE ORDERS:

1. *TSH - 04/20/11
2. *HgbA1C - 04/20/11
3. *Microalbumin, Urine - 04/20/11
4. *Urinalysis w/ Microscopy - 04/20/11
5. *Glomerular Filtration Rate - 04/20/11
6. *CBC with Plt and Diff - 04/20/11
7. *Basic Metabolic Panel - 04/20/11
8. *Lipid Panel - 04/20/11
9. *Hepatic Panel - 04/20/11
10. *Creatine Kinase (CPK), Total - 04/20/11

Diet comments: Continue a low fat diet for weight loss, Continue a diabetic diet for weight loss and Continue a balanced diet for weight loss
 Medications instructions: continue all other meds; increase insulin dose
 Lifestyle Comments: continue sessions with personal trainers
 Counseling time: Total visit over 15 minutes, greater than 50% of time spent counseling patient regarding: physiology of this disease medication side effects weight reduction proper administration of medications

DRUG RX:

1. fenofibrate 160 mg Tab, 30, 1 PO Q Day, Refills: 3
2. glipizide 10 mg Tab, 60, 1 po bid, Refills: 3
3. levothyroxine 200 mcg Tab, 30, 1 po qd, Refills: 3
4. levothyroxine 50 mcg Tab, 30, 1 PO qd for total of 250mcg qd (take with 200 mcg qd), Refills: 3
5. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 1, 50 units q am and 50 units q pm, Refills: 3
6. quinapril 5 mg Tab, 30, 1 po qd, Refills: 3

The following drugs were stopped:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 46 units q am and 46 units q pm

315

280

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 1/20/2011 9:1:46

Internal Medicine Associates of Greenville, P.A.
1025 Verdae Blvd, Suite A
Greenville, South Carolina 29607

Telephone (864)242-4683
Fax (864)240-8104

CHIEF COMPLAINT:

follow up of multiple medical problems

HISTORY OF PRESENT ILLNESS:

On 10/25/2010, Michael Worthen, a 54 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as above normal levels of Triglycerides, below normal levels of HDL and elevated TG GREATER THAN 150. The patient is on a low fat diet. The patient reports the following complications: HTN, DM and obesity. Since taking the medication, the patient has improving. The patient denies the following: chest pain, abdominal pain, focal weakness. There is family history of hyperlipidemia.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been A1c is 8.3. Side effects reported by the patient are none. Glucose levels were reported by the patient to be 170-180. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia.

hypothyroidism, which began 9 years ago. Severity was described as well controlled. It is aggravated by non-compliance with medication and relieved by Synthroid. An associated sign and symptom is none. The patient denies the following: changes in bowel habits, changes in hair texture, changes in skin texture, cold intolerance, constipation, diarrhea, dry hair, goiter, nervousness and palpitations.

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Levothyroxine 200 mcg Tab, 1 po qd
3. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
4. Prilosec OTC 20 mg Tab, 1 po qd
5. Quinapril 5 mg Tab, 1 po qd
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
8. Warm water/soap soaks to left foot, qd
9. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 35 units q am andd 35 units q pm
10. Glipizide 10 mg Tab, 1 po bid
11. Fenofibrate 54 mg Tab, 1 po qd
12. Multivitamin Tab, 1 po qd

ALLERGIES: Insulin that he can't remember name of- Hives

HEALTH MAINTENANCE HISTORY:

Tetanus Shot: 03/20/05
Cholesterol: 10/21/10
Colonoscopy: 06/20/05 normal
Dilated Eye Exam: 05/20/07
HgbA1c: 01/25/11

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
Physical Exam: 04/28/10
Urinalysis: 04/28/10
HGBA1C: 07/08/10
Refuses Health Maintenance-Influenza Virus Vaccine and Pneumovax.

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago and L 3rd toe amputation. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

REVIEW OF SYSTEMS:

GENERAL - (+) weight gain

SKIN - See HPI

RESPIRATORY - Denies shortness of breath, cough, wheezing

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND. No claudicaion.

GASTROINTESTINAL - Denies nausea, vomiting, diarrhea, constipation, abdominal pain, melena, or bright red blood

ENDOCRINE - See HPI

EXAMINATION:

VITAL SIGNS: B/P - 122/70, Sitting, Right arm, large cuff;

Pulse - 60: Regular, Respiration - 18

Height: 72 inches

Weight: 288.20 lbs. BMI 39.08

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

LOWER EXTREMITIES -

LEG/ANKLE : Inspection - no erythema, no edema and no deformity;

Reviewed Labs: LABS ABNORMAL, see EMR

DECISION MAKING:

ASSESSMENT:

1. Diabetes Mellitus Type II - Active Treatment Insulin Dependent
2. Hyperlipidemia, Nos - Improving
3. Hypertension - Controlled
4. Hypothyroidism Nos - Controlled

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
PLAN:

1. *HgbA1C - Diabetes Mellitus Type II
2. Refer to PCC pls schedule f/u visit - Diabetes Mellitus Type II
3. *Follow up visit 3 months - limited - Diabetes Mellitus Type II

1. Diabetes Mellitus Type II - *HgbA1C
2. Diabetes Mellitus Type II - *Follow up visit 3 months - limited

Referral: Refer to PCC, pls schedule f/u visit, 250.00, Diabetes Mellitus Type II

FUTURE ORDERS:

1. *TSH - 01/25/11
2. *HgbA1C - 01/25/11
3. *Lipid Panel - 01/25/11
4. *Hepatic Panel - 01/25/11
5. *Creatine Kinase (CPK), Total - 01/25/11

Diet comments: Stay on a salt-restricted diet for weight loss, Stay on a low fat diet for weight loss and Stay on a diabetic diet for weight loss
Medications instructions: Take medications as prescribed and increase fenofibrate dose

Lifestyle Comments: Continue a regular exercise program as tolerated

Preventative Health: Influenza vaccine declined by patient and Pneumococcal vaccine declined by patient

Counseling time: Total visit over 25 minutes, greater than 50% of time spent counseling patient regarding: physiology of this disease various treatment options medication side effects further studies needed to workup this disease

DRUG RX:

1. Fenofibrate 160 mg, Oral Tab, #30, 1 PO Q Day, Refills: 3

The following drugs were stopped:

1. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
2. Warm water/soap soaks to left foot, qd
3. Fenofibrate 54 mg Tab, 1 po qd

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 10/25/2010 9:38:33

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CHIEF COMPLAINT:

follow up of multiple medical problems

HISTORY OF PRESENT ILLNESS:

On 08/23/2010, Michael Worthen, a 53 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as above normal levels of Triglycerides, below normal levels of HDL and elevated TG GREATER THAN 150. The patient is on a low fat diet. The patient reports the following complications: HTN, DM and obesity. The patient denies the following: chest pain, abdominal pain, focal weakness. There is family history of hyperlipidemia. He has started fenofibrate without problems.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been A1c is 8.3. Side effects reported by the patient are none. Glucose levels were reported by the patient to be 100-200. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Sugar control has been excellent.

-- His toe amputation wound is almost completely healed. He will going back to work next week.

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
6. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
7. Levothyroxine 200 mcg Tab, 1 po qd
8. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
9. Warm water/soap soaks to left foot, qd
10. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 35 units q am andd 35 units q pm
11. Glipizide 10 mg Tab, 1 po bid
12. Fenofibrate 54 mg, Oral Tab, 1 po qd
13. Multivitamin Oral Tab, 1 po qd

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago and L 3rd toe amputation. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
EXAMINATION:

VITAL SIGNS: B/P - 110/66, Sitting, Right arm, large cuff;

Pulse - 88: Regular, Respiration - 20

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

SKIN - (+) near complete wound healing (by secondary intention) L foot

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

LOWER EXTREMITIES -

LEG/ANKLE : Inspection - no erythema, no edema and no deformity;

FOOT - see skin exam

DECISION MAKING:

ASSESSMENT:

1. Diabetes Mellitus Type II - Active Treatment Insulin Dependent
2. Hyperlipidemia, Nos - Active Treatment
3. Hypothyroidism Nos - Controlled

PLAN:

1. Follow up visit 2 months - intermediate - Diabetes Mellitus Type II

1. Diabetes Mellitus Type II - Follow up visit 2 months - intermediate

FUTURE ORDERS:

1. *TSH - 10/18/10
2. *Basic Metabolic Panel - 10/18/10
3. *Creatine Kinase (CPK), Total - 10/18/10
4. *Hepatic Panel - 10/18/10
5. *Lipid Panel - 10/18/10

Diet comments: Stay on a salt-restricted diet for weight loss, Stay on a low fat diet for weight loss and Stay on a diabetic diet for weight loss

Medications instructions: Continue all current medications

Counseling time: Total visit over 15 minutes, greater than 50% of time spent counseling patient regarding: potential medication side effects

Other: Patient was reassured.

Entered by: DAVID P GUIRAO MD

321
286

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
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Electronically signed by DAVID P GUIRAO MD 8/23/2010 16:40:51

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CHIEF COMPLAINT:

Followup of Diabetes Mellitus Type II

HISTORY OF PRESENT ILLNESS:

On 07/22/2010, Michael Worthen, a 53 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as above normal levels of Triglycerides, below normal levels of HDL and elevated TG GREATER THAN 150. The patient is on a low fat diet. The patient reports the following complications: HTN, DM and obesity. The patient denies the following: chest pain, abdominal pain, focal weakness. There is family history of hyperlipidemia. Recent triglyceride levels are worse.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been A1c is 8.3. Side effects reported by the patient are none. Glucose levels were reported by the patient to be 100-200. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Sugar control has been excellent.

-- Patient is followed at the wound center and healing is progressing as predicted. He denies fever, bleeding, or excessive discharge. The wound is healing by secondary intention

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
6. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
7. Levothyroxine 200 mcg Tab, 1 po qd
8. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
9. Diflucan 150 mg Tab, 1 PO Q Day x 5 days
10. Warm water/soap soaks to left foot, qd
11. Ciprofloxacin 500 mg Tab, 1 PO BID x 10 days
12. Clindamycin 300 mg Cap, 1 PO QID x 10 days
13. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 35 units q am andd 35 units q pm
14. Glipizide 10 mg Tab, 1 po bid

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago and L 3rd toe amputation. Other Physicians - New Horizon

REVIEW OF SYSTEMS:

GENERAL - Denies fever or chills

323

288

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
SKIN - See HPI
RESPIRATORY - Denies shortness of breath, cough, wheezing
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND. No claudicaion.
ENDOCRINE - See HPI

EXAMINATION:

VITAL SIGNS: B/P - 134/78, Sitting, Right arm, large cuff;

Pulse - 86: Regular, Respiration - 20

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

SKIN - (+) good wound healing (by secondary intention) L foot

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

DECISION MAKING:

ASSESSMENT:

1. Diabetes Mellitus Type II - Active Treatment
2. Hyperlipidemia, Nos - Uncontrolled
3. Open Wound Of Unspecified Site With Complication/Left - Active Treatment L foot

PLAN:

1. Follow up visit 1 month - limited - Diabetes Mellitus Type II
2. Clean and bandage wound - Open Wound Of Unspecified Site With Complication/Left

1. Diabetes Mellitus Type II - Follow up visit 1 month - limited
2. Open Wound Of Unspecified Site With Complication/Left - Clean and bandage wound

Medications instructions: Continue all current medications and start fenofibrate

Lifestyle Comments: continue wearing prescription boot till foot wound heals completely

Counseling time: Total visit over 15 minutes, greater than 50% of time spent counseling patient regarding: physiology of this disease various treatment options wound care

DRUG RX:

1. Fenofibrate Micronized 67 mg Cap, 30, 1 PO qhs, Refills: 3

The following drugs were stopped:

1. Diflucan 150 mg Tab, 1 PO Q Day x 5 days
2. Ciprofloxacin 500 mg Tab, 1 PO BID 324 days

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
3. Clindamycin 300 mg Cap, 1 PO QID x 10 days

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 7/22/2010 11:12:41

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CHIEF COMPLAINT:

Followup of Cellulitis Of Toe Nos/Left

HISTORY OF PRESENT ILLNESS:

On 07/08/2010, Michael Worthen, a 53 year old male presented with:

-- cellulitis, which began weeks ago. It is located on the L 3rd toe. Severity was described as worsening. The timing was sudden onset. It is aggravated by DM and relieved by Levaquin. An associated sign and symptom is pain, warmth, tenderness. The patient denies the following: fever, elevated blood sugars. The patient has had L 3rd toe amputation. Patient ended up having an amputation of his L 3rd toe on the night I sent him for a surgical evaluation. He received several days of IV antibiotics. He was discharged several days later with PO antibiotics. He has been followed several times by his vascular surgeon and is seen at the wound care clinic. Post op course has been uneventful.

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Glipizide 10 mg Tab, 1 po bid
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
8. Levothyroxine 200 mcg Tab, 1 po qd
9. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
10. Diflucan 150 mg Tab, 1 PO Q Day x 5 days
11. Warm water/soap soaks to left foot, qd
12. Ciprofloxacin 500 mg Tab, 1 PO BID x 10 days
13. Clindamycin 300 mg Cap, 1 PO QID x 10 days
14. Novolin 70/30 100 Unit/ml (70-30) Susp, Sub-q Inj, 35 units q am andd 35 units q pm

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

REVIEW OF SYSTEMS:

GENERAL - Denies fever or chills

ENDOCRINE - FSGs running from 90-150

EXAMINATION:

VITAL SIGNS: B/P - 116/62, Sitting, L 326 n, large cuff;

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

Weight: 279.20 lbs.

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

SKIN - L foot in walking boot (dressing was just changed prior to appointment)

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Peripheral Pulses - pulses present, equal in upper/lower extremities;
Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

ASSESSMENT:

1. Diabetes Mellitus Type II - Improving
2. Cellulitis Of Toe Nos/Left - Status Post Surgery L 3rd toe
3. Open Wound Of Unspecified Site With Complication/Left - Status Post Surgery L foot

PLAN:

1. *TSH - Hypothyroidism Nos
2. *Basic Metabolic Panel - Diabetes Mellitus Type II
3. *Creatine Kinase (CPK), Total - Diabetes Mellitus Type II
4. *Hepatic Panel - Diabetes Mellitus Type II
5. *HgbA1C - Diabetes Mellitus Type II
6. *Lipid Panel - Diabetes Mellitus Type II
7. Follow up 2 weeks - limited - Diabetes Mellitus Type II

1. - *TSH
2. Diabetes Mellitus Type II - *Basic Metabolic Panel
3. Diabetes Mellitus Type II - *Creatine Kinase (CPK), Total
4. Diabetes Mellitus Type II - *Hepatic Panel
5. Diabetes Mellitus Type II - *HgbA1C
6. Diabetes Mellitus Type II - *Lipid Panel
7. Diabetes Mellitus Type II - Follow up 2 weeks - limited

Medications instructions: Continue all current medications

Lifestyle Comments: will need custom made footwear for work

Physical Therapy: start PT soon

Other: Patient was reassured., He requests 2 week f/u vist. Labs drawn today are still pending

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 7/8/2010 15:11:25

327

292

Internal Medicine Associates of Greenville, P.A.
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Fax (864)240-8104

CHIEF COMPLAINT:
Worsening cellulitis

HISTORY OF PRESENT ILLNESS:

On 06/17/2010, Michael Worthen, a 53 year old male presented with:

-- cellulitis, which began 3 weeks ago. It is located on the L 3rd toe. Severity was described as worsening. The timing was sudden onset. It is aggravated by DM and relieved by Levaquin. An associated sign and symptom is pain, warmth, tenderness. The patient denies the following: fever, elevated blood sugars. Patient completed 2 weeks of Levaquin about a week ago and he states his cellulitis improved but 2 days ago, there was recurrence and rapid spreading of the cellulitis. Patient reports significant improvement of cellulitis.

-- Patient has also reported 3 episodes of hypoglycemia in the middle of the day

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Glipizide 10 mg Tab, 1 po bid
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
8. Levothyroxine 200 mcg Tab, 1 po qd
9. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
10. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 39 units q am andd 35 units q pm
11. Diflucan 150 mg Tab, 1 PO Q Day x 5 days
12. Warm water/soap soaks to left foot, qd

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

EXAMINATION:

VITAL SIGNS: B/P - 122/68, Sitting, Right arm, large cuff;

Pulse - 80, Temperature - 98.1: Taken Orally

CONSTITUTIONAL - in no distress, look **328**: stated age, well nourished, well
293

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
developed and obese

SKIN - severe inflammation, warmth of L 3rd toe extending proximally to distal forefoot and laterally to adjacent toes; (+) fluctuant area 3rd volar MTP joint. (+) crepitations

HEAD - no trauma, normocephalic

ASSESSMENT:

1. Abscess/Left - New L 3rd toe
2. Cellulitis Of Toe Nos/Left - Uncontrolled L 3rd toe
3. Hypoglycemia, Unspecified - Uncontrolled
4. Diabetes Mellitus Type II - Improving

PLAN:

1. Consult General Surgeon RINKLIFF, JOHN M.[00724] ph. 864/232-0055 fax 864/232-0055 35 MEDICAL RIDGE DRIVE DEPARTMENT OF SURGERY GREENVILLE, SC 29605 - Abscess/Left
2. Follow up 1 week - limited - Cellulitis Of Toe Nos/Left

1. Cellulitis Of Toe Nos/Left - Follow up 1 week - limited

FUTURE ORDERS:

1. *TSH - 07/08/10
2. *TSH - 08/04/10
3. *HgbA1C - 08/04/10
4. *Basic Metabolic Panel - 07/08/10
5. *Creatine Kinase (CPK), Total - 07/08/10
6. *Hepatic Panel - 07/08/10
7. *HgbA1C - 07/08/10
8. *Lipid Panel - 07/08/10
9. *Lipid Panel - 08/04/10

Medications instructions: patient refuses admission for IV antibiotics; start Clindamycin and Cipro as outlined below and decrease am dose of insulin by 5 units
Counseling time: Total visit over 25 minutes, greater than 50% of time spent counseling patient regarding: physiology of this disease various treatment options
Other: Dr. Jacques is out on vacation till next week. He will be seen by Dr. Rinkliff for I this afternoon.

DRUG RX:

1. Ciprofloxacin 500 mg Tab, 20, 1 PO BID x 10 days, Refills: 0
2. Clindamycin 300 mg Cap, 40, 1 PO QID x 10 days, Refills: 0
3. Novolin 70/30 100 Unit/ml (70-30) Susp, Sub-q Inj, 0, 35 units q am andd 35 units q pm, Refills: 0

The following drugs were stopped:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 39 units q am andd 35 units q pm

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 6/17/2010 15:36:46

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Fax (864)240-8104

CHIEF COMPLAINT:

Followup of Cellulitis Of Toe Nos/Left
Followup of Diabetes Mellitus Type II

HISTORY OF PRESENT ILLNESS:

On 06/02/2010, Michael Worthen, a 53 year old male presented with:

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been A1c is 10.7. Side effects reported by the patient are none. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Patient was taken off actos because of nausea. He has worked hard with PCC to control his diet. He has lost weight and 4 inches of his waistline. FSGs in the past week have ranged from 100-200+..

-- cellulitis, which began 1 week ago. It is located on the L 3rd toe. Severity was described as improving. The timing was sudden onset. It is aggravated by DM and relieved by antibiotics. An associated sign and symptom is pain, warmth, tenderness. The patient denies the following: fever, elevated blood sugars. Patient recalled having stubbed the affected toe on a wall several days ago. Patient reports significant improvement of cellulitis.

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Glipizide 10 mg Tab, 1 po bid
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
8. Levothyroxine 200 mcg Tab, 1 po qd
9. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
10. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 39 units q am andd 35 units q pm
11. Levaquin 500 mg Tab, 1 PO qd x 7 days

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

EXAMINATION:

VITAL SIGNS: B/P - 118/70, Sitting, F 330 .rm, large cuff;

295

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

Pulse - 82: Regular, Respiration - 20

Height: 72 inches

Weight: 281.00 lbs. BMI 38.11

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

SKIN - (+) improving erythema, tenderness, warmth of patient's whole L 3rd toe; (+) raw weeping area in between L 2nd and 3rd and 3rd and 4th toes

HEAD - no trauma, normocephalic

ASSESSMENT:

1. Tinea Pedis/Left - New
2. Diabetes Mellitus Type II - Improving
3. Cellulitis Of Toe Nos/Left - Improving L 3rd toe
4. Hypothyroidism Nos - Active Treatment

PLAN:

1. Follow up - in 6 weeks - Diabetes Mellitus Type II

1. Diabetes Mellitus Type II - Follow up - in 6 weeks

FUTURE ORDERS:

1. *TSH - 07/08/10
2. *TSH - 08/04/10
3. *HgbA1C - 08/04/10
4. *Basic Metabolic Panel - 07/08/10
5. *Creatine Kinase (CPK), Total - 07/08/10
6. *Hepatic Panel - 07/08/10
7. *HgbA1C - 07/08/10
8. *Lipid Panel - 07/08/10
9. *Lipid Panel - 08/04/10

Diet comments: Stay on a diabetic diet for weight loss and Stay on a balanced diet for weight loss

Medications instructions: continue levaquin x 1 week; take diflucan for 5 days; continue other meds

Counseling time: Total visit over 15 minutes, greater than 50% of time spent

counseling patient regarding: physiology of this disease various treatment options

Other: Call if unimproved, Patient was reassured.

DRUG RX:

1. Diflucan 150 mg Tab, 5, 1 PO Q Day x 5 days, Refills: 0
2. Levaquin 500 mg Tab, 7, 1 PO Q Day x 7days, Refills: 0

Entered by: DAVID P GUIRAO MD

~

Electronically signed by DAVID P GUIRAO MD 6/2/2010 11:0:56

Internal Medicine Associates of Greenville, P.A.
1025 Verdae Blvd, Suite A
Greenville, South Carolina 29607

Telephone (864)242-4683
Fax (864)240-8104

CHIEF COMPLAINT:

Swelling 1 3rd toe

HISTORY OF PRESENT ILLNESS:

On 05/27/2010, Michael Worthen, a 53 year old male presented with:

-- swelling and erythema, which began yesterday. It is located on the L 3rd toe. Severity was described as spreading. The timing was sudden onset. It is aggravated by DM. An associated sign and symptom is pain, warmth, tenderness. The patient denies the following: fever, elevated blood sugars. Patient recalled having stubbed the affected toe on a wall several days ago.

-- Patient has been having hypoglycemic episodes at 2 am associated with nausea. He started Actos around 2 weeks ago. He was instructed to stop actos and follow his FSGs closely. He is also followed at the PCC

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Glipizide 10 mg Tab, 1 po bid
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
8. Actos 15 mg Tab, 1 PO qd
9. Levothyroxine 200 mcg Tab, 1 po qd
10. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY
11. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 39 units q am andd 35 units q pm

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Education - GED. Illicit Drug Use - None. Sexual Activity - divorced.

EXAMINATION:

VITAL SIGNS: B/P - 128/76, Sitting, Right arm, regular cuff;

Pulse - 80: Regular, Respiration - 20

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

SKIN - (+) erythema, tenderness, warmth of patient's whole L 3rd toe extending proximally by about 2 cms; no petechiae, (+) slightly raw dorsum

HEAD - no trauma, normocephalic

ASSESSMENT:

1. Hypoglycemia, Unspecified - New
2. Cellulitis Of Toe Nos/Left - New L 3rd toe

PLAN:

1. *Keep previously scheduled appointment - Cellulitis Of Toe Nos/Left

1. Cellulitis Of Toe Nos/Left - *Keep previously scheduled appointment

FUTURE ORDERS:

1. *TSH - 08/04/10
2. *HgbA1C - 08/04/10
3. *Lipid Panel - 08/04/10

Medications instructions: Start taking medications as outlined below

Counseling time: Total visit over 15 minutes, greater than 50% of time spent

counseling patient regarding: physiology of this disease various treatment options

Other: Follow FSGs off the Actos

DRUG RX:

1. Levaquin 500 mg Tab, 7, 1 PO qd x 7 days, Refills: 0

The following drugs were stopped:

1. Actos 15 mg Tab, 1 PO qd

Entered by: DAVID P GUIRAO MD

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Electronically signed by DAVID P GUIRAO MD 5/27/2010 15:53:25

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SURGICAL CONSULTANTS OF GREENVILLE
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Greenville, South Carolina 29607
Phone 864/242-4683 * Fax 864-240-8112

Patient Name: Michael P Worthen
Soc Sec # : 264-17-8874
Requesting MD: GUIRAO, DAVID

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

On 05/24/2010, Michael Worthen, a 53 year old male presented with:

-- laceration located on the sole of left foot. The patient is status post laceration by nail on deck on mid-April. The wound is not healing. Associated symptoms are: none. Current wound care is dry gauze. The patient denies fever. Continues to work with EMS- wears boots at work now only when on a run- using foam flip-flop other times; bought OTC insole for sneakers in which he is also minimizing time.

MEDICATIONS HISTORY:

Current medications:

1. Fish Oil Cap, 1 po bid
2. Prilosec OTC 20 mg Tab, 1 po qd
3. Levothyroxine 25 mcg Tab, 1 po qd
4. Quinapril 5 mg Tab, 1 po qd
5. Glipizide 10 mg Tab, 1 po bid
6. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
7. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
8. Actos 15 mg Tab, 1 PO qd
9. Levothyroxine 200 mcg Tab, 1 po qd
10. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 39 units q am andd 37 units q pm
11. Ascensia Contour Test Strips, AND LANCETS 3-4 TIMES PER DAY

ALLERGIES: Insulin that he can't remember name of- Hives

VITAL SIGNS: B/P -

WOUND EXAM:

On evaluation the patient has a wound located on the plantar surface left foot, 3rd MT head. The wound measures 1.8 cm by 1.2 cm by 1.2 cm. The base of the wound is granulating peripherally and possible exposed flexor tendon in base of wound. The area around the wound is without cellulitis and developing callus along the margin of wound. wound bed overall is MUCH cleaner and healthy appearing than previously.

DECISION MAKING:

ASSESSMENT:

1. Open Wound Of Unspecified Site With Complication/Left Improving L foot

PLAN:

334

299

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
1. Open Wound Of Unspecified Site With Complication/Left - Follow up visit 1 month - limited

FUTURE ORDERS:

1. *TSH - 08/04/10
2. *HgbA1C - 08/04/10
3. *Lipid Panel - 08/04/10

Medications instructions: no further need for abx at this time

Lifestyle Comments: wear flip-flop or other foam soled shoes when not in work boot - may need to use pressure relief boot or consider disability if no ipmrovement soon

Wound Care: scrub lightly with washcloth, apply neosporin, pack with gauze BID

1. Follow up visit 1 month - limited, 879.9

Entered by: DANIEL M JACQUES MD

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Electronically signed by DANIEL M JACQUES MD 5/24/2010 11:46:4

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SURGICAL CONSULTANTS OF GREENVILLE
1025 VERDAE, SUITE A
Greenville, South Carolina 29607
Phone 864/242-4683 * Fax 864-240-8112

Patient Name: Michael P Worthen
Soc Sec # : 264-17-8874
Requesting MD: GUIRAO, DAVID

CHIEF COMPLAINT:
10 day f/u foot wound

HISTORY OF PRESENT ILLNESS:

On 05/10/2010, Michael Worthen, a 53 year old male presented with:

-- laceration located on the sole of left foot. The patient is status post laceration by nail on deck on mid-April. The wound is not healing. Associated symptoms are: none. Current wound care is only used Santyl x a few days, then Neosporin dressing daily-- has left wound open a few nights. The patient denies fever. Continues to work with EMS- wears boots at work, trying to wear just a sock other times.

MEDICATIONS HISTORY:

Current medications:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 37 units q am andd 35 units q pm
2. Fish Oil Cap, 1 po bid
3. Prilosec OTC 20 mg Tab, 1 po qd
4. Levothyroxine 25 mcg Tab, 1 po qd
5. Quinapril 5 mg Tab, 1 po qd
6. Glipizide 10 mg Tab, 1 po bid
7. Clindamycin 300 mg Cap, 1 PO QID x 7 days
8. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID
9. Levothyroxine 50 mcg Tab, 1 PO qd for total of 250mcg qd (take with 200 mcg qd)
10. Actos 15 mg Tab, 1 PO qd
11. Levothyroxine 200 mcg Tab, 1 po qd

ALLERGIES: Insulin that he can't remember name of- Hives

VITAL SIGNS: B/P -

WOUND EXAM:

On evaluation the patient has a wound located on the plantar surface left foot, 3rd MT head. The wound measures 1.5 cm by 1 cm by .6 cm. The base of the wound is ischemic/necrotic adipose. The area around the wound is peripheral granulation superficially (4mm of wound depth).

DECISION MAKING:

ASSESSMENT:

1. Open Wound Of Unspecified Site With Complication/Left Uncontrolled L foot

PLAN:

1. Open Wound Of Unspecified Site Wit 336 complication/Left - Follow up 2 weeks -

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
limited

FUTURE ORDERS:

1. *TSH - 08/04/10
2. *HgbA1C - 08/04/10
3. *Lipid Panel - 08/04/10

Lifestyle Comments: wear flip-flop or other foam soled shoes when not in work boot-
may need to use pressure relief boot or consider disability if no improvement soon
Wound Care: soak in warm soapy water 5-10 minutes, scrub lightly with washcloth to
remove debris and and apply Santyl ointment BID

1. Follow up 2 weeks - limited, 879.9

Entered by: DR JACQUES

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Electronically signed by DANIEL M JACQUES MD 5/10/2010 21:49:57

Internal Medicine Associates of Greenville, P.A.
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Greenville, South Carolina 29607

Telephone (864)242-4683
Fax (864)240-8104

CHIEF COMPLAINT:

follow up of multiple medical problems

HISTORY OF PRESENT ILLNESS:

On 05/04/2010, Michael Worthen, a 53 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as above normal levels of Triglycerides, below normal levels of HDL and elevated TG GREATER THAN 150. The patient is on no particular diet plan. The patient reports the following complications: HTN, DM and obesity. The patient denies the following: chest pain, abdominal pain, focal weakness.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been A1c is 10.7. Side effects reported by the patient are none. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Patient is on Novolin and Glipizide..

hypothyroidism, which began 9 years ago. Severity was described as last TSH was elevated. It is aggravated by non-compliance with medication and relieved by Synthroid. An associated sign and symptom is none. The patient denies the following: changes in bowel habits, changes in hair texture, changes in skin texture, cold intolerance, constipation, diarrhea, dry hair, goiter, nervousness and palpitations.

-- laceration to the plantar aspect of L foot, which resulted from stepping on a rusty nail and abruptly pulling his foot backward which sheared soft tissue which occurred 3 weeks ago. The patient characterized it as aching. The patient described the severity as improving. The following were described as aggravating factors: patient wearing socks, DM. An associated sign and symptom is purulent discharge. The patient denies the following: fever, chills, bleeding. Patient has been evaluated by Dr. Jacques. He will be seeing him again soon. No further surgical intervention was planned..

MEDICATIONS HISTORY:

Current medications:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 37 units q am and 35 units q pm
2. Fish Oil Cap, 1 po bid
3. Prilosec OTC 20 mg Tab, 1 po qd
4. Levothyroxine 200 mcg Tab, 1 po qd
5. Levothyroxine 25 mcg Tab, 1 po qd
6. Quinapril 5 mg Tab, 1 po qd
7. Glipizide 10 mg Tab, 1 po bid
8. Clindamycin 300 mg Cap, 1 PO QID x 7 days
9. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Illicit Drug Use - None. Sexual Activity - divorced.

REVIEW OF SYSTEMS:

GENERAL - No fever, chills, or fatigue

SKIN - See HPI

EYES - No changes in vision.

RESPIRATORY - Denies shortness of breath, cough, wheezing

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND. No claudicaion.

GASTROINTESTINAL - Denies nausea, vomiting, diarrhea, constipation, abdominal pain, melena, or bright red blood

MUSCULOSKELETAL - See HPI

ENDOCRINE - See HPI

EXAMINATION:

VITAL SIGNS: B/P - 110/70, Sitting, Left arm, large cuff;

Pulse - 74: Regular, Respiration - 18

CONSTITUTIONAL - in no distress, looks like stated age, well nourished, well developed and obese

HEAD - no trauma, normocephalic

THORAX - symmetric, normal respiratory movement and no deformities

LUNGS - Auscultation - clear, equal in all lung fields, no rales, rhonci and or pleural rubs

HEART - Peripheral Pulses - pulses present, equal in upper/lower extremities; Rhythm - regular rhythm; S1 - normal; S2 - normal; Murmurs - no murmur auscultated

LOWER EXTREMITIES -

LEG/ANKLE : Inspection - no erythema, no edema and no deformity;

Reviewed Labs: LABS ABNORMAL, see EMR

ASSESSMENT:

1. Hypothyroidism Nos - Uncontrolled
2. Diabetes Mellitus Type II - Uncontrolled
3. Hyperlipidemia, Nos - Uncontrolled
4. Open Wound Of Unspecified Site With Complication/Left - Improving L foot

PLAN:

1. Refer to PCC - Diabetes Mellitus Type II
2. Follow up visit 1 month - limited - Diabetes Mellitus Type II
3. Excuse Work/School 1 week - Diabet 339 litus Type II

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

FUTURE ORDERS:

1. *TSH - 08/04/10
2. *HgbA1C - 08/04/10
3. *Lipid Panel - 08/04/10

Diet comments: Encouraged a salt-restricted diet for weight loss, Encouraged a low fat diet for weight loss, Encouraged a diabetic diet for weight loss and Encouraged a balanced diet for weight loss

Medications instructions: start actos; increase synthroid; continue other medications; complete antibiotic therapy

Wound Care: as per Dr. Jacques; f/u with Dr. Jacques in 3 days

Counseling time: Total visit over 25 minutes, greater than 50% of time spent counseling patient regarding: medication compliance potential medication side effects physiology of this disease various treatment options

Entered by: DR GUIRAO

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Electronically signed by DAVID P GUIRAO MD 5/4/2010 12:58:52

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SURGICAL CONSULTANTS OF GREENVILLE
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Greenville, South Carolina 29607
Phone 864/242-4683 * Fax 864-240-8112

Patient Name: Michael P Worthen
Soc Sec # : 264-17-8874
Requesting MD: GUIRAO, DAVID

CHIEF COMPLAINT:

2 week old laceration plantar aspect left foot

HISTORY OF PRESENT ILLNESS:

On 04/29/2010, Michael Worthen, a 53 year old male presented with:

-- laceration located on the sole of left foot. The patient is status post laceration by nail on deck on 2 weeks ago. The wound is not healing. Associated symptoms are: none. Current wound care is soaking in peroxide, betadine, and dressing with neosporin.

MEDICATIONS HISTORY:

Current medications:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 37 units q am andd 35 units q pm
2. Fish Oil Cap, 1 po bid
3. Prilosec OTC 20 mg Tab, 1 po qd
4. Levothyroxine 200 mcg Tab, 1 po qd
5. Levothyroxine 25 mcg Tab, 1 po qd
6. Quinapril 5 mg Tab, 1 po qd
7. Glipizide 10 mg Tab, 1 po bid
8. Clindamycin 300 mg Cap, 1 PO QID x 7 days

ALLERGIES: Insulin that he can't remember name of- Hives

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago.

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Illicit Drug Use - None. Sexual Activity - divorced.

EXAMINATION:

VITAL SIGNS: B/P -

CONSTITUTIONAL - In no distress.

CARDIAC - 2+ dp/pt LLE, no pedal edema

WOUND EXAM:

On evaluation the patient has a wound located on the plantar surface left foot, 3rd MT head. The wound measures 2 cm by 341 by .4 cm. The base of the wound is

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued ischemic/necrotic adipose. The area around the wound is developing callus along the margin of wound and without cellulitis. Wound is debrided of callus around margin and necrotic tissue in the base. measurements are after debridement- skin defect is 1.5 x 1cm.

ASSESSMENT:

1. Open Wound Of Unspecified Site With Complication/Left Uncontrolled L foot

PLAN:

1. Open Wound Of Unspecified Site With Complication/Left - Followup 10 days

Medications instructions: wound is without cellulitis, but continue antibiotics as previously prescribed

DRUG RX:

1. Santyl 250 unit/g Ointment, apply to wound with saline dressings BID

1. Followup 10 days, 879.9

Entered by: DR JACQUES

~

Electronically signed by DANIEL M JACQUES MD 4/29/2010 21:6:28

ACCH
105 0756

INTERNAL MEDICINE ASSOCIATES OF GREENVILLE, P.A.

Name Worthen Michael Philip
(last) (first) (middle)Address 104 Anberdale Ln.Simpsonville SC 29680
(city) (state) (zip code)Social Security # 264-17-8874 Sex (M) F Date of Birth 9-8-56Marital Status: S M (D) W Emergency contact & number Terrie Jones 864-967-4253Home phone # 864-965-0039 Work phone # Same

Referring Physician _____ Phone # _____

Billing InformationPerson responsible for paying bills: Michael P. Worthen

Address if different than patient: _____

Primary Insurance Blue Cross/Blue ShieldClaim mailing address PO Box 100605 Columbia S.C. 29260Subscriber name Michael P. Worthen Patient relationship to subscriber SelfEmployer Laurens Co. EMS Phone 984-1574

Employer address _____

Subscriber Social Security # 264-17-8874 Date of birth 9-8-56Insurance ID # ZC504668065 Plan/Group # State Health

Secondary Insurance _____

Claim mailing address _____

Subscriber name _____ Patient relationship to subscriber _____

Employer _____ Phone _____

Employer address _____

Subscriber Social Security # _____ Date of birth _____

Insurance ID # _____ Plan/Group # _____

It is the patient's responsibility to pay deductibles, co-insurance/co-pays on the day of service, and to pay any other balance not paid for by insurance. If we are filing your claim, we will allow forty-five days from the filing date for the carrier to process your claim and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not diminish your responsibility to pay for services. Self-pay patients must pay for services the day on which they are rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by an insurance carrier.

I hereby authorize said assignee to release all information necessary to secure payment. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fees & collection expense.

Signature Michael P. Worthen Date 4-28-10

Parent (in minor) _____ Date _____

Internal Medicine Associates of Greenville, P.A.

111 Doctors Drive Greenville, SC 29605 Phone (864) 242-4683 Fax (864) 240-8104

New Patient Medical History - Please complete this two-sided form prior to your first appointment.

me: ~~David L. Hunter~~ Michael Phibbs Date of Birth: 9/18/1956 Age: 52 Sex: M
How did you hear about our practice?

CitiHealth

Please briefly state in the box below the reason for your visit.

Changing Doctors & Injury to Face

DAVID GUIRAO, M.D.

Past Medical History

Condition / Disease	Year Began	Condition / Disease	Year Began
☐ Hypertension		Other(s):	
☐ High Cholesterol			
☐ Hypothyroidism (low thyroid)			
☐ COPD, Emphysema or Asthma			
☐ Diabetes			
☐ GERD			
☐ Depression or Anxiety			
☐ Heart Problems -			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	Month / Yr	Operation / Hospitalization / Injury	Month / Yr
Back			
Broken Leg			
Sister over Eye			

Other Physicians and Specialists

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc).

Medication or Food Allergies or Intolerances

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea).

Medication / Food	Reaction	Medication / Food	Reaction

Medications, Vitamins and Herbal Supplements

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency
Example: Tylenol	500 mg	1 - twice daily	Glipizide	10 mg	Twice
Nasal In 10/30	37 mg/35 u	Twice			
Fish Oil	2000 mg	Twice			
Prilosec OTC	20 mg	1			
evothroxine	0.2 mg	1			
Quinapril	0.25 mg	1			
	5 mg	1			

Social, Educational and Work History

Marital Status: Divorced Age of children, if any: 30

Work Status (circle one): Employed Current or Prior Occupation: Laurens Co. EMS Hours worked per week: 40-50

Unemployed / Retired / Disabled

Highest Level of Education: GED Completed at which institution / school: _____

What type of exercises do you perform, duration & frequency? Walking

In what type of residence do you live (i.e. house, assisted living, nursing home)? _____

What are your hobbies? Hunting / Fishing

Do you drink alcohol? NO What type of alcohol? _____ No. of drinks per week? _____

Are you a current smoker? NO If you smoke, how many packs per day? _____

Are you a former smoker? yes If so, what year did you quit? _____ No. of years you smoked? _____

On average, how much did you smoke per day? Chewed

Are you sexually active: Yes / No Do you have sex with: Men / Women / Both How many partners have you had during the past 12 months? 1

Are you concerned that you may have been exposed to HIV? Yes / No

Family Health History

Please list below the health history of your blood (genetic) first degree relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Father:	<u>Deceased</u>	<u>68</u>	<u>Cancer</u>	
Mother:	<u>Deceased</u>	<u>78</u>	<u>U/K</u>	
Sister(s):	<u>Living</u>	<u>44</u>		<u>Unknown</u>
Brother(s):	<u>Living</u>	<u>54</u>		<u>Unknown</u>

Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Respiratory problems	<u>Wheezing</u>	Lumps in breast	<u>Frequent Urination</u>	Excessive hunger
Eating problems	<u>Asthma / COPD</u>	Breast discharge	Incontinence	Excessive thirst
Nutritional problems	<u>Emphysema</u>	Trouble swallowing	Blood in Urine	Weakness
Fever	<u>Bronchitis</u>	Nausea	History of STD's	<u>Fatigue</u>
Bleeds	<u>TB exposure</u>	Vomiting	Anemia	Fever / Sweating
Throat	<u>Chest pain</u>	Abdominal pain	Easy bruising	Fainting
Weakness	<u>Chest discomfort</u>	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	<u>Shortness of breath</u>	Gallstones	Joint pain / stiffness	Headaches
Oral problems	<u>High blood pressure</u>	Diarrhea	Blood clot	<u>Numbness / Tingling</u>
Weight	<u>Diabetes</u>	Constipation	Weight loss / gain	Anxiety / Depression
Spitting blood	<u>High cholesterol</u>	Blood in stool	Heat/cold intolerance	Difficulty sleeping

Place an "X" in the box to the left if you have none of the above.

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

Vaccine	Month/Yr	Month/Yr	Month/Yr
MMR Vaccine	<u>2009</u>	Mammogram	
Pneumonia Vaccine		Pap Smear	
Hepatitis B Vaccine		Colonoscopy	<u>6/2005</u>
Shingles Vaccine		Bone Density	
Herd Vaccine		EKG	
		Chest X-Ray	
		Eye Exam	<u>2007</u>
		Heart Catheterization	
		Endoscopy (EGD)	
		Heart Stress Test	<u>5/2005</u>
		ABG / Arterial Screen	
		HIV Test	

Internal Medicine Associates of Greenville, P.A.
1025 Verdae Blvd, Suite A
Greenville, South Carolina 29607

Telephone (864)242-4683
Fax (864)240-8104

CHIEF COMPLAINT:

New patient here to establish primary care

HISTORY OF PRESENT ILLNESS:

On 04/28/2010, Michael Worthen, a 53 year old male presented with:

-- Hyperlipidemia which began 9 years ago. Severity was described as unknown. The patient is on no particular diet plan. The patient reports the following complications: HTN, DM and obesity. The patient denies the following: chest pain, abdominal pain, focal weakness.

-- Type II Diabetes mellitus which began 9 years ago. Patient compliance took medication as instructed. Since taking the prescribed medication, the severity has been unknown. Side effects reported by the patient are none. He denies the following: hypoglycemia, polyuria, polydipsia, dry mouth, polyphagia, fatigue and weight change. Co-morbid conditions include HTN, Obesity, Dyslipidemia. Patient is on Novolin and Glipizide..

hypothyroidism, which began 9 years ago. Severity was described as stable and well controlled. It is aggravated by non-compliance with medication and relieved by Synthroid. An associated sign and symptom is none. The patient denies the following: changes in bowel habits, changes in hair texture, changes in skin texture, cold intolerance, constipation, diarrhea, dry hair, goiter, nervousness and palpitations.

-- Obesity, which began years ago. Severity was described as BMI is 39.

-- laceration to the plantar aspect of L foot, which resulted from stepping on a rusty nail and abruptly pulling his foot backward which sheared soft tissue which occurred 2 weeks ago. The patient characterized it as aching. The patient described the severity as severe. The following were described as aggravating factors: patient wearing socks, DM. Relieving factors were reported to be: H2O2. An associated sign and symptom is purulent discharge. The patient denies the following: fever, chills, bleeding.

MEDICATIONS HISTORY:

Current medications:

1. Novolin 70/30 100 unit/mL (70-30) Susp, Sub-Q Inj, 37 units q am andd 35 units q pm
2. Fish Oil Cap, 1 po bid
3. Prilosec OTC 20 mg Tab, 1 po qd
4. Levothyroxine 200 mcg Tab, 1 po qd
5. Levothyroxine 25 mcg Tab, 1 po qd
6. Quinapril 5 mg Tab, 1 po qd
7. Glipizide 10 mg Tab, 1 po bid

ALLERGIES: Insulin that he can't rem 346 name of- Hives

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Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued

HEALTH MAINTENANCE HISTORY:

Flu Vaccine: 10/20/09
Tetanus Shot: 03/20/05
Colonoscopy: 06/20/05 normal
Dilated Eye Exam: 05/20/07
HgbA1c: 04/28/10
Physical Exam: 04/28/10
Urinalysis: 04/28/10
HGBA1C: 04/28/10

PAST HISTORY: Childhood Illnesses - chicken pox, measles and mumps. Chronic Illnesses - Dyslipidemia, HTN, DM, Obesity and Hypothyroidism. Operations: back surgery 20 years ago. Other Physicians - New Horizon

ADVANCED DIRECTIVES: Living Will on File: No
Health Care POA: none

FAMILY HISTORY: Father - colon cancer - dxed at 68.

SOCIAL HISTORY: Alcohol Use - None. Smoking - former smoker and 1 1/2 PPD x 5 years quit in 1976. Diet - baked or grilled food. Lifestyle - trying to lose weight. Exercise - walking. Seat Belt Use - Always. Occupation - laurens county EMS and ex navy seal. Illicit Drug Use - None. Sexual Activity - divorced.

REVIEW OF SYSTEMS:

GENERAL - No fever, chills, or fatigue

SKIN - See HPI

EYES - No changes in vision.

RESPIRATORY - No cough, wheezing or dyspnea. No Hx of TB exposure or Asbestos exposure.

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND. No claudicaion.

GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No Hx of hepatitis or jaundice.

MUSCULOSKELETAL - No joint swelling or pain. No myalgia.

NEUROLOGICAL - No seizures or syncope. No paresthesias, tremor or weakness. No headache or confusion.

ENDOCRINE - See HPI

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No Hx of anemia. No lymphadenopathy.

EXAMINATION:

VITAL SIGNS: B/P - 128/80, Sitting, Left arm, large cuff;

Pulse - 70: Regular, Respiration - 20, Temperature - 97.9: Taken Orally

Height: 72 inches

Weight: 292.20 lbs. BMT 39.63

CONSTITUTIONAL - Well developed, well nourished, in no distress.

SKIN - (+) 4 cm laceration on plantar (anterior) aspect of L foot with surrounding pale, non-foul-smelling tissue with no bleeding and minimal expressible serosanguinous discharge

HEAD - Normal. No trauma.

EYE - PERRLA, EOMI, anicteric sclera

ENT - TM's normal color with distinct landmarks. Nasal membranes normal. No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation and percussion. Effort normal.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click. No JVD, carotid or abdominal bruits. Peripheral puls 347 mal and symmetric.

Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.
RECTAL - patient wanted rectal exam done during next visit
EXTREMITIES - No joint swelling or deformity. No edema.
NEUROLOGICAL - Alert, oriented, no focal signs.
PSYCHIATRIC - Normal mood and appropriate affect.
IMMUNOLOGIC - No lymphadenopathy.

ASSESSMENT:

1. Hypothyroidism Nos - Active Treatment
2. Diabetes Mellitus Type II - Active Treatment
3. Hyperlipidemia, Nos - Active Treatment
4. Hypertension - Controlled
5. Open Wound Of Unspecified Site With Complication/Left - New L foot

PLAN:

1. *TSH - Hypothyroidism Nos
2. *HgbA1C - Diabetes Mellitus Type II
3. *Microalbumin, Urine - Diabetes Mellitus Type II
4. *CBC with Plt and Diff - Diabetes Mellitus Type II
5. *Urinalysis w/ Microscopy - Diabetes Mellitus Type II
6. *Basic Metabolic Panel - Diabetes Mellitus Type II
7. *Hepatic Panel - Diabetes Mellitus Type II
8. *Lipid Panel - Diabetes Mellitus Type II
9. *Glomerular Filtration Rate - Diabetes Mellitus Type II
10. Follow up 1 week - limited - Diabetes Mellitus Type II
11. Request Prior Medical Records - Diabetes Mellitus Type II
12. Consult General Surgeon - Open Wound Of Unspecified Site With Complication - patient with infected laceration of L foot resulting from accidental nail puncture / laceration injury (patient may possibly need debridement of dead tissue)

1. Hypothyroidism Nos - *TSH
2. Diabetes Mellitus Type II - *HgbA1C
3. Diabetes Mellitus Type II - *Microalbumin, Urine
4. Diabetes Mellitus Type II - *CBC with Plt and Diff
5. Diabetes Mellitus Type II - *Urinalysis w/ Microscopy
6. Diabetes Mellitus Type II - *Basic Metabolic Panel
7. Diabetes Mellitus Type II - *Hepatic Panel
8. Diabetes Mellitus Type II - *Lipid Panel
9. Diabetes Mellitus Type II - *Glomerular Filtration Rate
10. Diabetes Mellitus Type II - Follow up 1 week - limited
11. Diabetes Mellitus Type II - Request Prior Medical Records from New Horizon FHS

Diet comments: Encouraged a salt-restricted diet for weight loss, Encouraged a low fat diet for weight loss, Encouraged a diabetic diet for weight loss and Encouraged a balanced diet for weight loss

Medications instructions: continue current medications; start Clindamycin as prescribed

Lifestyle Comments: start a regular exercise program as tolerated

Preventative Health: Cardiovascular risk factors discussed., Colon cancer screening is up to date, Prostate cancer screening is due at next visit, Pneumococcal vaccine due at next visit, Tetanus/Diphtheria vaccine up to date and Ophthalmology exam is discussed

Wound Care: Wound care BID; will need debridement (refer to Dr. Jacques for evaluation)

Counseling time: Total visit over 40 minutes, greater than 50% of time spent counseling patient regarding: prevent 348 health measures physiology of this disease

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Patient: WORTHEN, MICHAEL MRNO: 1050756 DOB: 09/08/1956 - Continued
various treatment options weight reduction wound care
Other: Patient to be seen by Dr. Jacques tomorrow at 11:45 am.

DRUG RX:

1. Clindamycin 300 mg Cap, 1 PO QID x 7 days

Entered by: DR GUIRAO

~

Electronically signed by DAVID P GUIRAO MD 4/28/2010 22:46:36

Respondents' APA Submission #12

Resident Koon Sr, Joe RIdentifier 733Date 2/02/2011**Section K Swallowing/Nutritional Status****K0100. Swallowing Disorder**

Signs and symptoms of possible swallowing disorder

↓ Check all that apply

- ☐ A. Loss of liquids/solids from mouth when eating or drinking
- ☐ B. Holding food in mouth/cheeks or residual food in mouth after meals
- ☐ C. Coughing or choking during meals or when swallowing medications
- ☐ D. Complaints of difficulty or pain with swallowing
- ☒ Z. None of the above

K0200. Height and Weight - While measuring. If the number is X.1 - X.4 round down; X.5 or greater round up7 4

Inches

A. Height (in inches). Record most recent height measure since admission

2 6 2

pounds

B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss0

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

1. Yes, on physician-prescribed weight-loss regimen
2. Yes, not on physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ Check all that apply

- ☐ A. Parenteral/IV feeding
- ☐ B. Feeding tube - nasogastric or abdominal (PEG)
- ☐ C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☒ D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- ☐ Z. None of the above

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked

Enter Code

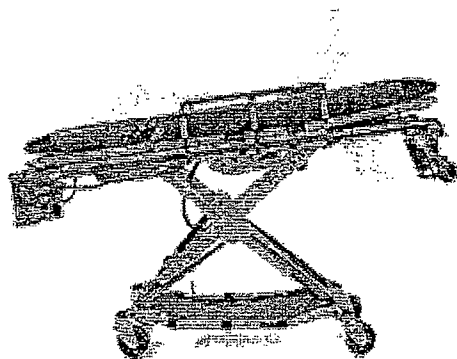
- A. Proportion of total calories the resident received through parenteral or tube feeding
1. 25% or less
2. 26-50%
3. 51% or more

Section L Oral/Dental Status**L0200. Dental**

↓ Check all that apply

- ☐ A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
- ☒ B. No natural teeth or tooth fragment(s) (edentulous)
- ☐ C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
- ☐ D. Obvious or likely cavity or broken natural teeth
- ☐ E. Inflamed or bleeding gums or loose natural teeth
- ☐ F. Mouth or facial pain, discomfort or difficulty with chewing
- ☐ G. Unable to examine
- ☐ Z. None of the above were present

Respondents' APA Submission #13



POWER-PRO™ XT

- The industry-leading Stryker Power-PRO XT powered ambulance cot dramatically reduces strenuous lifting and the associated risk of back injury. The innovative battery powered hydraulic system raises and lowers patients with the touch of a button. The Stryker Power-PRO XT sets the standard for superior performance and outstanding ergonomics.
- Easy to use manual back-up system provides complete cot operation in the event of power loss
- Foot end mounted DEWALT® Battery System is accessible and easily changed in any situation
- Retractable head section allows cot to be shortened in any height position for maximum versatility
- Exclusive automatic high speed retract feature reduces load and unload times

Specifications

Height		Wheels		Weight	
Lowest Position	14" (35.56 cm)	Width	2" (5 cm)	Weight	125 lbs (57 kg)
Highest Position	38" (96.5 cm)	Diameter	6" (15 cm)		
Width		Articulation		Maximum Weight	
23" (58 cm)		Backrest	0-75 °	700 lbs (318 kg)	
		Shock Position	+15 °		
		Knee Gatch	30 °		
Length		Minimum Operators		Recommended Loading Height	
Standard	76.5" (193.7 cm)	Occupied Cot	2	• Floor Mount Model 6370, 6377	
Minimum	55" (139.7 cm)	Unoccupied Cot	1	• Wall Mount Model 6371	
				• Loading Height Up to 36" (91 cm)	

Literature



[Download \(Adobe PDF\) Battery System Guidelines](#)



[Download \(Adobe PDF\) Power-PRO™ XT Specification Sheet](#)



[Download \(Adobe PDF\) Power-PRO™ XT Info Sheet](#)



[Download \(Adobe PDF\) 2009 Product Catalog](#)

Photography



Accessories

- Equipment Hook
- IV Pole (2 or 3 Stage)
- SMRT Power System
- Knee - Gatch
- Foot End Oxygen Bottle Holder
- Fowler Oxygen Bottle Holder
- Head Extension w/Pillow
- Bariatric Transfer Flat
- Defibrillator Platform
- Pocketed Backrest Storage Pouch
- Head End Storage Flat
- Base Storage Net
- Bolster Mattress
- Flat Mattress
- Knee - Gatch / Trendelenburg Mattress
- Removable Oxygen Bottle Holder

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Respondents' APA Submission #14



Laurens County Emergency Medical Services

Patient Care Record

Name: KOON, JOE R

Incident #: 1102018

Date: 02/26/2011

Patient 1 of 1

Patient Information				Clinical Impression	
Last	KOON	Address	304 Jacobs Highway	Primary Impression	Respiratory Distress
First	JOE	Address 2		Secondary Impression	
Middle	R	City	Clinton	Chief Complaint	difficulty breathing
Gender	Male	State	SC	Duration	2 Units Hours
DOB	06/14/1921	Zip	29325	Secondary Complaint	
Age	89 Yrs, 8 Months, 12 Days	Country		Duration	Units
Weight	350lbs - 159kg	Tel	(864)833-2550	Signs & Symptoms	Respiratory - Pulmonary Edema Respiratory - Dyspnea
SSN	250-25-5893	Physician		Injury	
Advanced Directive				Medical/Trauma	
				Barriers of Care	
				Alcohol/Drugs	

Medication/Allergies/History	
Medications	
Allergies	
History	

Time	AVPU	Side	POS	BP	Pulse	RR	SPO2	ETCO2	CO	BG	Temp	Pain	GCS	RTS	PTS
20:45	A	L	Sit	176/102 M	118 R	28 R	95						15		
20:55	A	L	Sit	146/92 M	116 R	26 R	98			195			15		
21:05	A	L	Sit	136/90 M	120 R	24 R	99						15		

Time	Treatment	Description	Provider
20:44	Oxygen	FlowRate 4; Patient Response: Unchanged	WORTHEN, MICHAEL
20:52	IV Therapy	18 ga; Hand-Left; Saline Lock; TotalFluid 10; Patient Response: Unchanged; Successful	LUNDIS, MICHAEL

Category	Comments	Abnormalities
Mental Status		Mental Status No Abnormalities
Skin		Skin No Abnormalities
HEENT		Head/Face No Abnormalities Eyes No Abnormalities Neck No Abnormalities
Chest		Chest Not Assessed Heart Sounds Not Assessed Lung Sounds ⊕ LL: Rales, LU: Rales, RL: Rales, RU: Rales
Abdomen		General No Abnormalities Left Upper No Abnormalities Right Upper No Abnormalities Left Lower No Abnormalities Right Lower No Abnormalities
Back		Cervical No Abnormalities Thoracic No Abnormalities Lumbar/Sacral No Abnormalities
Pelvis/GU/GI		Pelvis/GU/GI No Abnormalities
Extremities		Left Arm Not Assessed Right Arm Not Assessed Left Leg ⊕ Edema Right Leg ⊕ Edema Pulse Not Assessed Capillary Refill Not Assessed
Neurological		Neurological No Abnormalities

Assessment Time: 2/26/2011 8:55:00 PM



Laurens County Emergency Medical Services

Patient Care Record

Name: KOON, JOE R

Incident #: 1102018

Date: 02/26/2011

Patient 1 of 1

Narrative

C: 89 y/o w/m c/o difficulty breathing for about 2 hours. H: MEDS/Hx/allergies listed at ER. A: Patient found lying in bed at nursing home. Patient is alert and oriented to person, place, time, and event. Skin is pink, warm, and dry. Pupils are equal and reactive to light. Head, eyes, ears, nose, and throat are clear. No JVD or tracheal deviation is noted. Lung sounds reveal rales in all fields. Abdomen is firm and non tender with edema noted. Patient has pulse, motor, and sensation in all extremities with pedal edema noted as well as a wound vacuum on his left foot. Nothing remarkable back. No signs of trauma noted. Patient denies chest pain, nausea, vomiting, headache, or loss of consciousness. R: Vitals as noted above. Patient on oxygen 4 lpm by nasal cannula. Saline lock established in left hand using 18 gauge catheter. Saline lock flushed with 10 cc normal saline. Patient BGL 195 mg/dL. Cardiac monitor with held due to valid SC EMS DNR form. T: Patient transported non urgently to Laurens County ER. ER notified via radio with oral report to Angie, RN, in room 9. Patient in bed with side rails up, oxygen 4 lpm by nasal cannula, and saline lock patent. Patient left with staff.

Incident Details		Destination Details		Incident Times	
Location	NHC of Clinton	Disposition	Transported No Lights/Siren	Call Received	20:32:00
Address	304 Jacobs Highway	Transport Due To	Protocol	Dispatched	20:34:00
Address 2		Transported To	Laurens County Hospital ER	En Route	20:36:00
City	Clinton	Requested By	NH Staff	Resp on Scene	
State	SC	Destination	Hospital ER	On Scene	20:40:00
Zip	29325	Address	22725 Hwy 76 East	At Patient	20:42:00
Medic Unit	Medic 2	Address 2		Depart Scene	20:57:00
Run Type	911 Response (Emergency)	City	Clinton	At Destination	21:07:00
Priority Scene	Lights/Sirens	State	SC	Pt. Transferred	21:11:00
Shift	C Shift	Zip	29325	Incident Close	21:20:00
Zone	12 Clinton	Zone	12 Clinton	In District	
Level of Service		Condition at Destination			
		Destination Record #			

Personnel			
Personnel	Certification Number	Role	Certification Level
LUNDIS, MICHAEL	SC005891	Lead	EMT-Paramedic
WORTHEN, MICHAEL	SC012110	Driver	EMT-Basic

Insurance Details			
Insured's Name	Primary Payer	Dispatch Nature	
Relationship To Patient	Medicare 250255893A	Response Urgency	
Address1	Medicaid 7304557901	Job Related Injury	
Address2	Primary Insurance BlueCross Blue Shield -	Employer	
Address3	Policy # ZGN250235893A	Contact	
City	Group #	Phone	
State	Secondary Ins		
Zip	Policy #		
Country	Group #		

Mileage		Delays		Additional Agencies	
Scene	40.7	Category			
Destination	46.1				
Loaded Miles	5.4				
Start					
End					
Total Miles	90.0				

Next of Kin			
Next of Kin Name	Address1	City	
Relationship to Patient	Address2	State	
Phone	Address3	Zip	
		Country	

**Deposition Transcript of
Jon M. Bittrick, M.D.,
dated October 26, 2011**

BEFORE THE SOUTH CAROLINA
WORKERS COMPENSATION COMMISSION
W.C.C. FILE NO. 1103604

Michael Worthen,)
Claimant,)
-vs-)
Laurens County,)
Employer,)
AND)
Association of Counties,)
Insurer,)
Defendants.)

COPY

DEPOSITION OF JON M. BITTRICK, M.D.

PURSUANT to Notice and/or agreement between the parties, the deposition of JON M. BITTRICK, M.D., was taken at the offices of Upstate Cardiology, 2 Innovation Drive, Suite 400, Greenville, South Carolina, on Wednesday, October 26, 2011, commencing at the hour of approximately 4:45 p.m.

BRANDIE T. WILLIAMS, REPORTER

CAMPBELL/HADAWAY & ASSOCIATES
Deposition and Court Reporters
Post Office Box 4034
Greenville, South Carolina 29608-4034
(864) 801-4007

1 JON M. BITTRICK, M.D.

2 being first duly sworn was examined and testified as
3 follows:

4 EXAMINATION BY MR. DESAI:

5 Q. Dr. Bittrick, my name is Monty Desai and I represent
6 Mr. Worthen. I understand he's a patient of yours; is
7 that right, sir?

8 A. Yes.

9 Q. I believe the first time you saw him was in April
10 sometime; is that right? April 12th, I think.

11 A. The first time that I saw him looks to be February
12 27th.

13 Q. I realized that, once I --

14 MR. WORTHEN:

15 In the hospital, he seen me the one time.

16 EXAMINATION CONTINUES BY MR. DESAI:

17 Q. Doctor, tell us about your qualifications, your
18 accolades; say a little about yourself as far as what
19 you've accomplished. You're a cardiologist, I'm
20 assuming?

21 A. Yes, medical doctor. Did my medical school at
22 University of South Carolina; graduated in 1994. Then
23 internal medicine residency, University of Wisconsin,
24 from '94 to '97. And cardiology fellowship,
25 University of Tennessee, '97 to 2000. Interventional

1 cardiology fellowship at Baylor Texas Heart Institute,
2 2000 to 2001. I've been in private practice here in
3 Greenville since.

4 Q. Very impressive. Tell us what reason that you were
5 seeing Mr. Worthen.

6 A. He presented on February 27th with -- bear with me as
7 I review my records -- a non-Q wave myocardial
8 infarction and presented with the symptoms from that.
9 The initial presentation was for chest pain related to
10 that heart attack.

11 Q. Were you able to ascertain during your visits with Mr.
12 Worthen what the reason for that myocardial infarction
13 was?

14 A. I could read my History and Physical. I stated in the
15 History of Present Illness that "On the car trip to
16 the emergency room this morning the patient had just
17 moved a 500-pound patient with his EMT job, then
18 develops the chest pain at that time. He then
19 presented to the emergency room and demonstrated an
20 elevated troponin of 3.03 consistent with a non-Q wave
21 myocardial infarction."

22 Q. What exactly is a non-Q wave?

23 A. We classify heart attacks according to the changes
24 that we see on the EKG. If they have ST segment
25 elevation, that's one classification of heart attack.

1 When the -- without that ST segment elevation and the
2 chest pain and the abnormal enzymes, like Mr. Worthen
3 had, that's classified as a non-Q wave myocardial
4 infarction.

5 Q. Is there any science behind what causes one versus
6 another?

7 A. They're both plaque rupture.

8 Q. You stated that the cause was lifting a 500-pound
9 patient; is that right?

10 MR. KALE:

11 Object to the leading, first of all, and he didn't say
12 the cause; he said that was a history.

13 EXAMINATION CONTINUES BY MR. DESAI:

14 Q. Let me clarify. Is that what you have in your notes,
15 sir?

16 A. Yes, that the symptoms occurred while he was moving
17 this patient, that's when they first occurred.

18 Q. And this was a subjective finding of Mr. Worthen? How
19 did you get that information?

20 A. By history, asking the patient.

21 Q. Do you have any reason to believe that it didn't
22 happen that way?

23 A. No, no reason to believe that it didn't happen.

24 Q. Let me just give you a hypothetical. If somebody does
25 lift a 500 -- 400-pound person or weight, and goes

1 through that kind of stress, is it feasible that
2 somebody can suffer a myocardial infarction?

3 MR. KALE:

4 Let me make an objection because I don't think that
5 gives the doctor a proper basis for giving a
6 hypothetical person that you don't know what his
7 medical condition is, whether it would cause a
8 myocardial infarction or not.

9 MR. DESAI:

10 Okay, objection noted.

11 EXAMINATION CONTINUES BY MR. DESAI:

12 Q. Go ahead and answer.

13 A. Hypothetically, the strain of moving a heavy object
14 could elucidate a plaque rupture.

15 Q. What other things might cause the same?

16 A. There's actually quite a bit of things that could be
17 associated with a plaque rupture. We see plaque
18 ruptures -- well, let me rephrase. Most heart
19 attacks, anecdotally we seem to see people presenting
20 just doing their normal activities. I noted it just
21 because it seemed very out of the ordinary that
22 somebody would be able to temporally say, while I was
23 doing this activity is when I experienced the
24 symptoms. Most patients just develop chest pain and
25 we say, what were you doing, and they say, I wasn't

1 doing anything, and they were doing just kind of
2 normal activities of daily living. But that was
3 unusual about this.

4 Q. Do you believe to a medical degree of certainty that
5 it was that activity, one of lifting a 400- to 500-
6 pound patient, that caused Mr. Worthen's heart attack?

7 MR. KALE:

8 Let me impose an objection again. First of all, it
9 asks the doctor to assume facts that are not in the
10 record, and that is, the patient weighed 400 to 500
11 pounds. And secondly, it doesn't give any other basis
12 for him giving an opinion.

13 MR. DESAI:

14 Thank you.

15 EXAMINATION CONTINUES BY MR. DESAI:

16 Q. Go ahead and answer, please, sir.

17 A. My assumption at the time is that -- at this current
18 time, is that that was the precipitating factor;
19 that's my assumption was the precipitating factor.

20 Q. On your April 14th note, Doctor, you mentioned that
21 there was an ejection fraction of only 30 percent.
22 Can you explain that to me, sir? What exactly is
23 ejection fraction?

24 A. Let me find my note.

25 Q. It's actually a letter. I stand corrected; it's a

1 letter.

2 A. The normal human left ventricle works as a pump. And
3 when that heart muscle squeezes and pumps out the
4 blood that's contained within the chamber, it normally
5 pumps about 65 percent of the blood in that chamber
6 out; it doesn't drain completely. So that's the
7 ejection fraction, percent of blood within the
8 ventricle that gets ejected with each contraction
9 systole. As a measure of heart damage, the pump
10 becomes less efficient and that ejection fraction
11 drops. We measure that subjectively when we look at
12 an echocardiogram or nuclear stress test; but there's
13 other measures. But the lower that number, the more
14 indicative of the amount of damage that the heart
15 sustained.

16 Q. So lesser the percentage, higher the damage?

17 A. Yes.

18 Q. In your note on 5/16, May 16, 2011, you state that the
19 EF, which I'm assuming is ejection fraction, is now 45
20 to 50 percent. Is that an indication of the fact that
21 he's getting better?

22 A. There's some subjective variability to where if you
23 looked at an echocardiogram, or if two different
24 cardiologists looked at the same echocardiogram, they
25 may come up with a different ejection fraction. I

1 think, well, the ejection fraction improving from 30
2 to 45 to 50 is probably outside of intra-observer
3 variability. So my indication in my note would be
4 that I think his heart is getting better.

5 Q. Better as in it was prior to the heart attack, or
6 better than it was on April 14th?

7 A. I don't know what his heart looked like prior to the
8 heart attack; I only know what it looked like after
9 the heart attack.

10 Q. And, again, I'm sorry for my ignorance here. Is there
11 such a thing as a normal ejection fraction, and, if
12 so, what is it?

13 A. Sixty-five percent.

14 Q. What is his current ejection fraction, or do you know?

15 A. Most current is 45 to 50 percent, mildly decreased.

16 Q. So on a high range 50, low range 45. Still 15 to 20
17 percent lower than a normal ejection fraction; is that
18 right?

19 MR. KALE:

20 Object to the leading.

21 WITNESS CONTINUES:

22 A. Lower than normal. We classify degree of abnormality
23 mild, moderate, severe. This would be in the mildly
24 impaired category. When I first saw him, it would
25 have been severely impaired.

1 Q. He has a defib. in his heart?

2 A. Yes.

3 Q. And that's implanted in there; is that right?

4 A. Yes.

5 Q. What is the reason for that?

6 A. During his hospitalization he had ventricle
7 fibrillation arrest, which led to the placement of his
8 defibrillator.

9 Q. Explain that to us, sir.

10 A. He suffered at least one incident in the hospital of
11 the heart going into ventricular fibrillation; which
12 is essentially a chaotic, unorganized rhythm in the
13 bottom chambers, the ventricles, that is not
14 compatible with life. It's a fatal arrhythmia, that
15 when we see leads to implantation of a defibrillator.

16 Q. Do you know the reason or what causes this or what
17 caused it or what could cause it?

18 A. The discharge summary states postoperative ventricular
19 fibrillation and arrest requiring implantable cardiac
20 defibrillator. My presumed cause would be irritable
21 myocardium heart muscle that's just recently been
22 through an infarct and subsequent heart surgery.

23 Q. Don't let me put words in your mouth, but if I have to
24 explain this to my eight-year-old, is it fair to say
25 that it is caused by a previous heart attack or a

1 muscle was weakened by a previous heart attack and
2 thus triggered this?

3 MR. KALE:

4 Object to the leading.

5 WITNESS CONTINUES:

6 A. The ventricular fibrillation would probably be from
7 the current heart attack. The heart muscle becomes
8 very irritable and unstable post heart attack; and one
9 of the complications, known complications, is
10 arrhythmia.

11 Q. Is it normal to put a defib. in somebody after that
12 first episode?

13 A. Most patients that present with the heart attack don't
14 have ventricular arrhythmia, but of those that do most
15 receive a defibrillator.

16 Q. And is it more of a prophylaxis to make sure it
17 doesn't happen again?

18 A. It's prophylaxis. It doesn't treat the -- it doesn't
19 prevent the rhythm from coming back; it shocks the
20 heart if the rhythm were to return.

21 Q. Are there any complications associated with that, or
22 is there a maintenance for that defib., anything that
23 needs to be done to it over the period of its life?

24 A. Yes. We follow defibrillators with interrogations.
25 We're able to interrogate the device, assess whether

1 there's been any rhythms, whether there's been any
2 therapies delivered, the remaining battery life. All
3 of that is done on a routine basis multiple times
4 every year. With the average battery life of the
5 device being somewhere between five to seven years,
6 and then needing to get a new device about every five
7 to seven years.

8 Q. Doctor, you might not have an opinion as to this, but
9 do you know, if you had to rate Mr. Worthen's
10 impairment, are you in a position to do that today or
11 would you be in a position to do that in the near
12 future?

13 A. Functional capacity impairment or degree of left
14 ventricular function?

15 Q. Both, please.

16 A. Those two are not always connected in that some people
17 with an abnormal left ventricular ejection fraction
18 may have very few symptoms, while another patient may
19 be significantly impaired. What we do is reflect
20 basically in our notes what the patient tells us
21 they're capable of doing. We don't do objective
22 functional assessments in a standardized setting.

23 MR. DESAI:

24 Thank you, Doctor, I don't have anything else.

25 EXAMINATION BY MR. KALE:

1 Q. Dr. Bittrick, my name is Richard Kale and I'm
2 representing Laurens County and its Workers' Comp
3 carrier. One additional question about
4 qualifications. Are you board certified?

5 A. Yes, sir.

6 Q. Is that in cardiology?

7 A. Cardiology and interventional cardiology.

8 Q. Now, did Mr. Worthen have severe pre-existing coronary
9 artery disease?

10 A. That's unknown because the first time I saw him was
11 with the heart attack. I don't know how much license
12 you want us to take, but prior to the February 27th,
13 he was not a patient of mine so I would not have known
14 of any coronary artery disease.

15 Q. They did a catheterization; did they not?

16 A. Yes.

17 Q. Did that catheterization note occlusions?

18 A. Let me see. Yes; I can read you the impression, if
19 you would like.

20 Q. Sure.

21 A. "Three vessel coronary disease with three vessel total
22 occlusion after the proximal third of the left
23 anterior descending of the second and primary marginal
24 branch of the circumflex and of the proximal right
25 coronary artery."

1 Q. So he had three of the main arteries totally occluded?
 2 A. Or branches of those arteries, yes.
 3 Q. Isn't it true the way he was getting blood was through
 4 coronary arteries that were feeding because the main
 5 arteries were occluded?
 6 A. Collateral arteries.
 7 Q. Collateral arteries, okay. That's severe disease; is
 8 it not?
 9 A. Yes.
 10 Q. And that would have pre-existed his myocardial
 11 infarction?
 12 A. Yes, it would have. Plaque buildup is a process that
 13 takes --
 14 Q. Years?
 15 A. At least months to years.
 16 Q. What causes arteries to occlude? And when I say
 17 "occlude," that means basically they're closed off,
 18 correct?
 19 A. There's two processes: The plaque buildup over time
 20 can cause an artery to slowly become 100 percent
 21 occluded, with the development of that atherosclerotic
 22 plaque. And those are the arteries that often have
 23 collaterals that develop to them. The acute occlusion
 24 is often a plaque rupture with a thrombus, which would
 25 be the heart attack that he presented with.

1 Q. So what causes plaque to form?

2 A. That's multifactorial. If I knew the exact answer to
3 that, I'd have a book. But it's high cholesterol or
4 dyslipidemia; typically family history, the usual risk
5 factors: smoking, if a patient smokes; diet; exercise
6 levels.

7 Q. With regard to Mr. Worthen, did he have some risk
8 factors?

9 A. I documented that he had a history of diabetes. He
10 did not smoke. I did indicate a family history of
11 coronary disease. So he would have had a couple of
12 risk factors.

13 Q. How about hyperlipidemia? That's cholesterol; isn't
14 it?

15 A. Yeah, dyslipidemia.

16 Q. That would have been a risk factor?

17 A. Yes.

18 Q. Were you aware that he had a one-and-a-half pack
19 smoking history for 12 years but he quit in 1970?

20 A. No. My history indicates that I commented negative
21 for tobacco use.

22 Q. The fact that he might have smoked for 12 years, would
23 that have been a risk factor, even though he had quit
24 some time back?

25 A. It'd be considered a risk factor, yes.

1 Q. Now, what is the mechanism for a myocardial
2 infarction?

3 A. When blood flow is cut off to the heart muscle, it's
4 deprived of oxygen and begins to die; and in the
5 process of that muscle dying the cells rupture and
6 leak out the cardiac enzymes that we detect in him,
7 detected as the myocardial infarction.

8 Q. In his case, do you think that a piece of plaque broke
9 off and caused a blood clot that totally occluded and
10 brought on the myocardial infarction?

11 A. I'm reading the report. My opinion would be that he
12 suffered a plaque rupture and occlusion of his left
13 anterior descending.

14 Q. The plaque rupture, does plaque reach a critical level
15 where it can break off?

16 A. The plaque actually doesn't break off and embolize.
17 The structure of the plaque becomes unstable, and the
18 top portion, which we call the cap, cracks and exposes
19 the core of the plaque, which is typically a liquid
20 pool of cholesterol material, to the blood, which
21 causes the blood to thrombus or clot off right there.

22 Q. Can that occur with somebody being at rest?

23 A. Yes.

24 Q. Can it occur with people doing mild activity?

25 A. Yes.

1 Q. Basically, can it occur any time anywhere?

2 A. Yes.

3 Q. Is there any test or procedure that can determine why
4 a piece of plaque ruptured?

5 A. No.

6 Q. Does plaque reach a point where it's more susceptible
7 to breaking off? I've heard it referred to as being
8 "ripe."

9 A. The reference there would be what we call a vulnerable
10 plaque, one prone to rupture. And there's currently
11 no way to identify what plaque is vulnerable to
12 rupture. Some rupture at 20 percent narrowing of the
13 artery; some rupture at 80 percent. There's no
14 predicting in that.

15 Q. So you don't know in Mr. Worthen's case how his plaque
16 had progressed to where it was susceptible to
17 rupturing, highly susceptible to rupturing, or not
18 highly susceptible to rupturing?

19 A. No, you wouldn't have known what the underlying plaque
20 looked like the day before or how susceptible it would
21 have been.

22 Q. But without having that coronary artery disease, he
23 would not have had the plaque buildup and the plaque
24 would not have ruptured because the myocardial
25 infarction?

1 A. Coronary artery disease and plaque are interchangeable
2 in our vernacular.

3 Q. So the reason the plaque broke off was because he had
4 the coronary artery disease?

5 MR. DESAI:

6 I object to the form.

7 WITNESS CONTINUES:

8 A. We use those terms interchangeably. So when we say
9 somebody has coronary artery disease, we mean that
10 we're talking about the plaque buildup in the artery.

11 Q. But without the coronary artery disease, he would not
12 have had a heart attack?

13 A. Not completely true. We see heart attacks in people
14 with normal coronary arteries and no underlying
15 coronary artery disease.

16 Q. But in Mr. Worthen's case?

17 A. There would be speculation.

18 Q. If the plaque occluded the artery and brought on the
19 myocardial infarction, then without that plaque, the
20 mechanism that occurred would not have occurred,
21 correct?

22 A. That's a fair statement.

23 Q. Now, it was noted in there that Mr. Worthen had a left
24 ventricular aneurysm. What is that?

25 A. When a heart muscle infarcts and dies it forms a scar.

1 And in some cases that weakened muscle balloons out.
2 And that ballooned-out muscle we call an aneurysm;
3 that's high risk for rupture.

4 Q. And Mr. Worthen had that, correct?

5 A. Yes.

6 Q. Is that indicative that he had had a previous
7 myocardial infarction?

8 A. I've seen aneurysm formation in very short periods of
9 time; so seeing the aneurysm formation doesn't tell me
10 exactly that he had a previous heart attack.

11 Q. But it could indicate?

12 A. It could indicate that, but I've seen it in heart
13 attacks within very short periods of time, too.

14 Q. You did not do the surgery?

15 A. The heart catheterization or the bypass?

16 Q. The bypass.

17 A. Neither.

18 Q. So you really haven't seen what the aneurysm looked
19 like?

20 A. On non-invasive studies. But physically looking at
21 it, no, I wouldn't have seen it; the surgeon would
22 have.

23 Q. Would the surgeon be in a better position to determine
24 whether that aneurysm represented a prior myocardial
25 infarction?

- 1 A. If the aneurysm would have been sent to pathology, you
2 may be able to answer that question. But it would
3 probably require a pathologic or histologic
4 examination, which is not normally done.
- 5 Q. Mr. Worthen had quadruple bypass surgery; is that
6 correct?
- 7 A. Let me review the operative note. Yes, quadruple
8 bypass surgery with an aneurysmorrhaphy.
- 9 Q. What is that latter procedure?
- 10 A. Aneurysmorrhaphy is a resection or a cutting out of
11 that scar tissue.
- 12 Q. The aneurysm?
- 13 A. Uh-huh, (affirmative), yes.
- 14 Q. The reason for the quadruple bypass surgery, was that
15 to cure his coronary artery disease?
- 16 A. We don't use the word "cure," but it was to treat
17 that, yes.
- 18 Q. In other words, that was to get in his heart normal
19 blood flow, because his existing arteries were
20 occluded?
- 21 A. To give his heart, yeah, better blood flow. You can
22 never restore normal, but you can make it better.
- 23 Q. Better than it was prior to his myocardial infarction?
- 24 A. Yes.
- 25 Q. If he had not had the coronary artery disease but for

1 some reason had a myocardial infarction, you would not
2 have done the quadruple bypass surgery?

3 A. Repeat that.

4 Q. If he had not had the coronary artery disease but he
5 may have had a myocardial infarction from some other
6 reason, then you would not have done the quadruple
7 bypass surgery?

8 A. I'll be honest, that one's unanswerable. That's a
9 hypothetical that you can't really put together.

10 Q. But the purpose of the bypass surgery was to correct
11 the blood flow problem he had from the coronary artery
12 disease?

13 A. Yes.

14 Q. Would he have needed that surgery even if he had not
15 had the myocardial infarction?

16 A. Yes.

17 Q. Would it be also fair to say the most proximate cause
18 of his myocardial infarction was his pre-existing
19 coronary artery disease?

20 A. That was the substrate for his heart attack. The
21 questions are getting into very small nuances in
22 words. You have to have the substrate and you have to
23 have some elucidating condition.

24 Q. What are you talking about the substrate; is that the
25 coronary artery disease?

1 A. Yes, the coronary artery disease and then some sort of
2 stressor to cause the plaque rupture.

3 Q. Some type of precipitating factor?

4 A. Precipitating factor.

5 Q. Now, the defibrillator implant, could the ventricular
6 fibrillation have been a result of the surgery? I
7 mean, the fact that he was having this coronary
8 bypass, can that cause someone to have ventricular
9 defibrillation?

10 A. The actual surgery shouldn't cause the ventricular
11 fibrillation. We attribute it almost exclusively to
12 an ischemic or irritated myocardium. Probably, again,
13 in his case, left over from the anterior wall infarct.

14 MR. KALE:

15 That's all the questions I have.

16 RE-EXAMINATION BY MR. DESAI:

17 A. Just a couple of follow-ups, Doctor. I lied, I told
18 you I had four to five questions; I have more. You
19 answered a question which Mr. Kale asked about would
20 he have needed the surgery regardless of the heart
21 attack. And I might not have stated it the exact same
22 way, but that was essentially the question. While
23 your answer is yes, and I believe it was, do you know
24 when that surgery would have been indicated? Could it
25 have been ten years down the road?

1 A. We're in highly speculative grounds at this point.

2 Q. Absolutely, agreed.

3 A. There are presumably large numbers of people
4 functioning with coronary artery disease that are
5 unaware of it; and there's no predicting when they
6 would need an intervention, whether it be a stint or
7 bypass.

8 Q. If at all?

9 A. If at all.

10 Q. Is it fair then to say that there are several people
11 with coronary artery disease that never need a
12 surgery?

13 MR. KALE:

14 Object to the question because it's irrelevant to this
15 particular procedure.

16 EXAMINATION CONTINUES BY MR. DESAI:

17 Q. You can answer.

18 A. Yes, there's people with mild coronary artery disease
19 that never require any intervention.

20 Q. And those people would have the indicators, would have
21 family history, possibly diabetes, possibly
22 hyperlipidemia, history of smoking, etcetera?

23 A. Yes. We see the broad spectrum of people with
24 coronary artery disease and no appreciable risk
25 factors, to people with all of the risk factors and no

1 coronary artery disease.

2 Q. Is it fair then to say there's really no science that
3 says, if you have this, then a surgery is indicated?

4 MR. KALE:

5 Object to the leading.

6 WITNESS CONTINUES:

7 A. The presence of risk factors alone do not mandate that
8 you would end up having any type of intervention,
9 surgery or stint.

10 Q. And you noted earlier and I understand, I think, where
11 you said that there are people basically would just be
12 sitting around and have a heart attack?

13 A. Yes.

14 Q. You did say that, right?

15 A. Yes.

16 Q. Are there any triggering events that could cause heart
17 attacks, such as stress on the heart, muscle issues,
18 heart muscle?

19 A. Yes, there are triggers that could precipitate this:
20 physical stress, emotional stress, extreme activity
21 could all do it.

22 Q. Define extreme activity, Doctor.

23 A. An acute level of exertion, physical exertion, beyond
24 what you may normally do: lifting or running very
25 fast; exerting yourself in a strenuous manner.

1 Q. Lifting heavy weights?

2 A. Lifting heavy weights could do it; that increases the
3 blood pressure usually significantly and the stress in
4 the vascular system.

5 Q. Is it fair then to say that you could have all of
6 these risk factors, you can have coronary artery
7 disease and it could be triggered, and you could be
8 living normal and it could be triggered by an event,
9 a strenuous event?

10 MR. KALE:

11 Object to the leading.

12 EXAMINATION CONTINUES BY MR. DESAI:

13 Q. I'm saying "could."

14 A. Yes, it could.

15 MR. DESAI:

16 That's all I have. Thank you.

17 RE-EXAMINATION BY MR. KALE:

18 Q. Doctor, Mr. Worthen didn't have mild coronary artery
19 disease, did he?

20 A. No.

21 Q. He had severe?

22 A. Yes.

23 MR. KALE:

24 That's all I have.

25 DEPOSITION CONCLUDED AT APPROXIMATELY 5:12 P.M.

**Deposition Transcript of
Travis Ellison, M.D.,
Dated August 22, 2012**

W.C.C. FILE NO. 2203604

COPY

1 W. TRAVIS ELLISON, M.D.

2 being first duly sworn was examined and testified as
3 follows:

4 EXAMINATION BY MR. DESAI:

5 Q. Dr. Ellison, my name is Monty Desai, and I represent
6 the claimant in this case, Mr. Mike Worthen. As you
7 know, the reason we're here today is because you gave
8 an opinion on August 8th of 2011 about what you
9 thought was the reason my client, Mr. Worthen,
10 suffered a heart attack.

11 A. Yes.

12 Q. You've done several of these depositions, --

13 A. I have.

14 Q. -- I'm sure.

15 A. I have, yes.

16 Q. I don't need to go through all the ground rules; I'm
17 sure you already understand all of that stuff.

18 Let's just get into your qualifications, sir. Could
19 you please tell me a little bit about yourself?

20 A. Starting with undergraduate, or with medical school or
21 --

22 Q. Medical school.

23 A. Okay. Medical school at MUSC in Charleston; then a
24 flexible internship and internal medicine residency at
25 the University of Tennessee Memorial Hospital in

1 Knoxville, Tennessee, and began practice here in Greer
2 immediately after that, in 1980.

3 Q. You've been here quite a while; haven't you?

4 A. Yes, I have.

5 Q. So are you an internist?

6 A. I'm an internist, internal medicine, that's correct.

7 Q. Just to kind of -- yesterday we got a phone call from
8 your office stating that you were not willing to talk
9 to me today unless you talked to Mr. Kale, or you got
10 Mr. Kale's permission. Am I right in stating that?

11 A. Well, I wanted to be sure that we were actually doing
12 this, because what I had -- after I had had some talk
13 from your office, I talked to Mr. Kale and he said he
14 didn't think it was going to happen because the
15 hearing had already happened. And then it came up, so
16 I said, well, let me clear this with Mr. Kale before
17 we go doing -- scheduling a deposition. I'm not going
18 to schedule a deposition until I know what's going on.

19 MR. KALE:

20 Let me clarify that. This was actually before the
21 hearing that we talked, and I told him at that point
22 the Commissioner had not ruled on whether he was going
23 to leave the record open for you to take the
24 deposition.

25 MR. DESAI:

1 Sure. Good deal.

2 EXAMINATION CONTINUES BY MR. DESAI:

3 Q. I'm looking at a letter here from Mr. Kale, dated July
4 15th of 2011.

5 A. Yes.

6 Q. Do you have a copy of that letter?

7 A. I do, right here.

8 Q. And in that letter, the first line says, "Dear Dr.
9 Ellison: Thank you for agreeing to provide a medical
10 review of this case ..." I'm assuming that there was
11 a conversation that took place between you and Mr.
12 Kale prior to him writing this letter?

13 A. I'm not sure if it was he or his secretary; it's been
14 a year ago. Sometimes the secretaries will call up
15 and say, you know, Mr. Kale has a disability or -- a
16 medical disability thing, would you take a look at it,
17 and I'll say, fine. So I can't tell you that I
18 actually talked to Mr. Kale. He may remember; I don't
19 remember.

20 Q. How many of these opinions have you written for Mr.
21 Kale?

22 A. Not a huge number. I guess three or four, five, over
23 the years. I'd have to go look, and in the event I'm
24 not sure I have records. I don't really keep them
25 that long.

1 Q. There are things in this letter -- before I get to
2 your letter, there are things in this letter that I
3 kind of want to address --

4 A. Sure.

5 Q. -- that I don't believe might be 100 percent accurate.
6 Not because Mr. Kale was trying to mislead you, but at
7 the time none of us really had any clear picture of
8 what was going on.

9 A. Okay.

10 Q. So let me try to clear some things up for you. Do you
11 absolutely agree that, you know, when you were writing
12 this opinion, that you did understand that this was an
13 estimated weight of 350 pounds, and you didn't take
14 that for gospel, so to speak, of the patient that Mr.
15 Worthen was lifting?

16 A. Because I had a chance to look at some records, and I
17 don't remember what the weight was. I mean, when I
18 saw this letter, and I don't know if I saw different
19 opinions as to what amount of weight he listed when I
20 wrote my letter and when I read this one -- I mean,
21 after I got through reviewing the records that I
22 reviewed, I --

23 Q. Maybe I should ask the question a little better.

24 A. It's not -- I can't -- again, it's a long time ago.

25 Q. Sure, sure. Let me try to ask this a little

1 differently. On August 8th of 2011 you gave an
2 opinion; is that right?

3 A. Right.

4 Q. It was a two paragraph opinion.

5 A. That's correct.

6 Q. And that opinion was based on a letter that was
7 written to you on July 15th of 2011?

8 A. Plus other records. I have records from Dr. -- I have
9 the deposition, I have the Greenville Hospital
10 records, I have John Bettrick's records, and I have
11 Dave Guirao's records. I had them at that time; I
12 don't --

13 Q. Right, and I'm going to get into that in a minute as
14 far as what you had, --

15 A. So that's --

16 Q. -- but the facts provided to you were primarily laid
17 out in this letter dated July 15th of 2011; is that
18 right?

19 A. Well, the essentials, the framework of the facts.
20 This is all I knew -- when I got it on July 15th, this
21 is all I knew. When I wrote this letter, my opinion,
22 I had this other information, too, so it's not just
23 one thing, it's all of this together.

24 Q. Sure, I --

25 A. And really, my opinions are based more on the facts

- 1 rather than what he sent to me, versus what he wrote
2 to me.
- 3 Q. Okay, fair enough. But you did understand that it was
4 an estimated weight of 350?
- 5 A. That's what this letter says.
- 6 Q. Good, because the Run Report says 350; it doesn't say
7 anything about estimated or anything like that.
- 8 Q. The what does?
- 9 A. The Run Report, the Emergency Run Report.
- 10 A. And I don't -- again, I would have to go back and look
11 through all the records to see if I saw anything that
12 said anything differently, but I don't know that this
13 -- that there was anything to contradict this opinion.
14 I have nothing in my -- that I can remember or that I
15 know of that would contradict this opinion.
- 16 Q. Also in that letter, if you look halfway down that --
17 or three-quarters of the way down this page, it says,
18 "It is my understanding" -- and this is Mr. Kale
19 saying to you, "It is my understanding that with a
20 power stretcher you can raise or lower the stretcher
21 to the height of the bed and then pull the patient
22 onto the stretcher." Do you remember reading that?
- 23 A. Yes, I do.
- 24 Q. What's your understanding of that particular line? I
25 mean, this sentence means what?

1 A. I've seen power stretchers before, and they have a
2 hydraulic lift that raises and lowers it, and then --
3 you know, these things are level, and you pull or push
4 people from one and you roll them over, you lift them
5 on a board. Oftentimes, at least the ones I've seen,
6 most of the time they're lifted on boards and moved
7 from one to the other. When they're going into the
8 ambulance, they put it up to the ambulance and then
9 they raise it up, and the person at the back has to
10 hold it and push it in, you know. So that's my --
11 I've seen these work in the emergency room, in the
12 hospital, you know, just from my experience, so when
13 he said that, you know, my -- it says -- if he had
14 power stretcher, that would be my understanding, too.
15 I mean, I don't know, and again I have no remembrance
16 that there was anything said about power stretchers,
17 no power stretchers or whatever. I can't answer that
18 question without looking at records. And they may be
19 in these records here.

20 Q. What was your understanding of the mechanism as to how
21 the patient was transported from the bed to the
22 stretcher?

23 A. I mean, the only thing I would suppose, and this was
24 again my not remembering, guessing. You take a
25 stretcher into the room, you put it to the level of

1 the bed, you take the person and you roll them on a
2 board and carry it over, or you take the board and a
3 sheet and pull them over. That's what I see, have
4 seen done, and I would assume that that's what -- but
5 I don't know that.

6 Q. Was your opinion based on that assumption?

7 A. Yes.

8 Q. Would it change any if I were to tell you that that
9 stretcher was not level with that bed, there was no
10 draw sheet, there was no board? Would that change
11 your opinion at all?

12 MR. KALE:

13 Let me object because, what opinion are you talking
14 about?

15 MR. DESAI:

16 His entire opinion based on the fact -- he's -- can we
17 just go off the record just for a second, please?

18 (OFF RECORD DISCUSSION)

19 MR. DESAI:

20 Let's go ahead and note that objection, and go ahead
21 and answer the question now.

22 WITNESS CONTINUES:

23 A. It would not change what I wrote in this letter.
24 There's nothing about his picking it up, no matter
25 what he did at the site, that would change my opinion

1 as to this letter and what I wrote in this letter.

2 Q. And why is that?

3 A. Because I am not talking about anything except the
4 fact that his coronary artery disease is what caused
5 his infarction. The fact that he picked up something
6 else that may have been a contributing event to the
7 acute event, but it had nothing to do with the fact if
8 he had not had coronary artery disease, he would not
9 have had an infarction.

10 Q. So are you saying the pre-existing condition is what
11 caused this?

12 A. Yes, absolutely.

13 Q. I don't disagree with you.

14 A. Absolutely. That's what this says.

15 Q. But my question, let me ask you this. Is lifting a
16 fairly strenuous event?

17 A. Yes.

18 Q. Would you agree with the cardiologist, Dr. Bettrick,
19 when he says that lifting somebody, even -- let's just
20 say 350 pounds -- is strenuous? Would you agree with
21 that?

22 MR. KALE:

23 Let me object because you're misstating Dr. Bettrick's
24 testimony. Dr. Bettrick was told that the patient
25 weighed 500 pounds.

1 MR. DESAI:

2 Well, I'm giving the benefit of the doubt, telling him
3 350.

4 MR. KALE:

5 But then you can't quote it as being in agreement with
6 Dr. Bettrick if you're changing the facts that Dr.
7 Bettrick based his statement on.

8 EXAMINATION CONTINUES BY MR. DESAI:

9 Q. Would you agree that lifting a 300-pound person is
10 strenuous?

11 A. Yes.

12 Q. Don't you think that ought to be considered in giving
13 an opinion as to what could have triggered that acute
14 event that you just mentioned?

15 A. Well, I mean, there is no question that usually -- not
16 always -- there are events that go on in addition to
17 the acute infarction. Now many people have acute
18 infarctions at sleep, you know, and we think it's
19 elevated catechols and other reasons like that. Other
20 people will do it after strenuous events with high
21 catechols, high heart rate, and they will have -- you
22 know, it'll be a triggering event, if you will, if
23 they have a strenuous, that -- so that you -- yes, you
24 can -- when you have the heart attack, a strenuous
25 event may have been a triggering event, but it would

1 not have happened, it could not -- you know, you would
2 not see an acute myocardial infarction of the type
3 that he had if he did not have significant advanced
4 arteriosclerosis. That's all I can say.

5 Q. Let me go ahead and lay it out on the table.

6 A. Okay, put it out.

7 Q. You're not going to get a single objection out of me
8 --

9 A. Absolutely.

10 Q. -- if you say -- or when you say that this -- that he
11 had a pre-existing condition. There's no question
12 about that.

13 A. Right.

14 Q. I just want you to focus on the triggering event. I
15 want you to talk about what brought about this
16 particular incident. Is it possible to a reasonable
17 degree of medical certainty that him lifting this
18 350-pound man could have triggered what was a
19 pre-existing condition and then causing a heart
20 attack?

21 A. There's no question that a strenuous event, which
22 lifting 350 pounds would be, could trigger, because of
23 the stress and the catecholamines and everything else
24 that goes along with that, an acute event, yes, it
25 can.

1 Q. To a reasonable degree of medical certainty?

2 A. To a reasonable degree of medical certainty.

3 Q. Is it just coincidental that it just happened right
4 after he got done through this strenuous event?

5 A. I mean, it's kind of one of those things you say, is
6 it coincidental, no, I wouldn't think so. I mean, he,
7 he -- because he was doing some strenuous activity, he
8 then triggered severe myocardial ischemia, which
9 causes non -- it's a non-ST infarction. In other
10 words, he had a minimal amount of damage to his heart
11 at the time of the infarction, but, you know, he had
12 just advanced disease. It -- the event of his picking
13 it up did trigger that non-ST -- that non-STEMI --
14 infarction that brought him to the hospital. I would
15 say --

16 Q. More likely than not?

17 A. Yes, yes. I would agree that that's exactly right.

18 Q. So then you would say that to a reasonable degree of
19 medical certainty this event --

20 A. Was triggered by the fact that he did some heavy
21 lifting.

22 Q. The heart attack was?

23 A. Yes.

24 Q. There are certain facts stated in here about him
25 experiencing a pain when he woke up. Do you remember

1 that?

2 A. When was this, now, I'm sorry?

3 Q. If you'd just look at all the way --

4 A. Where are we talking about?

5 Q. The second page, second paragraph, --

6 A. Right.

7 Q. -- about midway.

8 A. Which --

9 Q. It starts mentioning the Hillcrest Memorial Hospital

10 E.R., on February 18th.

11 A. "Was treated on February 4, left shoulder pain."

12 Okay, okay. He had taken a nap and woke up with

13 shoulder pain. Okay.

14 Q. Now how was that of any significance in giving your

15 opinion, or did you even consider that?

16 A. It wasn't -- I mean, this could have been angina. It

17 definitely could have been angina. I mean, was it?

18 I mean, I can't tell you for sure; I don't know how --

19 because probably the chest -- the pain he had in the

20 back was -- obviously was heart-related, and if this

21 were the same I would assume that this was angina. If

22 it wasn't, then -- of course, it may or may not have

23 been, but my guess is it was angina.

24 Q. Would it --

25 A. Change my opinion?

1 Q. No, not this particular opinion, but would it surprise
2 you if I were to tell you that he didn't just wake up
3 with this and he actually fell down and dislocated his
4 shoulder, and that's what was the cause of the pain?

5 A. I mean, I don't remember seeing that.

6 Q. But it didn't play any part in your --

7 A. Oh, no.

8 Q. -- opinion, one way or the other?

9 A. No, it would not have made any -- that would not have
10 made any difference in that, no.

11 Q. Have you had an opportunity to review the Hillcrest
12 medical -- Memorial Hospital's medical records?

13 A. I don't think so. I think all mine, the records that
14 I reviewed, were just from Greenville Memorial. I
15 don't think I reviewed the Hillcrest records. Because
16 I didn't write down that I had, so I'm assuming that
17 I did not. Unless they were included with the
18 Greenville Memorial records, and I doubt that.

19 Q. And nobody's actually disagreeing that the heart
20 attack took place. And I think Mr. Kale would agree
21 on that.

22 A. There's no question about it.

23 Q. There are some facts stated in the letter, all the way
24 down at the end of that paragraph, about him having
25 his infected left third toe -- the amputation of his

1 toe?

2 A. I'm sorry, let me see where you're talking about here.
3 (Reviewing records) Yeah, I see that. Okay.

4 Q. That he had his toe amputated, do you remember reading
5 that?

6 A. Now that you say so, but I don't remember it.

7 Q. In June of 2010, and the fact there was an EKG
8 conducted prior to that operation?

9 A. Uh-huh (affirmative).

10 Q. And that that EKG was normal, so to speak?

11 MR. KALE:

12 No, it doesn't say that.

13 EXAMINATION CONTINUES BY MR. DESAI:

14 Q. Do you --

15 MR. KALE:

16 I object to you --

17 WITNESS CONTINUES:

18 A. Have I see an EKG? No.

19 Q. You have not seen the EKG?

20 A. No.

21 Q. So you have no way of knowing one way or the other
22 what that EKG said?

23 A. No, no clue about that.

24 Q. Really, assuming that EKG was -- did not show any kind
25 of abnormality, what would that tell you about an

1 individual?

2 A. Well, unfortunately, EKGs are not really good ways of
3 -- obviously, it didn't show that he had coronary
4 artery disease. Did it show that he had -- at that
5 juncture -- had not had a significant infarction that
6 you could see on the EKG? I would assume, if it says
7 normal, probably not. Is that 100 percent? No, you
8 can still have infarctions and not have -- and
9 particularly if they're small infarctions.

10 Q. Does that add validity to the fact that -- validity to
11 the fact that lifting this 300-pound man and the
12 stress that it could have caused is what led to that
13 heart attack?

14 A. You mean, does it make any difference? No. It
15 doesn't tell me one way or another. I mean, does it
16 still -- I mean, I don't think there's any question,
17 you know, that that was a contributing factor to the
18 fact that he had the heart attack, if you want a
19 triggering event, yes.

20 Q. That was the causation? That was the cause that that
21 heart attack took place, right?

22 MR. KALE:

23 Object to the question. I think it's been asked and
24 answered, and you're just testifying for him. You can
25 ask him a question.

1 WITNESS CONTINUES:

2 A. It was the precipitating event of that non-STEMI --
3 that acute ischemic event, mild heart attack that he
4 had that led him to the hospital to let him get
5 by-passed. No question.

6 Q. Does everybody have coronary artery disease to a --

7 A. Does everybody have --

8 Q. Does everybody have some sort of coronary artery
9 disease?

10 A. No.

11 Q. I mean, some sort of blockage, maybe some not so
12 severe than the other?

13 A. Oh, there are a lot of people who have some coronary
14 artery disease. We have all degrees. You know, if
15 you look at everybody's heart, including my own. I
16 mean, do I have some? Yeah, I'm pretty sure I do. Is
17 it enough to have anything done? No. Do you have
18 some? I don't know. I mean, everybody -- but unless
19 it becomes clinically significant, you don't go --

20 Q. I do; I take Lipitor.

21 A. I mean, but you don't get catheterizations and -- you
22 know, you may do a stress test and they may even do a
23 chest -- you know, a CT angio, but do we know how
24 much?

25 Q. And that's, I guess, really my point. So while Mr.

1 Worthen might have had this significant -- or he was
2 at significant risk because of his coronary artery
3 disease, had it not been for this strenuous event he
4 could have gone another five or six years without a
5 heart attack; is that right?

6 A. You're talking speculation.

7 Q. Exactly right, we are speculating at this point;
8 aren't we?

9 A. I cannot give you -- I mean, I'm surprised, honestly,
10 that he hasn't had an event and died suddenly before
11 he had this event. You know, honestly, he was very
12 lucky that he had a minor ST instead of an acute
13 transmural infarction, because if he'd had a
14 transmural he'd be dead. I can tell you right -- I
15 mean, there's no question in my mind, he would not
16 have survived it. But that's just an opinion. It
17 doesn't have anything to do with -- could it have
18 happened any time, you know, years before? Yes, it
19 could have, because this doesn't happen fast.

20 Q. Or years later?

21 A. Or years later, because some people go along for
22 substantial periods of time, and amazingly, despite
23 the fact they have advanced disease, never have a
24 heart attack.

25 Q. How much training have you had specifically with the

1 heart?

2 A. Other than taking -- no training, educational
3 training. All of mine has been basically what I
4 learned in my residency, and then as I worked through
5 the years.

6 Q. Would you agree that a cardiologist would probably
7 have more knowledge --

8 A. No question.

9 Q. -- in heart disease, heart attacks?

10 A. That's what they do, that's exactly right.

11 MR. DESAI:

12 All right, that's all I have.

13 EXAMINATION BY MR. KALE:

14 Q. Let me ask you this, Dr Ellison. As a part of your
15 practice, do you treat heart patients?

16 A. All the time.

17 Q. Is that a prominent part of your practice?

18 A. It is. In the past it's been the major part, and now
19 that I'm not doing hospital work it becomes less, but
20 it's still probably at least a large number.

21 Q. Are you knowledgeable then about heart disease,
22 coronary artery disease, heart attacks and those type
23 things?

24 A. I am, and I keep up with the literature on them.

25 Q. Now let me show you the catheterization report; if

1 you'll pull that out?

2 A. Okay.

3 Q. This was a catheterization report that was done one
4 day after Mr. Worthen had his M.I.

5 A. Right.

6 Q. What does it show? And just for the record, that's
7 APA No. 8, page 246, in the APAs.

8 A. His Impression at the end, from Dr. Ross, is "Three
9 vessel coronary disease with 3 vessel total occlusion
10 after the proximal 3rd of the [LAD] left anterior
11 descending of the second and primary marginal branch
12 of the circumflex and of the proximal right coronary
13 artery." And it says, "Left ventricular dysfunction."

14 Q. Would this be classified as severe coronary artery
15 disease?

16 A. Yes, it would.

17 Q. In someone who had that degree of heart disease --
18 excuse me -- of coronary artery disease, could they
19 suffer a heart attack at any time?

20 A. Oh, yes, absolutely.

21 Q. Do people who have that degree of coronary artery
22 disease suffer myocardial infarctions at rest?

23 A. Yes, they do.

24 Q. Can just walking cause a myocardial infarction?

25 A. I don't know if you -- that kind of an -- it can

1 happen at any time, whether you're at rest or at
2 activity, because you see it frequently, you know, not
3 only with activities, whether strenuous or not, and at
4 night and, you know, when they're resting and they're
5 sitting, so the correlation between events and
6 activity is something that is not definitive, by any
7 means.

8 Q. Now given the degree of severe coronary artery disease
9 that he had, would it be your opinion that that
10 coronary artery disease pre-existed his myocardial
11 infarction?

12 A. Yes, it did.

13 Q. In fact, if it hadn't pre-existed, could he have had
14 a heart attack?

15 A. In my opinion, no.

16 Q. And is that your opinion within a reasonable degree of
17 medical certainty?

18 A. Yes, it is.

19 Q. Now if you look at Dr. Ross' report on the
20 catheterization, the third sentence on his report,
21 what does he refer to?

22 A. According to what Dr. Ross says, "The patient had
23 extreme coronary [artery] disease and I thought
24 surgical consultation was in order."

25 Q. Okay. So he refers to it as extreme; you refer to it

1 as severe. Is that basically both of you think that
2 it's really a significantly bad coronary artery
3 disease?

4 A. Yes, we both do.

5 Q. Now according to the medical reports, Mr. Worthen had
6 diabetes mellitus?

7 A. Yes.

8 Q. Hyperlipidemia?

9 A. Yes.

10 Q. And hypertension?

11 A. Yes.

12 Q. Do these conditions play any part in the development
13 of coronary artery disease?

14 A. We know for sure that the hyperlipidemia and diabetes
15 have a significant effect on the development of
16 coronary artery disease. Hypertension is not as sure,
17 but it seems to, it seems to go along with it; in
18 other words, whether it's a cause or just an
19 associated medical condition is hard to know for sure.

20 Q. How about obesity, does that play a part in the
21 development of coronary artery disease?

22 A. As far as we know, no, sir. There are many obese
23 people with no coronary artery disease and many very
24 skinny people with advance coronary artery disease, so
25 obesity doesn't seem to play a part in that. Or not

1 directly.

2 Q. In your opinion, did Mr. Worthen's diabetes mellitus
3 and hyperlipidemia cause the development of his
4 coronary artery disease?

5 A. Were they significant factors in the development?
6 Yes, they were.

7 Q. Is that to a reasonable degree of medical certainty?

8 A. Yes, it is.

9 Q. Mr. Worthen has testified that he was unaware that he
10 had coronary artery disease before he had his
11 myocardial infarction. Is that an uncommon situation?

12 A. No, it is not.

13 Q. Do a majority of the people who have their first
14 myocardial infarction, are they unaware that they have
15 coronary artery disease?

16 A. Talking about statistics, it's hard to know. In the
17 past they have identified -- and again, how much that
18 is true now, as we move into newer situations -- that
19 as many as half the people who have heart attacks were
20 unaware. Is that still true? I am not sure.

21 Q. But it's not an uncommon situation?

22 A. It is not uncommon.

23 Q. How does a myocardial infarction occur in the presence
24 of coronary artery disease?

25 Q. Well, you have -- again, you have two different, well,

- 1 two different scenarios. In the case of the typical
2 -- what they call one of the more severe heart
3 attacks, I should say, you have a rupture of a plaque
4 with total occlusion of one of the coronary arteries.
5 In this case, from looking at what he wrote, he
6 couldn't tell for sure if there was any acute
7 occlusion or if it was just because of an
8 insufficiency of blood that caused this acute event.
9 At least I can't say that from what I see, and he
10 doesn't say that either. He did say in here --
- 11 Q. And when you say "he" --
- 12 A. Dr. Ross, I'm sorry. Dr. Ross, I was talking about
13 Dr. Ross.. He does not talk about an acute occluded
14 artery -- acutely occluded artery, that I can
15 ascertain from looking at it.
- 16 Q. If there was not an acute occluded artery, would that
17 mean that basically the myocardial infarction occurred
18 because there was not sufficient blood supply, based
19 on his pre-existing coronary artery disease?
- 20 A. That would be my interpretation of that; that would be
21 my understanding of that.
- 22 Q. The other way that it would occur would be for there
23 to be a blood clot formed?
- 24 A. Usually a ruptured plaque in one of the, one of the
25 coronary arteries, which then leads to a blood clot;

- 1 and then that is what precipitates the acute event.
- 2 Q. My understanding -- and you can disagree or agree --
- 3 is that when plaque ruptures, there is a release of
- 4 cholesterol and fatty acids into the blood, and those
- 5 cause the blood to clot?
- 6 A. The plaque is full of cholesterol and fatty acids, and
- 7 it has a -- the substance of a plaque has a tendency
- 8 to cause an acute thrombus formation.
- 9 Q. And the thrombus, if there is a thrombus, that would
- 10 further occlude the coronary artery?
- 11 A. That's correct, that occludes the coronary artery.
- 12 Q. But in this case, in reviewing the medical records you
- 13 cannot determine whether there was an acute occlusion
- 14 or not?
- 15 A. I mean, no, because he has so many blockages, I am not
- 16 sure what Dr. Ross' thoughts were when he saw it. You
- 17 know, he just gives what the information was. But, I
- 18 mean, his initial report here is that the emergency
- 19 room showed an anterior wall infarction and poor
- 20 inferior forces, and he has, of course, the LAD with
- 21 an occlusion of the -- with occlusion of the LAD, I
- 22 mean after the modification of the diagonal branch,
- 23 but it was -- you know, so I don't know if he thought
- 24 that was acute or not. I can't, I can't answer that
- 25 question, and so I don't -- I looked at this cath

1 report and I noted it, you know, when I saw it, but I
2 didn't pay a whole lot of attention, was this an acute
3 thrombus or was it an ischemic event related to poor
4 coronary flow because of his large --

5 Q. Well, let's --

6 A. That's kind of a -- I guess I'd consider that an
7 academic point at that -- when I looked at this.

8 Q. Assuming that plaque did rupture and that a thrombus
9 formed, can that be caused by physical exertion?

10 A. Well, what you would assume is that you have stress on
11 the heart that's greater than its ability to provide
12 blood, and that you also have catechols which cause a
13 coronary spasm, which may also add to that dynamic.

14 Q. But if you have a thrombus that further occludes the
15 coronary arteries, what activity you might have been
16 able to do pre the thrombus, you might not be able to
17 do after the thrombus further occludes. Is that a
18 fair statement?

19 A. Usually when you have an acute plaque rupture with a
20 thrombus formation, you have an acute event and you're
21 not -- you know, you're sick and you're going to the
22 hospital to get something done or you die.

23 Q. Now as far as someone with Mr. Worthen's extent of
24 coronary artery disease, would just going on an EMS
25 run, could that be enough emotional or physical stress

1 to cause a myocardial infarction?

2 A. I mean, I have seen people who do things that are not
3 physically strenuous who end up with myocardial
4 infarctions, and we assume that it's because of the
5 elevated catechols with increased coagulation and
6 platelet aggregation, ruptured plaque, those things
7 having occurred, you know, that were related more to
8 the emotional, if you will, psychological stress as
9 opposed to the physical stress. You can't measure
10 those kinds of things, and so it's all -- you
11 understand the physiology of it and you understand
12 that it could happen, but there's no way to clearly
13 make a definitive, you know, --

14 Q. Let me show you Dr. Bettrick's deposition, and I want
15 to call your attention to this statement. And I'll
16 read it into the record. "Most heart attacks,
17 anecdotally, we seem to see people presenting just
18 doing their normal activities." Would you agree with
19 that statement?

20 A. I think -- yeah, I mean, because -- and when you
21 include sleeping, resting -- you know when you say
22 "normal activity," a lot of those people are awakened
23 from sleep or sitting in a chair watching TV or, you
24 know, or just doing normal walking -- you know, doing
25 things around -- I mean, that would make -- that's

1 probably -- I would agree with that, I'm sorry. I
2 would agree with that.

3 Q. And let me ask you this. He was diagnosed as having
4 a non-Q-wave myocardial infarction. What is a
5 non-Q-wave myocardial infarction?

6 A. What that usually represents -- I mean, non-Q-wave
7 means that it doesn't completely -- it's usually
8 associated with a non-total occlusion -- an acute
9 occlusion of a coronary artery, but that's not 100
10 percent. I mean, if it doesn't cause a Q-wave -- in
11 other words -- and Q-waves are associated with
12 scarring of the heart -- then we consider -- we call
13 that a non-Q-wave, and then there's a non-ST segment
14 -- if they have a non-ST segment but not a Q-wave, and
15 so it's kind of a -- what it's talking about is
16 usually the degree of damage to the heart muscle. And
17 there's non-Q-wave, and I think -- I'd have to go back
18 and look -- his enzymes reflected the fact that there
19 was not a huge amount of damage to the heart with the
20 heart attack that he had at that time, right before
21 that catheterization, or that day, you know, when he
22 was seen. I think, as I remember. That -- again,
23 this is going back and I'd have to go back and look at
24 that.

25 Q. What is a silent myocardial infarction?

1 A. You can have a heart attack with absolutely no
2 symptoms, or nothing that you recognize. A lot of
3 these -- I mean, there are people who've come in and
4 you do catheterizations or other things, and you find
5 evidence for an infarct; and you go back and they had
6 no idea that it ever happened. If you could go back
7 and talk to them at the time, there probably were
8 symptoms, they just didn't realize it was a heart
9 attack. They were short of breath, they were tired,
10 they had chest discomfort, they had arm discomfort,
11 neck discomfort, you know, all kinds of other -- even
12 a back discomfort, and they just didn't realize it was
13 their heart.

14 Q. Now on March 2 of 2011, MR. Worthen had a quadruple
15 bypass grafting.

16 A. Uh-huh (affirmative).

17 Q. Was that done to treat his pre-existing coronary
18 artery disease?

19 A. Yes, it was.

20 Q. Would he have had to have that surgery, even if he had
21 not had a myocardial infarction if they knew that he
22 had the extent of coronary artery disease that he had?

23 A. Yeah. I mean, the fact that he had the infarction did
24 not -- would not have affected whether he had bypass
25 or not. It was his coronary anatomy, and they would

1 have said, this person needs a bypass.

2 Q. Now let me get you to refer to your letter again that
3 -- you mention in there that Mr. Worthen, based upon
4 your medical review of the records, may have had at
5 least on significant myocardial infarction previously.

6 A. And I say that because he was found to have an
7 aneurism, which is obviously a scarring or damaged
8 heart muscle.

9 Q. And that was based on --

10 A. Because he had that, and when he had the bypass -- let
11 me look at this thing again. (Reviews document) Yeah,
12 the apex is akinetic, and -- which usually -- you
13 know, akinesis means it doesn't move. A normal heart,
14 all parts of the heart move. A damaged heart, it
15 doesn't move. And so, therefore -- and again, the
16 angio-apical segment is akinetic. Those are areas --
17 the inferior wall is hypokinetic; that means it
18 doesn't work. So those all suggest damage to the
19 heart muscle, and I -- usually these are due to
20 smaller, if you will, silent or whatever, ischemic
21 events, myocardial -- small, maybe you call them
22 infarctions, call them ischemic events, I don't know
23 what you want to say there. So I was basing that on
24 the fact that, you know, he had some scarring to the
25 heart, and scarring to the heart with akinesis and

- 1 hypokinesia is due to the cardiac ischemia. It's due
2 to the coronary artery disease. I simplified it in
3 calling it a heart attack, and which I can't -- you
4 know, nobody knows for sure. I mean, you could ask a
5 cardiologist their thoughts on that.
- 6 Q. Now as far as the weight of the patient that Mr.
7 Worthen and his partner were picking up, let me advise
8 you that's in dispute.
- 9 A. I understand.
- 10 Q. But one thing, when you were asked about picking up a
11 certain weight, with paramedics and a stretcher there
12 are two people picking up that weight?
- 13 A. That's correct.
- 14 Q. So Mr. Worthen wouldn't have been picking up 350
15 pounds by himself?
- 16 A. I would assume not.
- 17 Q. Using a stretcher, they would not; would they?
- 18 A. No.
- 19 Q. Now let me show you a record that came from National
20 Health Care for the patient, which was Joe Koon
21 (phonetic). And what does it show is the weight of
22 Mr. Koon in that report?
- 23 A. Two hundred and 62 pounds. Is that correct? I guess
24 that's -- 200-and-something. Two hundred and 62, it
25 looks like. Okay.

1 Q. And basically for two paramedics, picking up a
2 262-pound patient, would that be something that they
3 would do quite -- every day?

4 MR. DESAI:

5 I object; he's not qualified --

6 WITNESS CONTINUES:

7 A. On a regular basis, I would think.

8 MR. KALE:

9 That's all the questions I have.

10 RE-EXAMINATION BY MR. DESAI:

11 Q. Did you get to see the Run Report, Doctor?

12 A. I did. I read the Run Report, but I cannot tell you
13 what it said.

14 Q. Do you remember reading Mr. Kale's letter to you,
15 dated July 15, 2011?

16 A. Yes.

17 Q. In that letter, do you remember Mr. Kale telling you
18 to base your opinion on a 350-pound man?

19 MR. KALE:

20 That is a total misstatement of what that says. What
21 that says, and let's read it into the record,
22 "However, the report of the ambulance run estimates
23 the patient's weight at 350 pounds." I did not tell
24 him to base his opinion on that; and, in fact,
25 previous to that I said Mr. Worthen estimates the

1 weight as being 400 to 450 pounds. I did not tell him
2 to base anything on any of those weights; and, in
3 fact, --

4 Q. Do you have that report?

5 A. Yes, I do.

6 Q. You've been asked to speculate a lot today. You've
7 been asked, could this pre-existing condition have
8 caused it. And there's no question that there was a
9 pre-existing condition, right?

10 A. That's correct.

11 Q. But as it pertains to this particular triggering
12 event, do you still hold your initial opinion that you
13 gave me that this strenuous event of transferring the
14 patient triggered his heart attack?

15 A. Yes, I think that's correct. It was a triggering
16 event.

17 Q. And you maintain that?

18 A. Yes.

19 Q. So regardless of what he had, hyperlipidemia,
20 diabetes, the triggering event was this particular
21 strenuous event; wouldn't you say?

22 A. Yes.

23 Q. And you mentioned that he wouldn't have had to have
24 surgery -- he would have eventually had to have
25 surgery, bypass, anyway; is that what you said?

1 A. Well, you know, that's speculative, obviously. If he
2 was found for some reason -- had angina, had some
3 other event that says, you know, hey, you need a
4 stress test and it's abnormal, or whatever, as soon as
5 they found out what his heart muscles looked like, he
6 would have bypassed.

7 Q. Not that particular day, though, right, had it not
8 been for this event?

9 A. Right. I mean, if he had had that event the next day,
10 then it would have happened; if it happened two days
11 before, one year later, one week later. I mean, I
12 can't tell you. There's too many other scenarios.
13 But because he had this event and because they found
14 his coronary artery disease, he had his bypass.

15 Q. And we are talking about a more severe and extreme --
16 that stuff doesn't happen overnight; that plaque
17 doesn't get built up --

18 A. That takes years and years, absolutely.

19 Q. But he hadn't had a heart attack since -- I mean,
20 could it happen several other years, had it not been
21 for this event, before he would have needed surgery?

22 A. There is no way I can even begin to tell you that. We
23 just cannot know; we just cannot know.

24 MR. DESAI:

25 Thank you, sir.

1 RE-EXAMINATION BY MR. KALE:

2 Q. If he had not had the surgery when he did, might he be
3 dead right now?

4 A. Could he, yes?

5 Q. If he hadn't had the coronary bypass surgery --

6 A. If he had an acute transmural -- you know, a Q-wave
7 infarction, I doubt -- without surgery, I don't think
8 he would survive it. And again, he was extremely
9 fortunate that they found it and did the bypass.
10 Davis is a great surgeon, does good work.

11 MR. KALE:

12 That's all.

13 MR. DESAI:

14 Just one more thing. Doctor, do you need your copy of
15 the letters? Can I make that an exhibit?

16 WITNESS:

17 Absolutely.

18 MR. KALE:

19 Let's just put them all since he was referring to
20 them.

21 MR. DESAI:

22 Exhibit 1 is Dr. Ellison's opinion, initial opinion.
23 Exhibit 2 is Mr. Kale's letter to Dr. Ellison
24 requesting an opinion.

25 And I think you referred to these; you made reference

1 to the APAs; did you not?

2 MR. KALE:

3 I'm going to put them in.

4 (Plaintiff's Exhibits Nos. 1 - 2 marked for
5 identification.)

6 (Defendant's Exhibits Nos. 1 - 3 marked for
7 identification.)

8

9 DEPOSITION CONCLUDED AT APPROXIMATELY 5:05 P.M.

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Spartanburg Regional

PHYSICIAN GROUP

at PELHAM



August 8, 2011

Mr. Richard B. Kale, Jr.
Willson Jones Carter & Baxley, P.A.
Attorneys at Law
872 S. Pleasantburg Drive
Greenville, SC 29607

RE: Michael Worthen vs. Laurens County
WCC File No.: 11036404 DOI: 2/27/2011
Claim No.: 58-232221
WJC&B File No.: 0560.00425

Dear Mr. Kale:

I have reviewed the deposition of Mr. Michael Worthen, records from Greenville Memorial Hospital, records from Dr. Jon M. Bettrick, and records from Dr. David Guirao as requested in reference to the above noted case. As noted in the records Mr. Worthen had advanced coronary disease, which led to his myocardial infarction and subsequent coronary artery bypass surgery. The cause of the coronary artery disease was his diabetes mellitus, hyperlipidemia, and possible hypertension. It is noteworthy that Mr. Worthen was remarkably functional and asymptomatic given the very advanced degree of his disease - all three main coronary arteries occluded with most of the heart muscle being perfused by collaterals. It is also noteworthy that Mr. Worthen had at least one significant prior myocardial infarction or several smaller events as indicated by his left ventricular aneurysm which was repaired at surgery.

Given the above noted facts, it is my medical opinion that his myocardial infarction could have occurred at any time. It is very fortunate for Mr. Worthen that because of his medical training, he recognized his symptoms as being possibly cardiac related and that he was able to get such excellent medical care so promptly.

If I may be of further assistance, please let me know.

Very truly yours,

W. Travis Ellison, M.D.

WILLSON JONES CARTER & BAXLEY, P.A.

ATTORNEYS AT LAW

GREENVILLE

CHARLESTON

COLUMBIA

CHARLOTTE

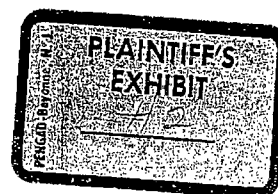
RALEIGH

Richard B. Kale, Jr.
Direct (864) 527-3272
Fax (864) 235-6015
rbkale@wjlaw.net

872 S. Pleasantburg Drive
Greenville, SC 29607
www.wjcbllaw.net

July 15, 2011

W. Travis Ellison, M.D.
Internal Medicine of Greer, P.A.
2755 S. Hwy 14
Village at Pelham
Greer, SC 29650



Re: Michael Worthen vs. Laurens County
WCC File No.: 1103604 DOI: 2/27/2011
Claim No.: 58-232221
WJC&B File No.: 0560.00425

Dear Dr. Ellison:

Thank you for agreeing to provide a medical review of this case for an opinion as to causation of Mr. Worthen's myocardial infarction. Mr. Worthen has been employed as an EMT in Laurens County since approximately 2008. On February 26, 2011, he and his partner were working in Medic 2 Ambulance in Laurens County and received a respiratory distress call from NHC of Clinton. When they arrived at the patient's room, they noted that the patient was in severe respiratory distress. Mr. Worthen has estimated that the Claimant weighed between 400-450 pounds, and that he and his partner lifted the patient off the bed onto a stretcher. However, the report of the ambulance run estimates the patient's weight at 350 pounds. I am enclosing a copy of Mr. Worthen's deposition and the ambulance run report for your review. Mr. Worthen testified that at that time he felt a pain behind his left shoulder blade, but no chest pain. Mr. Worthen testified that the pain lasted for a few seconds but then went away. He and his partner then loaded the patient into the ambulance using a power stretcher and transported him to the Emergency Room at Laurens County Hospital. It is my understanding that with a power stretcher you can raise or lower the stretcher to the height of the bed and then pull the patient onto the stretcher. Mr. Worthen testified that the Emergency Room was busy, so he and his partner again transferred the patient from the stretcher to a bed in the Emergency Room department. At that time, Mr. Worthen again felt a pain behind his left shoulder blade, which lasted 30 seconds to one minute. Thereafter, Mr. Worthen started experiencing difficulty breathing. On the way back to the station, Mr. Worthen told his partner to call their supervisor and advise him that he was going home because he thought he might have the flu. However, when he arrived back at the

station, his partner checked his oxygen which was 97%. Because the Claimant was not feeling "right", he asked his partner to put him on an EKG monitor which indicated he was having a heart attack. When another paramedic arrived at the station, he talked the Claimant into going to the hospital and he was transported to Greenville Memorial Hospital. Mr. Worthen was placed on a stretcher and was monitored with a cardiac monitor and started on IV until he arrived at the Chest Pain Center at Greenville Memorial Hospital. At the hospital, Mr. Worthen was treated by Dr. Jon M. Bettrick, a cardiologist. On March 2, 2011, Mr. Worthen underwent bypass surgery by Dr. Barry Davis.

I am enclosing the medical records we have obtained from the Greenville Memorial Hospital concerning the treatment of Mr. Worthen. I am also enclosing Dr. Bettrick's report of April 12, 2011. Mr. Worthen's family physician is Dr. David Guirao of Internal Medicine Associates of Greenville. Dr. Guirao was treating the Claimant for Type II diabetes mellitus, hypothyroidism, and obesity. Please note that Mr. Worthen was seen at Internal Medicine Associates on February 17, 2011 for complaints of sudden onset fevers, chills, severe body aches, headache, mild nausea, and loose stools. Of particular interest is that he felt some congestion, and some burning pressure in the chest when laying back. It was thought that he had influenza. Mr. Worthen was also treated at Hillcrest Memorial Hospital ER on February 18, 2011 for left shoulder pain. Apparently, Mr. Worthen had taken a nap and he woke up with shoulder pain. Finally, I am enclosing records from Greenville Memorial Hospital for treatment the Claimant had from June 17-21, 2010 for an infected left third toe. The toe was amputated. Mr. Worthen testified at his deposition that he had an EKG at the hospital in June 2010 to make sure that he was "okay" for surgery. The preoperative checklist did indicate that an EKG was completed, but I could not identify the actual EKG test in the medical records. We will check with the hospital to see if we can obtain the actual EKG report.

After you have had an opportunity to review the medical records, please contact me and give me your opinion on the medical causation issue. If you should need any additional information, please advise.

With cordial best wishes, I am

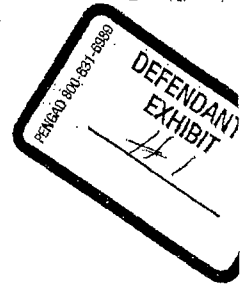
Very truly yours,

WILLSON JONES CARTER & BAXLEY, P.A.

Richard B. Kale, Jr.

RBK,Jr/jw
Enclosures

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD



NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

DATE OF OPERATION: 03/02/2011

REFERRING PHYSICIAN: Dr. Charles Ross.

SURGEON: Dr. Barry Davis.

PREOPERATIVE DIAGNOSIS: Ischemic coronary artery disease with left ventricular aneurysm, ejection fraction of 20% with congestive heart failure.

PROCEDURES: Left ventricular aneurysmorrhaphy with left ventricular thrombectomy, coronary artery bypass graft (CABG) x 4 using left internal mammary artery for bypass graft to the diagonal coronary artery, the saphenous vein for reverse coronary artery bypass graft to the distal left anterior descending coronary artery, the obtuse marginal coronary artery and right coronary artery.

INDICATIONS FOR OPERATION:

A 54-year-old gentleman who presented with 2 week history of flu-like symptoms. He presented here and was found to have a troponin of 3.03, consistent with a non-Q-wave MI. He had an echocardiogram that demonstrated an ejection fraction of about 25% to 30% with left ventricular thrombus. The cardiac cath showed severe 3 vessel coronary artery disease with the LAD 100% occluded, the circumflex 100% occluded and the right coronary artery 100% occluded. The LAD and circumflex system filled via homocollaterals and the right coronary artery system filled via heterocollaterals.

FINDINGS AT OPERATION:

The left internal mammary artery was small but had excellent flow. He had severe left ventricular hypertrophy. Had subacute myocardial infarction. His entire anterior wall was severely edematous as was his inferior wall. Ejection fraction was around 25% prior to cardiopulmonary bypass. After doing the bypass, it was around 50%. His diagonal, where it was bypassed, was 1.5 mm. The saphenous vein was excellent quality. The distal LAD was 1.5 mm. The obtuse marginal was 1.5 mm. The right coronary artery was greater than 2 mm. He had an apical left ventricular aneurysm with a significant amount/large amount of laminated clot, as well as free floating clot in the left ventricle.

OPERATIVE REPORT

Page 1 of 3

426

CHART COPY

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**GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD**

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

OPERATION:

The patient was taken to the operating room and placed in the supine position on the operating table. Following application of general anesthesia via oral endotracheal tube, the chest, abdomen and legs were prepped with DuraPrep and draped in a sterile fashion. The saphenous vein was harvested from both thighs via the endoscopic vein method. Drains were placed in the thighs. The wounds were closed in all layers with Vicryl in a running manner. Simultaneously, median sternotomy skin incision was made with the knife. Incision was carried to the sternum. The sternum was divided with by the power saw. The left pleural cavity was entered. The left internal mammary was harvested from the level of the first rib to its bifurcation at the diaphragm. Following systemic heparinization, an ACT of 400 seconds was obtained, it was divided on the chest wall and ligated with metallic clips. An XL drain was placed in the left pleural cavity and secured to skin. The pericardium was opened in an inverted "T" fashion and tacked to the chest wall. There was a significant amount of pericarditis noted along that. After systemic heparinization and ACT of 400 seconds, routine standard cannulation was performed. The patient was placed on cardiopulmonary bypass and cooled to 30 degrees Centigrade. The aorta was cross-clamped. Seven hundred and fifty mL of blood cardioplegia solution administered antegrade through the root and 500 mL retrograde through the coronary sinus catheter. This resulted in cold, flaccid arrest of the heart. Blood cardioplegia solution was supplemented intermittently retrograde throughout the aortic cross-clamp time, the last does being given warm. The heart was reflected.

The distal right was identified, opened longitudinally. A distal saphenocoronary anastomosis was made with 7-0 Prolene in a continuous fashion. The vein graft was tested with cardioplegia solution and found to run well. It was cut to the appropriate length. A 4.0 punch was made then made in the aorta and the proximal anastomosis was made with 6-0 Prolene in a continuous fashion. Prior to doing the bypasses, a left ventriculotomy was created parallel to the left anterior descending coronary artery, near the apex of the ventricle, for about 4 cm. A significant amount of laminated and free-floating clot was identified and removed manually. Great care was taken to wash the ventricle out, and suck it out in order to prevent any clot from embolizing. There was a significant amount of clot that was sent to pathology.

The left ventricle aneurysm, in the transition zone, was then seen and the left ventricle plicated here over felt strips using 3-0 Prolene in a horizontal mattress fashion. BioGlue was then placed along the anastomosis and another piece of felt strip placed on the suture line and then a separate suture of 3-0 plain was then run in 2 layers over the ventriculotomy.

Following completion of this, attention was turned to the coronary anastomosis. I have already described 1 of the grafts. The LAD and the obtuse marginal, distal and proximal vein grafts anastomosis was performed as previously described. The diagonal was identified, opened longitudinally, rewarming begun. The mammary artery was anastomosed here with 7-0 Prolene

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084D4429AM
Billing NO: 080011157521

a continuous fashion. Following the last anastomosis, warm blood was supplemented with aspartate and glutamate. It was administered retrograde. Deairing was achieved, the aortic cross-clamp was removed. The heart defibrillated several times requiring electrocardioversion. AV pacing wire was inserted and secured to the skin. The patient was warmed and being ventilated after which time de-airing was achieved and the needle vent was removed and the site secured. An intraaortic balloon pump was inserted into the right femoral artery in the modified Seldinger technique.

The patient was volume loaded easily and slowly weaned from cardiopulmonary bypass. The venous cannula was removed, the site secured. Heparin was reversed with Protamine given intravenously, and the arterial cannula was removed, and the site doubly secured. Hemostasis was maintained in what was felt to be a satisfactory fashion. Two 40 chest tubes and 1 XL drains were placed in the mediastinum and exteriorized on the skin. The sternum was approximated with heavy wire. The remainder of the wound was closed in three layers of Vicryl in a running manner.

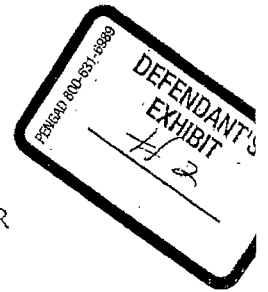
ADDENDUM: Please add William A. Spaugh as the physician assistant.

Barry R. Davis, MD

cc: Barry R. Davis, MD
Charles D. Ross, MD

D: 03/02/2011 12:59 P T: 03/03/2011 02:54 P zhj/C1/kjr mee DVI: 279906 / 288497 C/S#: 3299382

(Replacement Copy – Addendum added to original 03/16/2011 kjr)



GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084F4605AM
Billing NO: 080011157521

GREENVILLE MEMORIAL CARDIAC CATHETERIZATION:

DATE OF CATHETERIZATION: 02/27/2011

HISTORY: This 54-year-old gentleman has diabetes. He reported to the emergency room with chest pain and unusual shortness of breath. He had had an essentially normal electrocardiogram 6 or 8 months ago. His EKG in the emergency room appeared to show anterior wall infarction and poor inferior forces. His troponin has risen to 3. Cardiac cath and possible intervention was discussed this morning in detail with the patient. Hemodynamics and rhythm have remained stable.

PROCEDURE: The area over the right femoral artery was infiltrated with lidocaine. There were 6-French right and left Judkins coronary catheters used. The patient had extreme coronary disease and I thought surgical consultation was in order. There had been suspicion of an apical thrombus but I felt we should still have a left ventricular angiogram to supplement the echocardiogram in this 275 pound gentleman. A straight guidewire was carefully placed across the aortic valve and the pigtail catheter was specifically positioned at the base of the heart, just at the mitral inflow. The thrombus is said to be in the left ventricular apex. An angiogram was filmed using 20 mL of contrast over 2 seconds. Images were reviewed. Catheter and sheath were sutured in place, to be removed with ACT falls to an acceptable range.

CONTRAST: Oxilan

CONTRAST VOLUME: 75 mL.

HEMODYNAMICS: Left ventricular pressure 111/pre-A-wave 15, post-A-wave 22. Pullback revealed no aortic valve systolic gradient.

ANGIOGRAPHIC DATA: The left main coronary artery is intact. The left anterior descending has 70% to 80% stenosis just beyond the first septal. Then, at the bifurcation into the diagonal branch and the distal left anterior descending, the LAD is completely occluded. Filling of the LAD distally is by left collateral, I think septal collaterals and possibly from the first circumflex marginal. The distal LAD is visualized in its entirety along with the diagonal branch, but the mid segment of the vessel, I think, may have some narrowing. It is very difficult to evaluate by septal collateral filling. The diagonal appears to be an average sized diagonal branch and intact. First circumflex marginal is patent. The second circumflex marginal is a large, marginal system and fills very promptly by left coronary collateral. It is a very large system and intact. The right coronary artery is occluded proximally. There is some filling into the distal right coronary system

CARDIAC CATHETER.
Page 1 of 2

COPY FOR: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Patient Location: 084F4605AM
Billing NO: 080011157521

from left coronary collaterals and there is fairly good flow into the distal right coronary artery by a Kugel's collateral. The distal right coronary artery appears intact and consists of a posterior descending and 2 posterolateral branches. The larger posterolateral branch appears to be a significant vessel. I suspect there is good continuity between all 3 of these branches, through the conduit segment. The left ventricle appears mildly dilated but when corrected for body habitus, is probably normal volume. The apex is akinetic and in light of his echo findings, the apex does appear to be squared. There is no obvious apical filling defect but it does not have the usual rounded appearance of a left ventricular apex. The anterior apical segment is akinetic. The inferior segment is hypokinetic. I think ejection fraction is better than estimated on echocardiogram, at least in the single RAO view. I would estimate ejection fraction in this view to be approaching 45%. There is no significant mitral insufficiency.

IMPRESSION:

1. Three vessel coronary disease with 3 vessel total occlusion after the proximal 3rd of the left anterior descending of the second and primary marginal branch of the circumflex and of the proximal right coronary artery.
2. Left ventricular dysfunction.

Charles D. Ross, MD

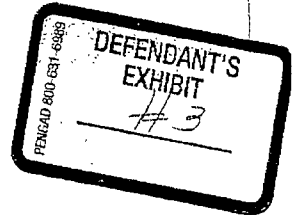
cc: Charles D. Ross, MD

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GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521



DATE OF ADMISSION: 02/27/2011
DATE OF DISCHARGE: 03/14/2011

REASON FOR ADMISSION: Angina and coronary artery disease.

FINAL DIAGNOSIS:

1. Hypothyroidism.
2. Hypertension.
3. Hyperlipidemia.
4. Type 2 diabetes mellitus.
5. Non-Q-wave myocardial infarction (MI)
6. Postop ventricular fibrillation, arrest, requiring implantable cardioverter-defibrillator (ICD) placement.

PROCEDURES:

1. Left heart catheterization on 02/28/2011.
2. Coronary artery bypass grafting (CABG) x 4 with left internal mammary artery to the diagonal artery (D1), saphenous vein graft to the left anterior descending (LAD), saphenous vein graft to the obtuse marginal (OM) 1, saphenous vein graft to the right coronary artery, left ventricular (LV) aneurysmectomy and left ventricular (LV) thrombectomy on 03/02/2011 by Dr. Barry Davis.
3. Implantable cardioverter-defibrillator (ICD) placement on 03/08/2011 by Dr. Manfredi.

CONSULTING PHYSICIANS:

1. Dr. Manfredi, EP.
2. Dr. Horton, endocrinology.
3. Dr. Treece, pulmonary medicine.

REFERRING PHYSICIAN: Dr. Ross, Upstate Cardiology.

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE: Patient is a 54-year-old white male who presented with acute myocardial infarction on 02/27/2011. Patient had a troponin that peaked at 2.6. He did have a non-Q-wave MI. He was taken to the cath lab 48 hours after admission where his cardiac catheterization showed severe, multivessel coronary artery disease with totally occluded LAD that filled by collaterals and totally occluded circumflex system and right system, filled via collaterals as well. EF was estimated at 30% with inferior apical hypokinesis. The echo showed a questionable mural thrombus with ejection fraction of 30%. It was felt that CABG, LV aneurysmorrhaphy were indicated. A MRI was recommended, however due to the patient's claustrophobia, this could not be done. The patient did have an

DISCHARGE SUMMARY
Page 1 of 3

COPY TO: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORDNAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

echocardiogram, again that demonstrated LV thrombus. As part of the preoperative evaluation for CABG, Dr. Horton from endocrinology, was consulted secondary to uncontrolled hyperglycemia, diabetes mellitus. Dr. Treece from pulmonary medicine was also consulted for preoperative clearance. The patient had a carotid duplex preoperatively, demonstrated bilateral 1:15% stenosis with antegrade vertebral flow. It was felt that the patient had sleep apnea but was cleared from a pulmonary standpoint. He was taken to the OR on 03/02/2011 where he underwent CABG x 4. Left internal mammary artery was used to the diagonal, saphenous vein graft to distal LAD, saphenous vein graft to the OM and saphenous vein graft to right coronary artery. Intraaortic balloon pump was placed at the time of surgery. LV aneurysmorrhaphy with LV thrombectomy was performed by Dr. Barry Davis. At the time of surgery, the patient had a subacute inferior MI with large amount of edematous as well as the inferior wall. Ejection fraction was 25% prior to cardiopulmonary bypass. The patient had a large amount of laminate clot as well as free floating clot in the left ventricle. The patient tolerated procedure and was transferred to the CV ICU. In the CV ICU Dr. Treece, from pulmonary medicine, continued followup for critical care management. The patient was hemodynamically stable with a hematocrit of 24, BUN and creatinine were stable at 15 and 1.3. He remained intubated and sedated on pressure support. Dr. Horton, from endocrinology, continued to follow the patient. He was placed on an insulin drip for hyperglycemia control. On postoperative day 2, the patient's intraaortic balloon pump was removed without difficulty. Upstate Cardiology continued to follow the patient. Again, he was intubated and sedated. He was weaned off all pressor support. Patient was scheduled to be transferred to 4D telemetry bed, however the patient developed V-fib arrest requiring CPR and defibrillation. This time, Dr. Manfredi from EP was consulted. The patient had an ICD placed on 03/08/2011 by Dr. Manfredi. The patient was also continued on IV Amio. Patient was subsequently transferred to 4D telemetry bed. From here, his hospital course has been fairly uneventful. His pacing wires and XL tubes were removed without difficulty. He has been ambulating with the assistance of physical therapy and Heart Life. He was started on Coumadin for his LV aneurysm thrombus. He was weaned off all oxygen. His blood sugars were under good control with the help of endocrinology. He will be discharged to home on 03/14/2011. On the day of discharge, the patient's vital signs included temperature 97.7, heart rate 66 and regular, blood pressure 122/74, 98% on room air. His lab values on the chart include white blood cell count is 12.3, hemoglobin 10.3, hematocrit 30.8, platelets are 333, potassium is 4, BUN is 12, creatinine 1.1.

MEDICATIONS ON DISCHARGE:

1. Enteric coated aspirin 81 mg 1 p.o. daily.
2. Coreg 3.125 mg 1 p.o. twice daily.
3. Quinapril 5 mg 1 p.o. daily.
4. Pravachol 80 mg 1 p.o. daily.
5. Ultracet 1 to 2 p.o. q. 4 to 6 hours p.r.n. for pain.
6. Coumadin 4 mg 1 p.o. daily.

DISCHARGE SUMMARY
Page 2 of 3

COPY TO: Charles D. Ross, MD

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
MEDICAL RECORDNAME: WORTHEN, MICHAEL PHILIP
PATIENT MR#: 000-971-36-6670

Billing NO: 080011157521

7. Levothyroxine 250 mcg 1 p.o. daily.
8. Prilosec OTC as taken at home.
9. Spiriva HandiHaler 1 inhalation daily.
10. Amiodarone taper 200 mg 1 p.o. b.i.d. x 1 week then decrease to 1 p.o. daily.
11. Novolin N 30 units subcutaneously q a.m. and q p.m.
12. NovoLog sliding scale as directed by Dr. Horton.

The patient's level of activity is restricted to no heavy lifting, no pushing or pulling with arms for 8 to 10 weeks, no driving for 4 weeks. He is instructed to wash all incisions daily with warm soapy water and keep clean and dry. He is encouraged to abstain from smoking and to attend cardiac rehab. If he has problems or questions prior to seeing Dr. Davis in 2 weeks, he is instructed to call 455-6800. The patient also has follow up appointment with Dr. Ross in 1 month and with Upstate Coumadin Clinic on 03/17/2011 at 10:30 a.m. for PT INR check. Again, the patient is on 4 mg tablets. His INR range needs to be between 2 and 3. He is on it for LV aneurysm repair with LV thrombus at the time of surgery and ventricular arrhythmias postoperatively. The patient, again, is encouraged to abstain from smoking, to attend cardiac rehab.

DICTATED BY: Sarah K. Miller, PA-C.

On Hold

Barry R. Davis, MD

cc: Barry R. Davis, MD
Charles D. Ross, MD

D: 03/14/2011 02:49 P T: 03/14/2011 04:04 P zhy DVI 287163 C/S#: 3308480

DISCHARGE SUMMARY
Page 3 of 3

COPY TO: Charles D. Ross, MD

Certificate of Appellant

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Appellate Panel
T. Scott Beck, Commissioner

RECEIVED

JUN 04 2014

SC Court of Appeals

WCC File No. 1103604

Appellate Case No. 2013-001515

Michael Philip Worthen, Employee, Claimant Appellant,

v.

Laurens County, Employer, and
SC Association of Counties SIF, Carrier, Defendants Respondents.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all
material proposed to be included by any of the parties and not any other material.

May 13, 2014



Monty D. Desai (S.C. Bar No. 73967)
J. Matthew Whitehead (S.C. Bar No. 73803)
THE CAROLINA LAW GROUP, LLC
910 E. Washington Street
Greenville, South Carolina 29601
(864) 312-4444
(863) 312-4447 (fax)
Attorneys for Appellant

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Appellate Panel
T. Scott Beck, Commissioner

WCC File No. 1103604

Appellate Case No. 2013-001515

Michael Philip Worthen,
Employee, Claimant,

Appellant,

v.

Laurens County, Employer,
And SC Association of
Counties SIF, Carrier,
Defendants,

Respondents.

PROOF OF SERVICE

I, Terra L. McKenzie, the undersigned employee of The Carolina Law Group, LLC, attorney for the Appellant, do hereby certify that I have served the Record on Appeal on Respondents Laurens County and SC Association of Counties SIF by hand-delivery, on May 16, 2014, to their attorney of record, Richard B. Kale, WILSON JONES CARTER & BAXLEY, P.A., 872 S. Pleasantburg, Greenville, South Carolina 29607.

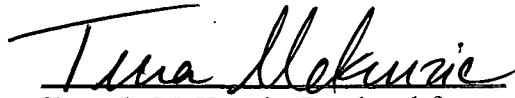
(Signature on Following Page)

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SC Court of Appeals

May 16, 2014



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