APPENDIX A

Electronic Text Phrases Abstracted from

Dictated Physician Reports in Cases

of Hospital-acquired Infections

Type of Document	Phrase
Emergency Department Report	She had noticed some redness, swelling, and discharge from her abdominal incision and had started on an antibiotic.
	1. Post operative cellulitis
	A CT of her abdomen showed an 8 x 6 x 6 cm fluid collection behind the uterus and anterior to the rectum.
	DOCTORNAME opened the surgical wound and has packed it.
	He had some fevers and chills and no frank rigors.
	He has had some increased pain and redness around the left knee as well as increased drainage.
	I can not exclude the possibility of infected seroma or septic arthritis, although this is most likely.
	I discussed the case with DOCTORNAME, the patient's surgeon, and DOCTORNAME subsequently drained this.
	Infected surgical wound, status post appendectomy.
	Possible wound infection and shortness of breath
	Postoperative fever
	Redness, warmth and swelling around her right knee.
	She had been taking Keflex for a couple of days and developed diarrhea.
	1. Leg cultures times two ordered 2. Ancef 2 grams IV.
	She has some erythema in her incision around her unbilicys.
	She has the wound in place, she has erythema, warmth and redness around the site.
	She now reports that she has had greenish drainage from her wound, had been put on Keflex, but now continues to have redness and warmth in the area, some fever and chills.

Type of Document	Phrase
Emergency Department Report (continued)	She stopped taking Keflex , but because of continued drainage from the wound contacted DOCTORNAME, who advised that she come to the emergency department.
	She will be admitted for IV antibiotics, DOCTORNAME surgeon and disposition regarding the knee per his evaluation.
	Since that time, the patient has developed some erythema in the region of the wound.
	The erythema does not extend much more than 1 cm past the wound.
	The lower portion of the abdomen is erythematous and indurated.
	The patient received 2 g of IV Mefoxin.
	The patient was given 2 g of cefoxitin IV.
	The wound appears infected, cannot tell at this point whether or not the prosthesis is infected.
	Ther is a minimal amount of induration.
	There is a slight amount of swelling and some discharge.
	There is erythema, edema, and tenderness noted distal to the wound.
	There is serosanguinous drainage in the wound which is sent for culture.
	There is some discharge noted along the wound.
	This gentleman appears to have difficulty with cellulitis and the wound on his left lower extremity
	This patient had noted the wound starting to drain some serosanguinous material before his discharge.
	White count 11,900 with 78% segs.
History/Physical Report	Cellulitis of the superficial skin, status post right total knee arthroplasty.
	At the bedside I opened the center of his incision only 1 cm or so to express what appeared to be some fluid which was under pressure.
	A CT scan of his abdomen was obtained, which showed a phlegmon/abcess superficial to the right edge of the live just beneath his surgical incision.
	Her complete blood count on 9/7/2001 showed her white blood cell count was 11.7, red blood cells 3.72, hemoglobin 10.9, hematocrit 33.1.
	Her sister called back on Friday afternoon, 9/7/2001 stating that the redness has not improved, her incision was still draining, and she was worried about a possible infection.
	It was very foul smelling, and a volumn of approximately 30 cc was expressed without any difficulty.
	PATIENTNAME returns to us with what is clearly an abcess in his abdomen at the site of his prior surgery.

Type of Document	Phrase
History/Physical Report (continued)	She contacted our office on 9/6/2001 stating that she had some erythema distally around her incision and some serous drainage coming from the distal incision.
	She does have a small area of erythema extending medially at the same point of the incision.
	She was started on Keflex 500 mg q.i.d. and was told to follow up p.r.n. or sooner if her condition acutely worsens.
	The patient came down with a CT of his abdomen and pelvis which was done at Logan Regional Hospital, which, as already mentioned, shows what appears to be an abcess in his abdominal cavity.
	The patient is a 30-year-old female, status post laparoscopic appendectomy with a pelvic abscess.
	The patient was admitted and started on IV antibiotics.
	The patient was admitted for apparent cellulitis of the left total knee arthroplasty.
	The wound was lightly packed with new gauze, and I was not more aggressive in my debridement given the fact that we plan on taking this patient to the operating roon tonight.
	There also appeared to be a fluid collection just beneath the surface of the skin just underneath the incision.
	There is an erythema extending from the distal mid incision laterally approximately 3 cm in a transverse pattern.
	There is evidence of slight serous drainage from her midline incision.
	There is no further serous drainage.
	They also fel t that he may have a posoperative abcess, given his elevated white count and fever as well.
	To radiology for CT-guided drainage. Will admit and place on intravenous antibiotics, and replace electrolytes as needed.
	We will continue the IV antibiotic until the erythema has cleared.
	We will stop his tube feeds and give his morphine for pain control, and continue him on Primaxin 500 mg intravenously q.6h.
General Surgery Report	1. Abdominal exploration and drainage of pelvic abscess. 2. Loop ileostomy.
	1. Bilateral oophorectomy. 2. Proctectomy with colonic J-pouch and coloanal anastomosis.
	1. Exploratory laparotomy. 2. Radical resection of right retroperitoneal tumor. 3. Ligation of right internal iliac vessels. 4. Resection of left retroperitoneal mass. 5. Bilateral ureterolysis. 6. Partial bladder resection with repair. 7. Right ur
	Abdominal abscess.
	Cultures were taken and the pelvis was examined.

Type of Document	Phrase
General Surgery Report (continued)	Drainage of upper abdominal abcess
	He presented to the Logan Regional Hospital in a severely dehydrated state and also had a CT scan obtained at that time which showed abcess, just deep to the Whipple incision and came up to almost the level of the skin.
	Left total knee arthroplasty
	Pelvic abscess and infected ascites.
	She had a repeat CT scan which showed persistent fluid, most likely which was infected, and she is here today for abdominal exploration and loop ileostomy.
	She had an attempted percutaneous drainage of an abscess, and this did not resolve her symptoms.
	The purulent material was then suctioned out and a tonsil clamp was then used to spread open the abcess pocjet and then digital palpation of the pocket revealed one large pocket with a number of smaller loculations on the right side of the pocket.
	The skin was left open, and a right lower quadrant loop ileostomy was brought out and matured using 4-0 Vicryl sutures.
	There was a small abscess noted in the pelvis; this had been previously drained.
	Total vaginal hysterectomy
	Total wide-field laryngectomy.
General Consult Report	1. Status post left total knee arthropathy with now swelling and redness as well as increased tenderness.
	An 82-year-old woman with pneumonia, hypoxemia, and hypoventilation on morphine sulfate patient-controlled analgesia, status post right shoulder rotator cuff surgery.
	Because of her high oxygen requirements, she should be transferred to an Intensive Care Unit where her FIO2 should be titrated to keep her saturation greater than 90%.
	Blood cultures time two, and urine culture with empiric IV antibiotic therapy for pneumonia consisting of levofloxacin and clindamycin.
	Chest x-ray shows bibasilar infiltrates
	Considerations will be given to, of course, a postoperative infection.
	Decreased breath sounds bilaterally in the bases with shallow inspirations.
	For the pneumonia, Zosyn
	He certainly could have aspirated two days ago when he was vomiting. That has to be in the differential diagnosis for the pneumonia picture even though the location of the opacification is kind of unusual for aspiration.

Type of Document	Phrase
General Consult Report (continued)	He did fairly well until several days ago he developed anorexia, some mild confusion, some increased swelling of the left knee and leg with associated redness of the knee.
	He has no other joint pain or swelling except for the left knee.
	He was observed to aspirate this vomitus.
	I was called by DOCTORNAME, the patient's orthopedic surgeon, and was asked to evaluated this 82-year-old female status post right rotator cuff repair on 09/17/2001, now with worsening oxygenation and increasing FIO2 requirements.
	I wonder if this could be signs of a developing pneumonia.
	Increasing postoperative confusion
	LUNGS: Bibasilar crackles heard half way of the lung fields.
	My diagnosis would be most likely bilobar pneumonia, hospital acquired most likely
	Reveals crackles at both lung bases. Breath sounds are generally diminished.
	T 38.5 degrees Centigrade, P 91, B/P 84/55, R 13-27, oxygen saturation 84% to 91% by pulse oximeter on a 15 liter face mask.
	The left leg is moderate to severly swollen from above the ankle to the knee.
	The patient clearly has aspirated and has pneumonia from that process, regardless of whether this caused the arrest or not
	White cell count 11,000 with 79 polys, 13 bands and 6 eosinophils.
Radiology Report - Diagnostic	A triangular opacity persists within the left apex, thought to largely be secondary to partial collapse of the left upper lung, although underlying inflammatory process could also be present.
	Basilar atelectasis or lung consolidation is also noted on the right
	Basilar infiltrates, more left than right. Consider aspiration.
	Basilar opacities are present, much more on the left than the right. Consider aspiration pneumonia.
	Bilateral multilobar lung consolidation is appreciated. There is left upper lobe consolidation. There are patchy opacities in the right upper lobe.
	Consolidation of the left lung base persists, with continued loss of visualization of left hemidiaphragm.
	Continued right lower lobe atelectasis or lung consolidation exists as does mild subsegmental atelectasis on the left.
	Diffuse right lung airspace opacity is again appreciated.This certainly could represent bronchopneumonia.
	Elevated temperature

Type of Document	Phrase
Radiology Report – Diagnostic (continued)	Hazy opacity within the left hilum and left lower lobe may represent focal atelectasis, or pneumonia in the appropriate clinical setting.
	Left lower lung and lingular consolidation is now present and concerning for pneumonia.
	Persistent moderate bilateral pulmonary infiltrates unchanged from yesterday's exam.
	Respiratory distress
	Rule out pneumonia
	Single frontal view of the chest demonstrates increased opacity at the right lung base, likely representing focal pneumonia.
	Subsegmental opacity in the retrocardiac left lower lobe, consistent with atelectatic or consolidated lung
	There are patchy opacities in the right upper lobe.
	There is increased hazy opacity within the left lower lobe and within the left hilar region. This may represent compressive atelectasis, but focal pneumonia may have a similar appearance
	there is increased patchy opacity throughout the right lung but most prominently at the right base. Given the patient's history of dehydration, this most likely represents focal pneumonia rather than asymmetric pulmonary edema.
	There is mild increase in ill-defined air space disease seen within the mid aspect of the right lung as compared to previous study and a focus of inflammation/pneumonia is suspected in this region.
	There is previously described left lower lobe is consolidated with complete obscuration of the left hemidiaphragm.
	There is progression of air space disease in the left upper lobe and retrocardiac region at the left lung base. Additionally right perihilar infiltrate is present.
	There is progressive left lower lobe and right middle and lower lobe parenchymal lung opacities detected with air bronchograms noted and small bilateral pleural effusions observed. This is concerning for multifocal pneumonia, perhaps aspiration.
	This appearance is most suspicious for multilobar pneumonia or other inflammatory process.
	Worsening infiltrate within the left upper lobe, retrocardiac region of the left lower lobe, and right perihilar region
	1. Subphrenic, well defined fluid collection in the region of the previously resected spleen suspicious for an abscess.
	Fluid collection 8 x 5 x 5-6 cm in the low mid posterior pelvis, anterior to the rectum and posterior to the uterus.

Type of Document	Phrase
Radiology Report – Diagnostic (continued)	In the region of the pelvis I define substantial infiltrative soft-tissue induration and thickening.
	In this region there are also several small (1-2 cm) fluid collections with irregular, slightly thickened walls.
	Inflammatory mesenteric thickening in the pelvis, particularly on the right, with small fluid collections.
	Most likely this is abscess post appendectomy.
	The ureteral stents courses through this fluid collection.
	There is a discrete rim enhancing fluid collection containing multiple air bubbles in the right pelvis measuring 5.0 cm by 8.0 cm by 10 cm in greatest transverse, AP, and vertical dimensions, respectively.
	There is a fluid collection which measures about 6 x 8 x 5-6 cm posterior/anterior to the rectum and posterior to the uterus.
	This fluid collection certainly could be an abscess or pocket of infected fluid in the low mid pelvis in patient who is postop.
	This has an appearance suggesting post-operative inflammatory or hemorrhagic change.
	With this in mind, the patient was admitted for appropriate antibiotic therapy and perhaps additional imaging evaluation.
Radiology Report - Procedural	The spleen has been removed and in the area of the previously resected spleen, is a fluid collection with some enhancing of the wall suggesting an abscess.
	A total of approximately 60 cc of turbid fluid was aspirated from this peritoneal space.
	ABSCESS DRAINAGE
	Approximately 2 cc. of thick foul smelling purulent material was obtained indicating an abscess.
	CT Drainage Retroiperitoneal/Peritoneal Abscess Percutaneous Procedure - 09/24/2001
	CT guided aspiration and possible drainage catheter placement was requested.
	CT GUIDED DRAINAGE CATHETER PLACEMENT
	CT GUIDED DRAINAGE OF LEFT SUBPHRENIC ABSCESS AND CT GUIDED PLACEMENT OF LEFT PLEURAL TUBE
	CT GUIDED DRAINAGE PERITONEAL COLLECTION
	Frank pus was obtained. This was sent for cultures and multiple studies including a smear.
	Post procedural images demonstrated near complete aspiration of the fluid collection and contrast adjacent to the ureteral stent.
	Previous CT showed a fluid collection in the low pelvis.

Type of Document	Phrase
Radiology Report – Procedural (continued)	Successful drainage of large lower pelvic abscess.
	Suspect left subphrenic abscess from CT study today. Drainage of subphrenic fluid collection and sampling of left pleural effusion requested.
	1. CT guided drainage of subphrenic abscess accomplished with 8 French pigtail APD catheter.
	Upon free return of cloudy, slightly tan thin fluid the drainage catheter was elected.
	Upon return of turbid serosanguinous fluid exchange was made over a 0.018 guide wire for a series of dilators extending to 5 French.
	With this catheter in place a total of 600 cc of tan cloudy fluid was aspirated from the peritoneal spaces.
Discharge Summary	...; Keflex 250 mg p.o. q.6h. times seven days.
	...; Keflex 500 mg p.o. q.i.d.;...
	2. Incisional abscess.
	2. Wound infection.
	2. Abdominal abcess
	4. Postoperative pneumonia
	A 58-year-old G2, P2 on postoperative day nine status post debulking of primary peritoneal adenocarcinoma and resection of the bladder now with a pelvic abscess, no urinoma.
	A consult was called from medicine. The medical resident responded as well as pulmonary critical care.
	A CT scan at that institution showed a mass in the pelvis consistent with urinoma versus abscess.
	A Gram stain showed 3+ WBCs and no bacteria.
	All blood cultures were negative to date.
	Also of note, he did develop hematuria during his hospitalization. This was thought possibly secondary to his infection.
	Also on postoperative day number five she developed increasing redness around her incision and purulent drainage.
	Approximately 10 cc of purulent fluid was removed and her incision was irrigated copiously with sterile saline and packed with wet-to-dry dressing.
	Aspiration pneumonia
	At that time, his white count was elevated at 12.3, although the patient was afebrile.
	At the time of discharge, her wound was clean and granulating well.

Type of Document	Phrase
Discharge Summary (continued)	Because of some concern for possible pelvic abscess Levaquin and clindamycin were started at that time.
	Blood cultures with no growth.
	By October 31, 2000, the swelling and erythema in the leg was markedly diminished
	By the fifth postoperative day the patient continued to be completely disoriented.
	By the sixth postoperative day the patient was doing significantly better.
	Cellulitis in the left leg
	Cellulitis right knee, status post right total knee arthroplasty.
	Cipro 500 mg p.o. b.i.d. time three days, then discontinue
	CT scan with right greater than left fluid collection approximately 1 to 2 cm size inflammatory in nature consistent with abscess.
	Diagnosis given was aspiration pneumonia.
	Discharge instructions: Home health to change dressings b.i.d.
	Erythema was noted to decrease and resolve.
	Following the third day of antibiotics on 03/26/2001, her erythema was improving, and her pain was under good control.
	For this, he was placed on IV clindamycin in addition to the perioperative prophylactic antibiotics routinely prescribed for his knee surgery.
	He arrived at the OR, complaining of serosanguineous drainage from the lower portion of his incision.
	He continued to improve with antibiotics and aggressive pulmonary management.
	He did have temperature elevations up to 38.6 and a chest x-ray showed a left lower lobe infiltrate/atelectasis, possibly consistent with aspiration pneumonia during this period of confusion.
	He presented to the emergency room with cellulitis in the leg.
	He received Ancef 2 gm IV q .8h times three full weeks.
	He remained intubated and on a respirator in the Intensive Care Unit, on aggressive pulmonary treatment and intravenous antibiotics until the eighth postoperative day,when the endotracheal tube was removed and the patient continued on positive airwaypress
	He was continued on his IV antibiotics.
	He was discharged with prescription for Lortab 7.5 mg 1-2 tablets p.o. q.4-6h p.r.n. and Keflex 500 mg p.o. q.i.d. times seven days.

Type of Document	Phrase
Discharge Summary (continued)	He was exquisitely tender to palpation and at the bedside I opened up the incision and was able to express over 50 cc of purulent, thick, foul smelling discharge.
	He was further instructed that if he experiences increasing abdominal pain, persistent nausea or vomiting, or fevers of 101.5 or greater that he should call DOCTORNAME's office or return to the emergency room.
	He was given daily b.i.d. wet-to-dry dressing changes.
	He was immediately placed on IV Ancef.
	He was therefore admitted to the hospital for IV antibiotics.
	He was to have dressing changes twice a day, moist to dry.
	Hematuria, most likely secondary to urinary tract infection
	Her donor site did show some cellulitis and she was begun on Keflex.
	Her erythema slowly resended.
	Her family member called the day later stating that the redness had not improved.
	Her incision was found to be increasing redness and drainage, and was opened and packed wet-to-dry.
	Her incision was opened and packed.
	Her incision was opened on 09/23/2001 and it was packed with Kerlix wet-to-dry packing.
	Her incision, however, was mildly erythematous the inferior portion, and she was started on nafcillin for probable incisional cellulitis.
	Her skin staples were removed and her wound was cared for with b.i.d. wet-to-dry dressing changes.
	His convalescence was remarkable only for a mild ileus and some mild wound erythema, both of which resolved with conservative measures.
	His hospital course was uncomplicated, as the erythema decreased and the wound was packed with wet-to-dry dressings t.i.d.
	His staples were removed and the bottom portion of the wound was open.
	His white blood cell count was 13,200, but he had no significant fever.
	Home health care was arranged to help her to pack her wound with wet-to-dry dressings.
	Home health nurse will assist with wound care and the patient is further instructed to call his local medical doctor, call DOCTORNAME or the local emergency room if he has any increased swelling, redness, or drainage from his abdominal wound site.
	Home health was to see the patient twice a day for damp to dry dressing changes.

Type of Document	Phrase
Discharge Summary (continued)	However, early in the morning at 0300 hours on the fourth postoperative day, August 28, 2001, the patient began to show signs of hypoxia.
	However, on Saturday, she developed some erythema over her left foot and in her right tibia.
	However, secondary to the erythema around the incision site, however, without drainage or other evidence of infection, the patient was placed on Keflex which she tolerated well.
	However, the following day the wound did look more erythematous.
	I was called back in around midnight on the second night with her on 15 liters and a rebreather.
	In regards to the patient's abdominal examination at the time of discharge it was soft but was still having some serosanguinous drainage coming out of the abdominal wound.
	Included Augmentin 875 mg p.o. b.i.d. times ten days, Lortab 7.5 mg one to two p.o. q.4-6h. p.r.n., ibuprofen 800 mg p.o. t.i.d. p.r.n., Colace 100 mg p.o. b.i.d. p.r.n.
	It did appear that the patient did have mild hemarthrosis into the knee in addition to the cellulitis.
	It should be noted that the patient's confusion was almost completely resolved at the time of this transfer.
	It was also noted on this day that the patient's chest x-ray showed there to be a mild right lower lobe infiltrate. This was highly suspicious for aspiration pneumonitis, and so antibiotics were begun.
	It was also noted that there was a large amount of peripheral erythema.
	It was, however, thought prudent that the patient receive additional three full weeks of antibiotic therapy.
	Lortab 7.5 mg one to two q.4-6h. p.r.n., Keflex 500 mg one t.i.d., Levsinex 0.375 mg b.i.d. p.r.n.
	Mild suprapubic tenderness to palpation.
	PATIENTNAME is a 50-year-old gentleman, who was readmitted on 07/27/2001 with a postoperative wound
	On 09/14/2001 the patient began to have a fever to 38.4 at 8 p.m.
	On 09/14/2001, the patient did undergo a CT-guided placement of a pigtail catheter to drain her pelvic abscess.
	On 09/17/2001, slight erythema and a moderate amount of fluid was able to be expressed from her incision, and therefore all of her staples were removed.
	On postoperative day 6 the inferior portion of the wound appears to have a small amount of drainage as well, and the wound was opened along its entire length and packed with moist gauze.
	On postoperative day four a small amount of serosanguinous drainage was noted from the inferior portion of the wound, but there did not appear to be any surrounding erythema at that time.
	On postoperative day number nine in the morning it was noted that the right lateral portion of her neck incision was erythematous with evidence of a small abscess.

Type of Document	Phrase
Discharge Summary (continued)	On the day of discharge the patient was found to have an infection of the midline incision with expression of some creamy, red-colored pus.
	On the following day the patient's erythema was markedly decreased in his knee.
	One-half of the lower portion of the inferior region of his midline incision was opened, and the wound was packed in the ER.
	Osteoarthritis right knee, status post right total knee arthroplasty, status post-respiratory arrest, status post aspiration pneumonia
	Phenergan suppository 25 mg PR q.4h. p.r.n., #15; Levaquin 500 mg p.o. q.d. times 10 days; Flagyl 500 mg p.o. q.i.d. times 10 days, #40; Lortab 5/500 one to two p.o. q.4-6h. p.r.n., #20.
	Postoperative pneumonia
	Postoperative wound infection
	Postoperatively, the patient began to experience a lot of weepage from his rectal incision that appeared to be serosanguinous.
	She contacted our office on 9/6/2001 stating she had increased erythema distally around her incision and had slight serous drainage from the distal incision.
	She did start to develop fevers, with complaints of back pain and, therefore, the patient underwent a CAT scan.
	She felt a little bit better in the morning, but by later that evening, around 10 o'clock she started to have more and more difficulty breathing.
	She had a low-grade fever which was attributed to the wound infection
	She underwent percutaneous drainage of the fluid collections and these were found to grow Klebsiella.
	She was admitted in Idaho on 09/13/2001 and appeared to be responding to Unasyn antibiotic therapy.
	She was continued in the hospital for observation because of the intermittent fevers, and on 09/16/2001 her white count was 9.6 with 76% PMNs, and 50% lymphs.
	She was discharged home on Darvocet, ciprofloxacin and Imodium and told to resume all of her preoperative medications.
	She was discharged on 6/30/2001, with plans for home health to continue changing her dressing b.i.d., control her TPN, and change her Duoderm.
	She was initially started on Keflex 500 mg p.o. q.i.d.; however, this made no improvement.
	She was started non IV Ancef and given Darvocet for pain control
	She was started on Cleocin and Levaquin. She responded well.

Type of Document	Phrase
Discharge Summary (continued)	She was started on Keflex 500 mg q.i.d. and was told to follow up p.r.n.
	She was started on oral Keflex.
	She was switched to Ancef 1 gram q.8h. and then later switched to 2 grams q.12h.
	She was transferred to the unit, and they took over her care for postoperative day two.
	Status post pneumonia
	The CT scan showed increasing fluid and this could not be drained adequately percutaneously and, therefore, on 04/06/2001, the patient underwent an abdominal exploration and drainage of pelvis abscess and a loop ileostomy.
	The erythema continued to improve very nicely.
	The incision was still draining, and she was brought in for admission to rule out infection and pain control
	The operative incision did become infected, and needed to be opened.
	The patient after this exploration and washout and drainage of this pelvic collection began to improve significantly.
	The patient also had several days of fever with development of pneumonia, requiring antibiotics for therapy.
	The patient developed a wound infecion postoperatively.
	The patient developed apparent aspiration pneumonitis sometime after surgery and had mental confusion.
	The patient developed wound cellulitis of the right inguinal lymphadenectomy and was begun on Keflex and received one day of IV antibiotics of cefazolin and was improving at time of discharge.
	The patient did develop some slight erythema around her incision which was consistent with bruising.
	The patient did experience some postoperative fevers on postoperative day number two which were felt to be secondary to atelectasis.
	The patient did have a postoperative fever of 38.1 which resolved at the time of discharge which was thought to be secondary to the cellulitis.
	The patient did spike a fever and urinalysis was remarkable for leukocytosis and leukocyte esterase, nitrate positive. There were no organisms on the Gram stain. Unfortunately, a culture was not performed.
	The patient had been taking Keflex for mild cellulitis of her incision.
	The patient was admitted to LDS Hospital and started on ampicillin, gentamicin and clindamycin for probable vaginal cuff abscess.
	The patient was started on cefoxitin at that time.

Type of Document	Phrase
Discharge Summary (continued)	The patient was started on Unasyn for broad-spectrum coverage for pelvic infection, and this will continue until culture results return.
	The patient was transferred to the Coronary Intensive Care Unit, was reintubated, placed on a respirator as well as antibiotics, and treated for pneumonitis
	The patient was transferred to the floor on postoperative day three and developed a wound infection on postoperative day four in which half of his wound was opened at the bedside and wet to dry dressing changes were started.
	The patient's antibiotic coverage was switched to Levaquin and clindamycin.
	The rest of his wound required opening with dressing changes b.i.d., and home health was set up to assist with this.
	The still ws some moderate swelling present.
	The superior portion of the incision was opened using sterile Q-tips, was cleaned out, and packed with wet dressings.
	There was no active bleeding or discharge from either incision.
	There was no evidence of pus in the abdomen except for a cavity around and in the pelvis which had previously been drained with the percutaneous catheter.
	This is a 58-year-old G2, P2 on postoperative day nine status post debulking of primary peritoneal adenocarcinoma and resection of the bladder now with a pelvic mass concerning for urinoma versus abscess.
	This revealed perianastomotic fluid and also ascites.
	This was further helped by discontinuing the Ancef and starting her on the nafcillin and so we felt that she was not totally resending, and the change of nafcillin was successful in clearing up the erythema.
	This was obviously an abcess pocket which had been opend and after packing with gauze the decision to take the patient to the operating room for additional debridement of this area and further exploration of the abcess pocket.
	This was opened and drained and packed with 1/4 inch iodoform dressing.
Death Summary Report	On postoperative day three he developed a fever of 39. The following day he was again febrile.
	Chest x-ray was done on 11/05/2000 which showed a left lower lobe infiltrate consistent with pneumonia. He was then started on Zosyn for coverage of this hospital-acquired pneumonia.