Supplementary Material 1 for

Research Article

The neuro-inflammasome in Alzheimer's disease and cerebral stroke

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Materials and Methods: The Patient's Medical Records

This study is based on the results of the Seoul cohort. The patient's medical records were issued legally according to Korean medical law. All medical records in this supplement are copies of the patient's original medical charts. (English translations were added to some parts of the record written in Korean when needed.) On 10 May 2020, the patient presented abnormal behaviours such as restlessness and crawling rather than walking; she took 2 tablets (total 200 mg) of DDS p.o.. The next morning, the patient took 200 mg of DDS as scheduled, and on May 11, 2020, she visited the emergency room of Deahan Hospital due to continuing abnormal behaviour but normal conversation and orientation. The computed tomography (CT) examination revealed a few lacunar infarctions in the bilateral basal ganglia but were otherwise unremarkable. Magnetic resonance imaging (MRI) revealed acute infarction in the left parietal white matter and forceps major with a few lacunar infarctions in the bilateral basal ganglia.

The patient was transferred to the intensive care unit (ICU). The neurosurgeon in the ICU stopped the patient's usual medications, including DDS. On the morning of 12 May 2020, the patient showed normal conversion and a 4+/5 rating scale for both extremities in the muscle strength test, but it later changed to a 1+/5 rating scale for the right extremities. Diffusion and perfusion MRI showed an increased area of acute infarction in the left postero-superior temporal lobe and decreased perfusion in the left MCA and PCA territories. On 13 May 2020, the patient underwent other radiological examinations, including chest CT showing patchy pneumonia in the left lower lobe, minimal pneumonia in the right lower lobe, a small calcified granuloma in the left upper lobe, dependent atelectasis in the bilateral lower lobe, and small left pleural effusion. From May 2020 18:00 to 14 May 2020 08:50, the patient had not taken DDS according to the neurosurgeon's order. The patient's guardian (son), a physician who graduated from Seoul National University College of Medicine and had been taking of her, persistently asked that DDS be added to her regimen again. The patient resumed taking DDS at 200 mg p.o. three times a day. Thereafter, her symptoms became stable and improved gradually.

Table 1

Date	Cerebral infarct	DDS intake	CT exam	MRI exam	culture
10-05-2020 04:00 11:00	Abnormal behaviour (suspicious) Restless, crawling rather than walking	2T po Bid/ibuprofen 2T po			
11-05-2020	Suspicious Cerebral stroke, abnormal behaviour, normal conversation & orientation	Morning 9:00 2T, 18:00 Stop	A few lacunar infarctions in bilat basal ganglia. Otherwise unremarkable.		
12-05-2020	Morning: verbal conversation, bilateral extremities – gravity 4+ Noon: confirmed, hemiparesis, right extremities – gravity 1+	Stop		(Diffusion MR) Increased area of acute infarction in left postero-sup. temporal lobe (perfusion MR) Decreased perfusion of left MCA and PCA territories.	
13-05-2020	Confirmed	Stop	(CT of abdomen & pelvis) No abnormality in liver, Gb, spleen and BK. (Chest CT) Patchy pneumonia in LLL. R/o Minimal pneumonia in RLL. A small calcified granuloma in LUL. Dependent atelectasis in BLL. Small lt. pleural effusion. Cardiomegaly. R/o Pul arterial hypertension.		
14-05-2020	Confirmed	- Stop, 08:50 Restart 2T po Tid			
20-05-2020		2T po Tid			*P. pneumoniae* & *H. influenzae*

Copy of Medical Records

Patient Name:

Social Security Number or Personal Number:

Medical Record Number:

Access to this medical record is available only to the person with legal permission because it includes the patient's medical treatment and personal information.

- ◆ This copy is certified to be the same as the original medical record.

Name of Hospital Seal

Emergency Medical Records

Record Number : 00011408 Name : Gender/Age : F / 86 SSN or Personal No :
Doctor Information : NS xxx Date of Hospitalization : 20200511 ICD : I63.8 I10.9 F00.9
Address : Phone No :

Date Prescribed : 2020-05-11

PN Doctor name J H Kim

Neurosurgery ER note on 2020.5.11

CC: Rt. lateral weakness (2 days ago)

PI) Pt. is a senior citizen who lives alone. The patient was admitted when she presented with rt-side paralysis that started at approximately 4 am on May 10th.

pmhx) Old CVA
AD (Dapsone 200 mg BID)
Anti-HTN Med + Amlodipine 2.5 mg : BP at arrival 140/70

Social hx) Difficulty eating yesterday

PEx and NEx)
Alert, drowsy (time, person, place)–intact
Pupil 3/2 intact
Motor : right side weakness – Gr 1
Sensory : decreased
DTR : rt side decreased (brachioradialis, knee jerk)
Face motor/sensory : rt side weakness, sensory change

Imp) acute infarction, left side
r/o AD with VD
r/o HTN

Plan) admission and fluids
MR study and brain CT
Consider internal medicine referral

Emergency Medical Records

Record Number : 00011408 Name : Gender/Age : F / 86 SSN or Personal No :
Doctor Information : NS xxx Date of Hospitalization : 20200511 ICD : I63.8 I10.9 F00.9 J18.9
Address : Phone No :

Date Prescribed : 2020-05-11

PN Doctor name J H Kim

Neurosurgery ICU note on 2020.5.12

CC : Rt. lateral weakness (2 days before ER visit)
PI) Pt. is a senior citizen who lives alone. The patient was admitted when she presented with rt-side paralysis that started at approximately 4 am on May 10th.
pmhx) Old CVA
AD (Dapsone 200 mg BID)
Anti-HTN Med + Amlodipine 2.5 mg : BP at arrival 140/70
Social hx) Difficulty eating before visit

PEx and NEx)
Alert drowsy (time person place)- intact
Pupil 3/2 intact
Motor : right side weakness – Improvement to Gr 4
Sensory : decreased
DTR : rt side decreased (brachioradialis, knee jerk)
Face motor/sensory : rt side weakness, sensory change
Imp) acute infarction, left side
r/o AD with VD
r/o HTN

Plan) Guardian (son) meeting – difficulty with cooperation.
Guardian wants to continue previous medication (Dapsone) – explained possible side effects.
Agreement to L-tube feeding
Permit Dapsone medication
Plan2) Displays progression of lt side weakness
. **Additional MR check for diffusion/perfusion due to Rt side motor 4->2 or 3**

Image result) **Increased in left PCA-MCA borderzone infarction**
Add Novastan

Emergency Medical Records

Record Number: 00011408 Name: Gender/Age: F/86 SSN or Personal No:
Doctor Information: NS xxx Date of Hospitalization: 20200511 ICD: I63.8 I10.9 F00.9 J18.9
Address: Phone No:

Date Prescribed: 2020-05-11

PN Doctor name J H Kim

Neurosurgery ICU note on 2020.5.12

CC: Rt. lateral weakness (2 days before ER visit)
PI) Pt. is a senior citizen who lives alone. The patient was admitted when presented with rt-side paralysis that started at approximately 4 am on May 10th. Acute infarction, left PCA-MCA borderzone -> present ICU care
pmhx) Old CVA
AD (Dapsone 200 mg BID)
Anti-HTN Med + Amodipin 2.5 mg: BP at arrival 140/70
Social hx) Difficulty eating before visit

PEx and NEx)
Alert drowsy –stupor (time person place)- not intact
Pupil 3/3 intact
Motor: right side weakness – decreased to Gr 1
Sensory: uncheckable d/t poor cooperation
DTR: rt side decreased (brachioradialis, knee jerk)
Face motor/sensory: rt side weakness, sensory change
Study result)
2020.5.12 image result) **Increase in left PCA-MCA borderzone infarction density**
Imp) acute infarction, left side
r/o AD with VD
r/o HTN

Plan) Guardian (son) meeting – difficulty with cooperation.
Guardian wants to continue previous medication (Dapsone) – explained possible side effects.
Agreement to L-tube feeding
Permit Dapsone medication
Maintain Novastan

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address:
Phone:

Date/Time	Nursing Activities	
20-05-11 16:32	Admitted via ER by str-car C/C: Rt weakness, dysarthria PI: symptom started around 4am before ER visit. Symptom continued until ER adm Phx: DM/HTN/Tbc/hepatitis(-/+ more than 10 yrs/-/-), Dementia diagnosed in 2008, previous visit history in 2014 due to stroke(?), leg oedema more than 10 yrs F/Hx: DM/HTN/Tbc/hepatitis (-/-/-/-) Alcohol: none Smoking: never Pneumonia vaccine injection history: none Fall down hx within 3 months: 20.05.11 Allergy: none BW/HT: 58 kg/160 cm V/S: 162/89-89-88-22-36.0C Mental: drowsy Pupil: +/+/(ovoid) Eye opening well Motor localize. Autonomous movement but no cooperation. Right hand: good response to stimulation Bruises on both knees. Continuous yelling. Difficult to communicate. O_2 administered at 5 L/min (via nasal prong) Unaided respiration stable Repeated self-removal of O_2 mask. Only responds correctly to name. EKG monitor application Explained the need for ICU care to pt. Explained manual for ICU. Meeting with guardian.	Nr. Name
20-05-11 16:32	Repeated self-removal of O_2 mask. Yelling and kicking of both legs. Used restraints on both hands and legs. Checked blood circulation.	Nr. Name
20-05-11 17:16	Order from IM	Nr. Name
20-05-11 17:21	Continuous complaining SpO_2 check: 91% Notified attending Dr	Nr. Name
20-05-11 17:21	ABGA (including Lactic Acid, Ca++)	
20-05-11 17:26	No cooperation when water given. No cooperation with PO medication. Notify Dr Kim.	
20-05-11 17-30	Dr Kim made rounds	
20-05-11 17:30	Maintain fast	
20-05-11 17:32	Message ordering application of L tube (for p.o. medication)	
20-05-11 18:07	Meeting with guardian. Explained the necessity of L-tube to guardian. PO medication with guardian's help. Coughed a little.	
20-05-11 18:08	Preparation for p.o. self-administration **Dapsone** 100 mg 4T #2 (20T), Lodien 2.5 mg 1T (6day)	
20-05-11 18:10	Guardian asked for Dr Kim's email address. Explained that physician cannot give out personal email address. Delivered guardian's email address to Dr Kim.	
20-05-11 18:30	**Confirmation from Dr Kim about patient's medication.** **Order from Dr Kim to take only Lodien.**	
20-05-11 19:00	Position change & back care were performed	
20-05-11 20:00	BT 37.6 C check	
20-05-11 21:00	I/O 650/700 check	

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address: Phone:

Date/Time	Nursing Activities	Nr. Name
	BT 37.7°C check	
20-05-11 22:00	Nr. made rounds Mental: drowsy Eyes opening well Pupil: +/+ (ovoid) O_2 5 L inhalation state, via simple mask Self RR mild deep. Answers questions but difficult to understand Motor: localizing Maintain usage of restraints Blood circulation checked BT 37.9°C check Foley cath kept Elevation of head (30°)	
20-05-11 22:44	**Pt. called for help wanting to go outside and refuses being restraint. Explained the need for bed rest but was not cooperative.** HR 120-130 check	
20-05-11 23:00	Position change and back care was done BT 37.4°C check	
20-05-12 01:00	Unable to fall asleep and shows irritability BP **170/90 mm Hg** check Prn) hydralazine 0.5 A iv injection was done.	
20-05-12 01:30	F/U BP 134/81 mmHg check	
20-05-12 03:00	Position change and back care was done.	
20-05-12 04:00	Oral care and facial cleansing was done Gum bleeding sign: none.	
20-05-12 05:00	BP 171/86 mmHg, HR 112/min check Manual **BP 180/100** check Prn) hydralazine 0.5 A iv injection was done	
20-05-12 06:00	I/O 700/750, total I/O 1350/1450(stool*0) check BT 37.1°C check. Still unable to fall asleep and shows irritability	
20-05-12 08:00	Nr. made rounds Mental: drowsy Pupil: +/+ Eye opening to pain. Shows autonomous movement but is not cooperative. Use of restraints on both arms maintained. Checked for blood circulation O_2 5 L/min inhalation state (via mask) Unaided respiration stable **Mumbles and answers to questions but hard to understand.** **Gave medication with a little of bit water but started coughing so stopped.** Foley cath kept Elevation of head (30°)	
20-05-12 08:05	Guardian (son) called and asked for update on pt.'s condition.	
20-05-12 08:18	Guardian (son) called. Verified medication and diagnosis. Helped to schedule a meeting with Dr Kim in the morning.	
20-05-12 08:25	Guardian (son) called and double-checked PO. Helped to schedule a meeting with Dr Kim in the morning	
20-05-12 08:43	Informed Dr Kim about the calls from the guardian. Monitor showed SpO_2 of 91%; ABGA was performed accordingly.	
20-05-12 08:55	Dr Kim made rounds. Verified ABGA result. Switched to O_2 nasal prong.	

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address: Phone:

Date/Time	Nursing Activities	
20-05-12 09:00	Position change and back care was done.	Nr. Name
20-05-12 09:09	Guardian(son) called and asked for active thrombus treatment Informed guardian to talk to Dr Kim	
20-05-12 09:21	CBC and diff and ESR, Routine Urinalysis, Electrolyte Profile, LFT, Cardiac Profiles check	
20-05-12 09:30	EKG check	
20-05-12 10:30	Dr Kim rounded Meeting with guardian Explained the need for L-tube insert (R: agree) Guardian asked if SBP can be dropped to 120. Dr Kim explained that dropping is possible but condition of pt. could worsen. Guardian wants pt. to take patient-owned medication (Dapsone). Dr Kim explains there's no direct neurological effect in the treatment aspect but can be taken if pt. wants to. Explained pt. condition could worsen due to old age and general worsen of condition	
20-05-12 10:49	Guardian agreed to perfusion MR.	
20-05-12 10:53	Guardian said he is the PI of research. Expressed that he wants to give 2T of Dapsone right now and 1T every 6 hrs. Informed Dr Kim (R: take medication)	
20-05-12 11:00	Position change and back care were performed	
20-05-12 11:05	An L-tube (18 Fr) was inserted.	
20-05-12 11:33	Moaning when stimulated and shows weakness on the right side. Informed Dr Kim Diffusion MR added	
20-05-12 12:00	BT 37.6 °C check	
20-05-12 12:15	Guardian (son) agreed to adding diffusion MR.	
20-05-12 13:00	BT 37.7 C check	
20-05-12 13:30	I/O 630/300 check	
20-05-12 13:35	Guardian called and asked to give another 2T of Dapsone 6 hrs after the first intake of 2T, followed by 1T every 6 hrs. Informed Dr Kim	
20-05-12 13:47	Transferred to the MRI room for check-up via S-car V/S: 138/78-87-20-3702 C check	
20-05-12 14:15	Returned to ICU after check-up V/S 138/78-90-20-37.2 C check	
20-05-12 14:20	0.9% NS 500 ml + Novastan HI inj. 10 mg 6AMP[Rmk] for the day (5 gtt)	
20-05-12 15:00	Nr. Rounded Mental: drowsy Pupil reflex + pin point/+ pin point Intermittently opens eyes when stimulated O_2 5 L/min inhalation state via nasal prongs Self RR stable Moans when stimulated. Rt side weakness remained. No movement of right arm or withdrawal of right leg when stimulated. SZ sign: none. Vomiting (-) Use of restraint on left elbow and left leg maintained. Checked for blood circulation. Elevation of head (30°)	
20-05-01 16:00	Position change and back care were performed	
20-05-12 16:01	BT 37.4° C check	
20-05-12 17:01	BT 37.3° C check	
20-05-12 17:24	Dr Jang (IM) made rounds.	

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address:
Phone:

Date/Time	Nursing Activities	
20-05-12 17:30	Took medication with small amount of water through L-tube.	Nr. Name
20-05-12 18:01	BT 37.2 °C check.	Nr. Name
20-05-12 19:00	BT 37.3 °C check.	Nr. Name
20-05-12 19:00	Position change & back care were performed.	Nr. Name
20-05-12 20:00	BT 37.5 °C check.	Nr. Name
20-05-12 20:30	I/O 800/400, DE I/O 1430/700 check.	Nr. Name
20-05-12 21:00	BT 37.3 °C check.	Nr. Name
20-05-12 22:00	BT 37.1 °C check.	
20-05-12 22:00	Nr. made rounds. Mental: drowsy Eye opening to speech. Pupil: +/+ (ovoid) O_2 5 L inhalation state. via nasal prongs Self RR stable. Moans to stimuli. Motor: localizing Rt. lateral weakness remained. Shows hardly any movement of right arm or leg. Use of restraints on left arm and leg maintained. Checked for blood circulation. BT 37.1 °C check. Foley cath., L-tube kept. Elevation of head (30°).	Nr. Name
20-05-12 23:00	Position change & back care were performed.	
20-05-13 00:00	BP 167/86 mmHg, BT 38.2 °C check.	Nr. Name
20-05-13 01:00	V/S 163/89-105-18-38.4 °C-90% check. Informed Dr Ban who was on call. R: NS 100 + denogan 1 V order. Followed order. Responds to questions but incomprehensible. Motor: Lt. localizing/Still shows hardly any movement of right arm or leg.	
20-05-13 02:00	BT 38.2 °C check. Ice bag applied.	
20-05-13 03:00	Position change & back care were performed. BT 38.5 °C check.	
20-05-13 04:00	Oral care & facial cleansing were performed. Gum bleeding: none. BT 37.6 °C check.	
20-05-13 06:00	I/O 1030/600, Total I/O 2460/1300 (stool*0) No defecation for 2 days. BT 38.1 °C check. Ice bag change.	
20-05-13 07:30	BT 38.7 °C check. Informed Dr Ban, who was on call. R: Inform Dr Kim.	
20-05-13 07:36	Informed Dr Kim about the fever. (A: Consider IM referral today.)	
20-05-13 08:00	Nr. rounded. Mental: drowsy Pupil: +/+ Eye opening well. Shows autonomous movement but is not cooperative. Use of restraint on left hand maintained. Checked for blood circulation. Can slightly flex right hand. Cannot move right leg. O_2 5 L/min inhalation state. Unaided respiration stable. SpO_2 91% check.	Nr. Name

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address:
Phone:

Date/Time	Nursing Activities	
	When asked for name, repeated the word "name."	
	Difficult to communicate.	
	Took medication with small amount of water.	
	Foley cath., L-tube kept.	
	Elevation on head (30°).	
	BT 38.6 °C check.	
20-05-13 08:55	Dr Kim rounded.	
20-05-13 09:00	Position change & back care were performed.	Nr Name
20-05-13 09:00	BT 38.4 °C check.	Nr Name
20-05-13 09:29	Order from IM.	
20-05-13 09:30	Proceeded with bedside PT.	
20-05-13 09:34	Blood culture (Sensi) * 2, ordinary urine culture (Sensi, Urinary system), Gram stain, ABGA (Lactic Acid, Ca++) check. NS 100 mL + Gomcephin 1 VIA add. Main fluid and Liveract 500 mg/5 mL 1AMP mix. CAP(P) add.	
20-05-13 09:49	Gomcephin AST: negative check.	
20-05-13 10:00	BT 38.5 °C check.	
20-05-13 10:37	Chest CT (contrast), CT Abd./Pelvis [contrast] ordered. prn) NS 100 mL + denogan 1 V #1 ordered.	Nr. Name
20-05-13 10:40	N/S 100 mL + denogan 1A IV injection was done. (by prn order)	Nr. Name
20-05-13 11:00	Position change & back care were performed. BT 37.4 °C check.	Nr. Name
20-05-13 11:08	Contrast agent AST (R: Negative)	
20-05-13 12:30	NPO state.	
20-05-13 14:00	I/O 910/650 check.	Nr. Name
20-05-13 14:02	Transferred to radiology for check-up. v/s: 148/78-87-20-36.7 °C check.	Nr. Name
20-05-13 14:37	Returned to ICU. v/s: 150/81-93-20-36.7 °C check.	
20-05-13 15:00	Nr. rounded. Mental: drowsy Pupil reflex + pin point./+ pin point Intermittently opens eyes when stimulated. O_2 5 L/min inhalation state via nasal prongs. Self RR stable. Moans when stimulated. Rt. lateral weakness remained. No movement of right arm and withdrawal of right leg when stimulated. SZ sign: none. Vomiting (-) Use of restraints on left elbow and left leg maintained. Checked for blood circulation. Elevation of head (30°).	Nr. Name
20-05-13 16:00	Position change & back care were performed.	
20-05-13 17:25	NPO state.	Nr. Name
20-05-13 19:00	Position change & back care were performed.	Nr. Name
20-05-13 19:05	Sputum in the mouth. Proceeded with suctioning – secretion copious & thick.	
20-05-13 20:30	I/O 700/550, DE I/O 1610/1200 check.	
20-05-13 22:00	Nr. rounded. Mental: drowsy Eye opening well. Pupil: +/+ (ovoid) O_2 5 L inhalation state via nasal prongs	Nr. Name

Nursing Record

Printing Period: May 11th, 2020 - May 20th, 2020

Patient Name F/86 NS Dr Joon Hak Kim May 11th, 2020
HD: 10 OP: Unspecified ICU-01-03
Address:
Phone:

Date/Time	Nursing Activities	
	Self RR stable.	
	Freq. suction was done.	
	Secretion amount large.	
	Moans when stimulated.	
	Motor: localizing	
	Rt. lateral weakness sign remained.	
	Shows hardly any movement of right arm or leg.	
	Use of restraints on left arm and leg maintained.	
	Checked for blood circulation.	
	Constant screaming.	
	Foley cath., L-tube kept.	
	Elevation of head (30°).	
20-05-13 22:20	Perineal care was done.	Nr Name
20-05-13 23:00	Position change & back care were performed.	Nr Name
20-05-14 00:00	BT 37.5 °C check.	Nr Name
20-05-14 01:00	Sleeping	
	BT 37.9 °C check.	
20-05-14 02:00	BT 37.7 °C check.	
20-05-14 03:00	Position change & back care were performed.	
	BT 37.4 °C check.	
20-05-14 04:00	Oral care & facial cleansing were performed.	
	Gum bleeding: none.	
	BT 37.0 °C check.	
20-05-14 06:00	I/O 800/550, Total I/O 2410/1750 (stool*0) check.	
	No defecation for 3 days.	
	BT 37.1 °C check.	
20-05-14 08:00	Nr. rounded	Nr. Name
	Mental: drowsy	
	Pupil: +/+	
	Eye opening well.	
	Shows autonomous movement but is not cooperative.	
	Use of restraint on left hand maintained.	
	Checked for blood circulation.	
	Can slightly flex right hand.	
	Cannot move right leg.	
	O_2 5 L/min inhalation state.	
	Unaided respiration stable	
	SpO_2 91% check	
	Moans when stimulated.	
	L-tube feeding was done.	
	Aspiration.	
	Dyspepsia, vomiting signs: none.	
	Foley cath., L-tube kept.	
	Elevation on head (30°).	
20-05-14 08:45	Dr Jang rounded.	
20-05-14 08:50	Dr Kim rounded.	
	Informed Dr Kim that pt. only moans when stimulated.	
	Orders to give Dapsone as guardian wanted.	
20-05-14 09:00	Position change & back care were performed.	
20-05-14 09:30	Bedside PT	
20-05-14 10:35	Ordinary sputum culture, Gram stain, screening for bacterial pneumonia, streptococcal pneumonia antigen, urine (SPNEU), Legionella urinary Ag check.	
20-05-14 10:41	Levloxin 500 mg 1B0T, Levloxin 250 mg 1B0T added.	
	Muteran 300 mg 1AmP * 3 added.	
20-05-14 11:00	Position change & back care were performed.	
20-05-14 12:30	Freq. suction was performed.	
	L-tube feeding was performed.	
	Aspiration.	
	Dyspepsia, vomiting signs: none.	

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ER

Gender/Age: F/86 **Department:** ER **Referring Physician:** B K Lee, MD

DOB: 19331209

Date of Order: 20200520. 504 Ordered by Dr.: J. H. Kim

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Type of Exam: Chest AP

Date/Time of Reading: 2020-05-11 15:54

Date of Exam: 2020-05-11 15:46
Time of Exam: 2020-05-11 15:46

Findings: No abnormality in either lung or in mediastinum.
Otherwise unremarkable.

Impression : Negative study.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ER

Gender/Age: F/86 **Department:** ER **Referring Physician:** Byeong Gook Lee, MD

DOB: 19331209

Date of Order: 20200511. 509 Ordered by Dr.: J. H. Kim

Type of Exam: B-MRI & MRA & Diffusion

Date of Exam: 2020-05-11 14:53
Time of Exam: 2020-05-11 14:53

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Date/Time of Reading: 2020-05-11 15:50

Impression: MRI of brain, noncontrast, DWI

T1 sagittal, T2 axial, FLAIR axial, T1 axial, T2 coronal, Gradient FFE axial, DWI axial

Clinical information: r/o cbr. infarction

Acute infarction in lt parietal white and gray matter and forceps major.
A few lacunar infarctions in bilat basal ganglia.

MRA, cerebral (brain) and carotid

Marked occlusion at lt M2 bifurcation portion.
Mild stenosis at rt M1, M2, bilat P2, bilat distal vertebral and rt proximal ICA.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ER

Gender/Age: F/86 **Department:** ER **Referring Physician:** Byeong Gook Lee, MD

DOB: 19331209

Date of Order: 20200511. 511 Ordered by Dr.: J. H. Kim

Type of Exam: Brain CT (Non contrast)

Date of Exam: 2020-05-11 15:50
Time of Exam: 2020-05-11 15:50

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Date/Time of Reading: 2020-05-11 16: 36

Impression: A few lacunar infarctions in bilat basal ganglia.
Otherwise unremarkable.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ICU-01-03

Gender/Age: F/86 **Department:** NS **Referring Physician:** Joon Hak Kim, MD

DOB: 19331209

Date of Order: 20200512. 28 Ordered by Dr.: J. H. Kim

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Type of Exam: Diffusion MR

Date/Time of Reading: 2020-05-12 14: 42

Date of Exam: 2020-05-12 14:02
Time of Exam: 2020-05-12 14:02

Impression: Increased area of acute infarction in lt posterosup temporal lobe.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ICU-01-03

Gender/Age: F/86 **Department:** NS **Referring Physician:** Joon Hak Kim, MD

DOB: 19331209

Date of Order: 20200512. 14 Ordered by Dr.: J.H. Kim

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Type of Exam: Perfusion MR

Date/Time of Reading: 2020-05-13 09:58

Date of Exam: 2020-05-12 14:02
Time of Exam: 2020-05-12 14: 02

Impression: 2020. 5. 11 acute infarction, left PCA-MCA border zone infarction (hypoperfusion infarction).
Perfusion MR to check perfusion state due to atherosclerosis change found in brain MR angio.

CBF: Left Occipito-parietal, temporal area decreased
CBV: Left Occipito-parietal, temporal area BK.
MTT: Left Occipito-parietal, temporal area prolonged state
TTP: Left Occipito-parietal, temporal area prolonged state

[conclusion]
Decreased perfusion at left MCA and PCA territories.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ICU-01-03

Gender/Age: F/86 **Department:** IM **Referring Physician:** Joon Hak Kim, MD

DOB: 19331209

Date of Order: 20200513. 36 Ordered by Dr.: T. H. Jang

Type of Exam: CT Abd./ Pelvis [contrast]

Date of Exam: 2020-05-13 14:07
Time of Exam: 2020-05-13 14: 07

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Date/Time of Reading: 2020-05-13 15: 55

Impression: CT of abdomen and pelvis, postcontrast

Mild dilation of body and tail portion of P duct, R/o benign stenosis, D/Dx IPMN.
No abnormality in liver, Gb, spleen and BK.
Otherwise unremarkable.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ICU-01-03

Gender/Age: F/86 **Department:** IM **Referring Physician:** Joon Hak Kim, MD

DOB: 19331209

Date of Order: 20200513. 35 Ordered by Dr.: T. H. Jang

Type of Exam: Chest CT (contrast)

Date of Exam: 2020-05-13 14:07
Time of Exam: 2020-05-13 14: 07

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Date/Time of Reading: 2020-05-13 15: 51

Impression: Patchy pneumonia in LLL.
R/o Minimal pneumonia in RLL.
A small calcified granuloma in LUL.
Dependent atelectasis in BLL.
Small lt pleural effusion.
Cardiomegaly.
R/o Pul arterial hypertension.

Radiology Report

Patient ID: **Patient Name:** **Date of Admission:** May 11th, 2020 **Ward:** ICU-01-03

Gender/Age: F/86 **Department:** NS **Referring Physician:** Joon Hak Kim, MD

DOB: 19331209

Date of Order: 20200520. 13 Ordered by Dr.: J. H. Kim

Type of Exam: Chest AP

Date of Exam: 2020-05-20 08:06
Time of Exam: 2020-05-20 08:06

Radiologist 1: Sang Heung Kim (52584)
Radiologist 2: Sang Heung Kim (52584)

Date/Time of Reading: 2020-05-20 09: 19

Impression: Atelectasis in RLL.

Microbiology Culture Report

Institute Name: Daehan Hospital	Institute No.: 11101156	Order No.: 20200214-112-5306
Pt. Name: x x	Registration No.: 000114008	Collection Day: 2020/05/14
Department/Ward: IM/ICU	Personal No: 331209-2******	Rcvd: 2020/05/14 18:08
Doctor Name:	Gender/Age: F/86	Tested: 2020/05/15
Specimen: Nasal and oropharyngeal		Released: 2020/05/15 06:40
Others: 2005140105		

Medical Insurance Code	Organism	Result	Units	Reference
D680104C	*B. pertussis*	Negative		Attached report
	C. pneumoniae	Negative		Attached report
	H. influenza	Positive (31.6)		Attached report
	L. pneumophilia	Negative		Attached report
	M. pneumoniae	Negative		Attached report
	S. pneumonia	Positive (36.6)		Attached report
	M. pneumoniae A2063G mutation	N/A		Attached report
	M. pneumoniae A2064G mutation	N/A		Attached report

Culture Report was done

The results are accurate and reliable because this lab was approved by KSLM.

Lab Name Green Cross	Cultured by Y.J. Oh M.T. (23780)	
Lab No.: 41303059	Lab Address	Reported by S.G. Lee M.D. (671)
GCL-AAAA-F09-01(00)	Phone: 1566-0131	Specimen Charger: J.S. Park

Medical Certificate

Record Number
Year Number

Name of Patient		Social Security Number	
Address			
Diagnosis [■Clinical Impression [ ] Final Diagnosis	(Main diagnosis) Acute Brain Infarction (Main diagnosis) Hypertension	ICD	I 63.8, I 10.9
Onset Date	May 10th, 2020	Diagnosis Date	May 11th, 2020
Medical Opinion	Right paralysis started on May 10th, 2020. Visited ER and was admitted on May 11th, 2020. Currently being treated in the ICU and expected to stabilize further.		
Purpose			
Remark	Department of neurology		

[Medical law] This diagnosis is made in accordance with Article 17 and Article 9 (1) of the same act.

May 20th, 2020

Medical Institution:

Address:

[■] Physician [ ] Dentist [ ] Oriental Medical Doctor License Number: 87798

Name: Joon Hak Kim

Original medical records

Copy of Medical Records

의 무 기 록 사 본

Name
성 명 : [redacted]

Social Security Number
주민번호 : [redacted]

Record Number
병록번호 : 000114008

상기 의무기록지는 환자의 진료사항 및 인적사항 등이 기재되어 있으며, 본 의무기록지는 허가된 사람만이 열람이 가능합니다.

◆본 의무기록은 원본과 동일함을 확인합니다.
This copy is certified to be the same as the original medical record.

원본대조필 101 장

[redacted]

Emergency Medical Records
응 급 진 료 기 록 지

Record Number
병록번호: 000114008

Name
성명: [redacted]

Gender/Age
성별/나이: F / 86

Social Security Number
주민번호: [redacted]

Doctor Information
주치정보: NS 김준학

Date of Hospitalization
입원일자: 20200511

ICD 진단 코드: 주) I63.8 보) I10.9_01 보) F00.9

Address
주 소: [redacted]

Phone 전화번호: [redacted]

Date Prescribed
처 방 일: 2020年05月11日

PN

김준학 Joon Hak Kim

neurosurgery ER note on 2020.5.11

CC: Rt. side weakness (2일전) (2 days ago)

PI) Pt. is a senior citizen who lives alone. She was admitted when she presented with right side paralysis that started at approximately 4 am on May 10th. 독거노인으로 5월 10일 새벽 4시경부터 시작된 우측의 마비를 주소로 내원함.

pmhx) Old CVA
AD (닥손 200mg 2회) (Dapsone 200 mg BID)
혈압약 + 아모디핀 2.5mg : 본원 140/70
HTN Med + Amodipin 2.5 mg: BP at arrival 140/70

social hx) 어제 식사를 거의 잘 못함. Difficulty eating yesterday.

PEx and NEx)
alert drowsy (time person place)- intact
pupil 3/3 intact
motor : right side weakness - Gr 1
sensory : decreased
DTR : rt side decreased (brachioradialis, knee jerk)
face motor/sensory : rt side weakness, sensory change

imp) acute infarction, left side
r/o AD with VD
r/o HTN

plan) admission and fluid
mr study and brain ct
추후 내과 협진. Consider internal medicine referral.

[redacted]

Emergency Medical Records
병 동 진 료 기 록 지

Record Number 병록번호: 000114008 | Name 성명: 조[redacted] | Gender/Age 성별/나이: F / 86 | Social Security Number 주민번호: 3[redacted]
Doctor Information 주치정보: NS 김준학 | Date of Hospitalization 입원일자: 20200511 | ICD 진단 코드: 주) I63.8 보) I10.9_01 보) F00.9 보) J18.9
Address 주 소: 서[redacted] | Phone 전화번호: 01[redacted]
Date Prescribed 처 방 일: 2020年05月12日

PN 김준학 Joon Hak Kim

neurosurgery ICU note on 2020.5.12

CC: Rt. side weakness (내원 2일전) (2 days before ER visit)
Pt. is a senior citizen who lives alone. She was admitted when she presented with right side paralysis that started at approximately 4 am on May 10th.
PI) 독거 Old 여 10th 5월 10일 새벽 4시경부터 시작된 우측의 마비를 주소로 내원함. acute infarction, left PCA_MCA borderzone 으로 진단 ICU care중임. Acute infarction, left PCA-MCA border zone → present ICU care.

pmhx) Old CVA
AD (닥손 200mg 2회) - 한센병약 (Dapsone 200 mg BID)
혈압약 + 아모디핀 2.5mg : 본원 140/70
HTN Med + Amodipin 2.5 mg: BP at arrival 140/70
social hx)내원전 식사를 거의 잘 못함. Difficulty eating before visit.

PEx and NEx)
alert drowsy (time person place)- intact
pupil 3/3 intact
motor : right side weakness - Gr 4 로 호전 Improvement to Gr 4
sensory : almost intact
DTR : rt side decreased (brachioradialis, knee jerk)
face motor/sensory : rt side weakness, sensory change

imp) acute infarction, left side
r/o AD with VD
r/o HTN

plan) 보호자 면담 - 협조 잘 안됨. Guardian (son) meeting – difficulty with cooperation.
자가약 댑손에 대해서는 유지 희망-추후 문제의 발생 가능성설명 Guardian wants to continue previous medication (Dapsone) – explained possible side effects.
L tube feed 동의함. Agreed to L tube feeding.
약물치료 동의함. Permit Dapsone medication.

plan2) left side weakness progression하는 양상을 보임. Displays progression of left side weakness.
Rt. side motor 4-->2 or 3로 감소하는 소견을 보여 추가적으로 diffusion 및 perfusion mr check하기로 함. **Additional MR check for diffusion/perfusion due to decrease in right side motor function from 4 to 2 or 3.**

image result) left PCA-MCA borderzone infarction density증가 **Increase in left PCA-MCA border zone infarction**

노바스탄 추가 결정함. Add Novastan.

Emergency Medical Records
병 동 진 료 기 록 지

Record Number
병록번호: 000114008

Name
성명: [redacted]

Gender/Age
성별/나이: F / 86

Social Security Number
주민번호: [redacted]

Doctor Information
주치정보: NS 김준학

Date of Hospitalization
입원일자: 20200511

ICD 진단 코드: 주) I63.8 보) I10.9_01 보) F00.9 보) J18.9

Address
주 소: [redacted]

Phone
전화번호: [redacted]

Date Prescribed
처 방 일: 2020年05月13日

PN

김준학 Joon Hak Kim

Neurosurgery ICU note on 2020.5.13

CC: Rt. side weakness (내원 2일전) (2 days before ER visit)
Pt. is a senior citizen who lives alone. She was admitted when she presented with right side paralysis that started at approximately 4 am on May 10th.
PI) 독거 노인으로 5월 10일 새벽 4시경부터 시작된 우측의 마비를 주소로 내원함. acute infarction, left PCA_MCA borderzone 으로 진단 ICU care중임. Acute infarction, left PCA-MCA border zone → present ICU care.

pmhx) Old CVA
AD (닥손 200mg 2회) - 한센병약 (Dapsone 200 mg BID)
혈압약 + 아모디핀 2.5mg : 본원 140/70
HTN Med + Amodipin 2.5 mg: BP at arrival 140/70
social hx)내원전 식사를 거의 잘 못함. Difficulty eating before visit.

PEx and NEx)
alert drowsy-stupor(time person place)- not intact
pupil 3/3 intact
motor : right side weakness - Gr 1으로 감소함. Decreased to Gr 1.
sensory : uncheckable d/t poor cooperation
DTR : rt side decreased (brachioradialis, knee jerk)
face motor/sensory : rt side weakness, sensory change

study result)
2020.5.12
mage result) left PCA-MCA borderzone infarction density증가 **Increase in left PCA-MCA border zone infarction density**

imp) acute infarction, left side
r/o AD with VD
r/o HTN

plan) 보호자 면담 - 협조 잘 안됨. Guardian (son) meeting – difficulty with cooperation.
자가약 댑손에 대해서는 유지 희망-추후 문제의 발생 가능성설명 Guardian wants to continue previous medication (Dapsone) – explained possible side effects.
L tube feed 동의함. Agreed to L tube feeding.
약물치료 동의함. Permit Dapsone medication.
노바스탄 유지 Maintain Novastan.

[redacted]

Nursing Record
간 호 기 록 지

Printing Period 출력기간 : 2020년05월11일 ~ 2020년05월20일

조[redacted] F / 86 000114008 NS Dr. 김준학 2020년05월11일
Dr Joon Hak Kim

HD : 10 OP : 비지정 ICU-01-03

주 소 : 서[redacted] Phone 전 화 번 호 : 010[redacted]

Address

등록일/시 Date/Time	간호활동 Nursing Activities	
20-05-11 16:32	admitted via ER by str-car. C/C : Rt weakness, dysarthria PI : 내원 전일 4am경부터 상기 증상 지속되어 ER통해 adm. Phx : DM/HTN/Tbc/hepatitis(-/+ 10년이상/-/-), dementia - 2008년 진단, 2014년 stroke(?) 본원, 다리 부종 10년 이상 F/Hx : DM/HTN/Tbc/hepatitis(-/-/-/-) Alcohol : none. smoking : never 폐렴 백신 접종 여부 : 무 3개월내 낙상 여부 : 20.05.11. Allergy : none. BW/HT : 약 58/160 V/S : 162/89-88-22-36.0'c mental : drowsy pupil : +/+(ovoid) eye opening well. motor localize check. 자가 움직임있으나 협조 안됨. 자극에 오른쪽 손도 잘 올라오는 모습임. 양쪽 무릎 멍들어있음. 지속적으로 소리침. 의사 소통 어려움. 02 5L/min apply.(via nasal prong) self respiration stable. 02 mask self remove 반복함. 질문에 이름만 정확히 대답함. EKG monitor apply. 환자분게 중환자실 치료 필요성 설명함. 보호자분께 중환자실 병실 생활 안내, 욕창 예방 안내 후 긴급 상황시 연락처 확인함. 보호자 면회함.	Soon Hwa Lee 순화 Symptom started at approximately 4 am before ER visit. Symptom continued until ER adm. DM/HTN/Tbc/hepatitis (-/+ more than 10 yrs/-/-), dementia – diagnosed in 2008, previous visit history in 2014 due to stroke (?), leg oedema more than 10 yrs. Pneumonia vaccine injection (negative) Fall hx within 3 months: 20.05.11. Self-movement but not cooperative. Right hand – good response to stimulation. Bruises on both knees. Continuous yelling. Hard to communicate. Repeated self-removal of O_2 mask. Only responds correctly to name. Explained the need for ICU care to pt. Explained manual for ICU. Meeting with guardian.
20-05-11 16:32	02 mask self remove 반복됨. 소리치며 발길질함.(양쪽 발) 양쪽 손, 양쪽 다리 억제대 사용함. 혈액 순환 확인함.	Repeated self-removal of O_2 mask. Yelling and kicking of both legs. Used restraints on both hands and legs. Checked blood circulation.
20-05-11 17:16	1내과 협진 처방남.	Order from IM.
20-05-11 17:21	지속적으로 우는 소리냄. spo2 91% check. 김준학 과장님께 알림.	Continuous complaining. Notified Dr Kim
20-05-11 17:21	ABGA(포함Lactic Acid, Ca++) check.	
20-05-11 17:26	물 소량 드리나 협조 안됨. po 협조 안되어 복용하기 어려움을 김준학 과장님께 알림.	No cooperation when water given. No cooperation with PO medication. Notify Dr Kim.
20-05-11 17:30	김준학 과장님 회진함.	Dr Kim visited on rounds.
20-05-11 17:30	금식 유지중임.	Maintain fast.
20-05-11 17:32	L tube apply (PO medication) Message 처방남.	
20-05-11 18:07	보호자분 면회함. 환자분 협조 안되어 L-tube 필요함을 보호자분께 설명함. 천천히 설명하면 듣는다며 본인이 먹여보겠다고 함. 보호자분 보조하에 po 복용함. 기침 조금함.	Meeting with guardian. Explained the need for an L-tube to guardian. PO medication with guardian's help. Coughed a little.
20-05-11 18:08	* self po prepare. Dapsone 대극탕손정 100mg 4T#2(20T), 로디엔정 2.5mg 1T#1(6day)	Lodien
20-05-11 18:10	보호자분 담당 과장님 E-mail 알려달라고 함. 개인 E-mail 알려드릴수 없다고 설명함. 보호자분 E-mail 적어주시면서 담당 과장님께 전달해 달라고 함. 김준학 과장님께 전달함.	Guardian asked for Dr Kim's email address. Explained cannot give out personal email address. Delivered guardian's email address to Dr Kim.
20-05-11 18:30	자가약 복용 여부 김준학 과장님께 확인함. 로디엔정만 복용하자고 함.	**Confirmation from Dr Kim about patient's medication.**
20-05-11 19:00	Position change & back care was done.	**Order from Dr Kim to take only Lodien.**
20-05-11 20:00	BT 37.6'c check.	
20-05-11 21:00	I/O 650/700check.	

Nursing Record
간 호 기 록 지

Printing Period 출력기간: 2020년05월11일 ~ 2020년05월20일

조[redacted] F / 86 000114008 NS Dr. 김준학 2020년05월11일
Dr Joon Hak Kim
HD : 10 OP : 비지정 ICU-01-03
주 소: 서[redacted] Address Phone 전 화 번 호: 01[redacted]

등록일/시 Date/Time	간호활동 Nursing Activities	
	BT 37.7'c check.	
20-05-11 22:00	Nr. rounded. mental : drowsy eye opening well. pupil : +/+(ovoid) O2 5L inhalation state. via simple mask self RR mild deep. 질문에 대답하나 알아듣기 어려움. Answers questions, but difficult to understand. motor : localizing 사지 억제대 유지중임. Maintain usage of restraints. -순환 상태 확인함. Check for blood circulation. BT 37.9'c check Foley cath. kept. Elevation on Head(30°) 유지중임.	Tae Hoon Oh 오태훈
20-05-11 22:24	밖에 나가야 한다면서 억제대 풀어달라며 직원들 부르고 있음. 현재 병원에 입원중이며, 침상안정 필요성 설명하나 협조안됨. 침대 밖으로 나가려고 상체 일으켜 세우는 등 힘쓰고 있음. HR 120~130대 check.	**Pt. called for help, wanting to go outside, and refused to be restrained. Explained the need for bed rest, but pt. was not cooperative.** Bo Ram Han 한보람
20-05-11 23:00	Position change & back care was done. BT 37.4'c check.	Tae Hoon Oh 오태훈
20-05-12 01:00	잠들지 못하고 깨어있음. 지속적으로 뒤척거리며 irritable한 양상 보임. Unable to fall asleep and shows irritability. BP 170/90mmHg check. **170/90** prn) hydralazine 0.5A ivs injection was done.	Tae Hoon Oh 오태훈
20-05-12 01:30	F/U BP 134/81mmHg check.	
20-05-12 03:00	Position change & back care was done.	
20-05-12 04:00	oral care & facial cleansing was done. gum bleeding sign none.	
20-05-12 05:00	BP 171/86mmHg, HR 112회/min check. manual BP 180/100 check. **180/100** prn)hydralazine 0.5A ivs injection was done.	Bo Ram Han 한보람
20-05-12 06:00	I/O 700/750, total I/O 1350/1450 (stool*0) check. BT 37.1'c check. Still unable to fall asleep and shows irritability. 방새 한숨도 안주무시며 소리지르고 irritable한 모습 보임.	Tae Hoon Oh 오태훈
20-05-12 08:00	Nr. rounded. mental : drowsy pupil : +/+ eye opening to pain. self motor있으나 협조 안됨. Shows autonomous movement but is not cooperative. 양쪽 손 억제대 유지중임. Use of restraints continued for both arms. 혈액 순환 확인함. Checked for blood circulation. O2 5L/min inhalation state.(via mask) self respiration stable. 질문에 웅얼거리고 대답하나 알아듣기 어려움. **Mumbles and answers questions, but difficult to understand.** 물 소량과 함께 약 드리나 기침하여 중단함. **Gave medication with a small amount of water, but stopped because pt. started coughing.** foley cath. kept. Elevation on Head(30°)유지중임.	Soon Hwa Lee 이순화
20-05-12 08:05	보호자(아들)분 전화옴. Guardian (son) called and asked for pt.'s condition update. condition 문의함.	
20-05-12 08:18	보호자(아들)분 전화옴. Guardian (son) called. 먹는약, 진단명 확인함. Verified medication and diagnosis. 당당 과장님과 오전에 면담하도록 안내함. Helped to schedule a meeting with Dr Kim in the morning.	
20-05-12 08:25	보호자(아들)분 전화옴. Guardian (son) called and double-checked PO. po 다시 한번 확인함. 치료 방향에 대해서는 과장님과 면담하시도록 다시 한번 안내함. Helped to schedule a meeting with Dr Kim in the morning.	
20-05-12 08:43	아침에 보호자분 3차례 전화왔고 진단명, po 확인함을 김준학 과장님께 전달함. monitor상 spo2 91% 측정되어 ABGA 확인해보자고 함. Informed Dr Kim about the calls from the guardian. ABGA check. Monitor showed SpO_2 of 91%; ABGA performed accordingly.	
20-05-12 08:55	김준학 과장님 회진함. Dr Kim made rounds. ABGA 결과 확인함. Verified ABGA result. O2 nasal prong으로 변경함. Switched to O_2 nasal prongs.	

Nursing Record
간 호 기 록 지

Printing Period 출력기간: 2020년05월11일 ~ 2020년05월20일

[redacted] F / 86 000114008 NS Dr. 김준학 Dr Joon Hak Kim 2020년05월11일

HD : 10 OP : 비지정 ICU-01-03

Address 주 소: [redacted] Phone 전 화 번 호: [redacted]

등록일/시 Date/Time	간호활동 Nursing Activities	
20-05-12 09:00	Position change & back care was done.	박소희 So Hee Park
20-05-12 09:09	보호자(아들)분 전화옴. Guardian (son) called and asked for active thrombus treatment. 혈전 치료를 적극적으로 해달라며 담당 과장님께 전달해달라고 함. 담당 과장님과 전화 면담하시도록 안내함. Instructed guardian to talk to Dr Kim.	이순화 Soon Hwa Lee
20-05-12 09:21	CBC & diff & ESR (8종),Routine Urinalysis,Electrolyte P ,LFT 6종, CARDIC PROFILE(4종) check.	박소희 So Hee Park
20-05-12 09:30	EKG check.	
20-05-12 10:30	김준학 과장님 회진함. Dr Kim made rounds. 보호자분 면회함. Meeting with guardian. L-tube insert 필요성 설명함.(R:동의) Explained the need for an L-tube insert. (R: 보호자분 SBP 120대로 맞출수 없냐고 문의함. Guardian asked if SPB can be dropped to 120. 혈압 지금보다 더 떨어트릴수는 있지만 경과 나빠질 가능성 높음을 김준학 과장님 설명함. 자가약중 답손 복용하고 싶다고 함. Guardian wants pt. to take her own medication (Dapsone). 보호자분이 원하시면 복용할수 있지만 신경외과적인 치료와는 직접적인 관계가 없음을 김준학 과장님 설명함. Dr Kim explains treatment has no direct neurological effect but can be taken if pt. wishes. old age, general condition 악화로 condition 떨어질수 있음을 설명함.	이순화 Soon Hwa Lee Dr Kim explained that dropping is possible but condition of pt. could worsen. Explained pt. condition could worsen due to old age and general worsening of condition.
20-05-12 10:49	* 보호자(아들)에게 금일 Perfusion MR (급여,약 19만원) 검사 진행예정임을 설명함.(R: 동의) 동의서 작성위해 MRI로 안내함. Guardian agreed to perfusion MR.	박소희 So Hee Park
20-05-12 10:53	보호자(아들)분이 본인이 연구 책임자라면서 답손정을 지금 2T주고 6시간마다 1T씩 줬으면 좋겠다고 함. Guardian is the PI of research. Expressed that he wants to give 2T of Dapsone right now and 1T every 6 hrs. 김준학 과장님께 전달함.(R:복용) Informed Dr Kim. (R: take medication)	이순화 Soon Hwa Lee
20-05-12 11:00	Position change & back care was done.	박소희 So Hee Park
20-05-12 11:05	L-tube(18Fr) insert was done.	이순화 Soon Hwa Lee
20-05-12 11:33	자극에 신음소리밖에 못내고 오른쪽 weakness있음. Moaning when stimulated and shows weakness on the right side. 김준학 과장님께 알림. Informed Dr Kim. Diffusion MR (단독 급여) add.	
20-05-12 12:00	BT 37.6'c check.	
20-05-12 12:15	보호자(아들)분께 Diffusion MR (단독 급여)추가 되어 13만원정도 추가금 발생함을 알림. 검사 진행해달라고 함. Guardian agreed to the addition of diffusion MR.	
20-05-12 13:00	BT 37.7'c check.	
20-05-12 13:30	I/O 630/300check.	
20-05-12 13:35	보호자(아들)분 전화옴. Guardian called and asked to give another 2T of Dapsone 6 hrs after the first intake of 2T, followed by 1T every 6 hrs. 답손정 2T 복용 6시간 이후 2T 한번 더 복용하고 그 이후로 6시간마다 1T씩 복용시켜달라고 함. 김준학 과장님께 전달함. Informed Dr Kim.	
20-05-12 13:47	검사위해 S-car로 MRI실로 이동함. Transferred to the MRI room for check-up via S-car. v/s 138/78-87-20-37.0'c check.	
20-05-12 14:15	검사마치고 중환자실로 돌아옴. Returned to ICU after check-up. v/s : 138/78-90-20-37.2'c check.	박소희 So Hee Park
20-05-12 14:20	0.9% NS 500ml + Novastan Hl Inj.10mg 6 AMP[Rmk] 하루동안 들어가게 해주세요(5가트)	최환성 Hwan Sung Choi
20-05-12 15:00	간호사 순회함. Nr. made rounds. mental : drowsy pupil reflex + pin point./+ pin point 자극에 간헐적 눈뜨는 모습임. Intermittently opens eyes when stimulated. 02 5L/min inhalation state via nasal prong. self RR stable. 자극에 신음소리만 냄. Moans when stimulated. Rt. side weakness remained. No movement of right arm; withdrawal of right leg when stimulated. -자극에 오른팔 움직임 없음, 오른발만 움찔하는 정도임. S.Z sign none. vomiting (-) 기구유지 및 침상안정위해 왼팔 팔꿈찌 억제대, 왼쪽다리 억제대 유지중임. Use of restraints on left elbow and left leg maintained. -혈액순환 확인함. Checked for blood circulation. Elevation on Head(30°)유지중임.	
20-05-12 16:00	Position change & back care was done.	
20-05-12 16:01	BT 37.4 check.	
20-05-12 17:01	BT 37.3 check.	
20-05-12 17:24	장태훈 부장님 회진하여 청진함. Dr Taehoon Jang made rounds.	공대한 Daehan Gong

Nursing Record
간 호 기 록 지

Printing Period 출력기간: 2020년05월11일 ~ 2020년05월20일

[redacted] F / 86 000114008 NS Dr. 김준학 Dr Joon Hak Kim 2020년05월11일

HD : 10 OP : 비지정 ICU-01-03

Address 주 소: [redacted] Phone 전 화 번 호: [redacted]

등록일/시 Date/Time	간호활동 Nursing Activities	
20-05-12 17:30	L-tube로 소량 물과 함께 약 복용함. Took mediation with small amount of water through L-tube.	공대한 Daehan Gong
20-05-12 18:01	BT 37.2 check.	최환성 Hwan Sung Choi
20-05-12 19:00	BT 37.3 check.	문현정 Hyun Jung Moon
20-05-12 19:00	Position change & back care was done.	최환성 Hwan Sung Choi
20-05-12 20:00	BT 37.5'C check.	공대한 Daehan Gong
20-05-12 20:30	I/O 800/400, DE I/O 1430/700check.	최환성 Hwan Sung Choi
20-05-12 21:00	BT 37.3'C check.	문현정 Hyun Jung Moon
20-05-12 22:00	BT 37.1'C check.	
20-05-12 22:00	Nr. rounded. mental : drowsy eye opening to speech. pupil : +/+(ovoid) O2 5L inhalation state. via nasal prong self RR stable. 자극에 신음소리만 내는 정도임. Moans when stimulated. motor : localizing Rt. side weakness sign remained. 오른쪽 팔, 다리 거의 못움직이는 모습임. Shows hardly any movement of right arm or leg. 왼쪽 팔 다리 억제대 유지중임. Use of restraints on left arm and leg maintained. -순환 상태 확인함. Checked for blood circulation. BT 37.1'c check Foley cath., L-Tube kept. Elevation on Head(30°) 유지중임.	오태훈 Tae Hoon Oh
20-05-12 23:00	Position change & back care was done.	
20-05-13 00:00	BP 167/86mmHg, BT 38.2'c check.	오태훈 Tae Hoon Oh
20-05-13 01:00	V/S 163/89-105-18-38.4'c-90% check. 당직의 반병준과장님께 보고함. Informed Dr Byeong Joon Ban, who was on call. R: NS100 + denogan 1V 주세요. 실시함. Followed order. 질문에 대답하시나 정확히 알아듣기 어려움. Responds to questions, but incomprehensible. motor : Lt. localizing / 오른쪽 상/하지 여전히 움직임 거의 없음. Still shows hardly any movement of right arm or leg.	
20-05-13 02:00	BT 38.2'c check. Ice bag apply.	
20-05-13 03:00	Position change & back care was done. BT 38.5'c check.	
20-05-13 04:00	oral care & facial cleansing was done. gum bleeding sign none. BT 37.6'c check.	
20-05-13 06:00	I/O 1030/600, Total I/O 2460/1300 (stool*0) 대변 2일째 없음. No defecation for 2 days. BT 38.1'c check. Ice bag change.	
20-05-13 07:30	BT 38.7'c check. 당직의 반병준과장님께 보고함. Informed Dr Byeong Joon Ban, who was on call. R: 주치의 보고하세요. R: inform Dr Kim.	
20-05-13 07:36	김준학과장님께 fever양상 보고함.(A: 네. 오늘 내과 협진볼게요.) Informed Dr Kim about fever. (A: Consider IM referral today.)	
20-05-13 08:00	Nr. rounded. mental : drowsy pupil : +/+ eye opening well. self motor있으나 협조 안됨. Shows autonomous movement but is not cooperative. 왼쪽 손 억제대 유지중임. Use of restraint on left hand maintained. 혈액 순환 확인함. Checked for blood circulation. 오른쪽 손 살짝 구부린 상태 유지 가능함. Can slightly flex right hand. 오른쪽 다리 움직이지 못함. Cannot move right leg. O2 5L/min inhalation state. self respiration stable. spo2 91% check.	이순화 Soon Hwan Lee

Nursing Record
간 호 기 록 지

Printing Period 출력기간: 2020년05월11일 ~ 2020년05월20일

[redacted] F / 86 000114008 NS Dr. 김준학 2020년05월11일
Dr Joon Hak Kim

HD : 10 OP : 비지정 ICU-01-03

Address 주 소: [redacted] Phone 전 화 번 호: [redacted]

등록일/시 Date/Time	간호활동 Nursing Activities	
	이름 묻자 이름 말하지 않고 이름이라고 따라 말함. When asked for name, repeated the word "name."	
	의사 소통 어려움. Difficult to communicate.	
	물 소량과 함께 약만 복용함. Took medication with small amount of water.	
	foley cath., L-tube kept.	
	Elevation on Head(30°)유지중임.	
	BT 38.6'c check.	
20-05-13 08:55	김준학 과장님 회진함. Dr Kim made rounds.	
20-05-13 09:00	Position change & back care was done.	박소희 So Hee Park
20-05-13 09:00	BT 38.4'c check.	이순화 Soon Hwan Lee
20-05-13 09:29	1내과 협진 처방남. Order from IM.	
20-05-13 09:30	bedside PT 시행함. Proceeded beside PT.	
20-05-13 09:34	Blood culture(Sensi포함) * 2, urine Ordinary culture(Sensi포함,Urinary system), Gram stain, ABGA(포함Lactic Acid, Ca++) check.	
	NS 100ml + Gomcephin 1VIA add.	
	main fluid에 Liveract 500mg/5ml 1AMP mix.	
	CAP(P) add.	
20-05-13 09:49	Gomcephin AST : negative check.	
20-05-13 10:00	BT 38.5'c check.	
20-05-13 10:37	Chest CT (contrast),CT Abd./ Pelvis[contrast] 처방남.	박소희 So Hee Park
	prn) NS 100ml + denogan 1V #1 처방남.	
20-05-13 10:40	N/S 100ml + denogan 1A IV injection was done.(By prn order)	이순화 Soon Hwan Lee
20-05-13 11:00	Position change & back care was done.	박소희 So Hee Park
	BT 37.4'c check.	
20-05-13 11:08	조영제 AST 시행함.(R: Negative)	
20-05-13 12:30	NPO state.	
20-05-13 14:00	I/O 910/650check.	이순화 Soon Hwan Lee
20-05-13 14:02	검사위해 침대채 영상의학과실로 이동함. Transferred to radiology for check-up.	박소희 So Hee Park
	v/s : 148/78-87-20-36.7'c check.	
20-05-13 14:37	검사마치고 중환자실로 돌아옴. Returned to ICU.	
	v/s : 150/81-93-20-36.6-90% check.	
20-05-13 15:00	간호사 순회함. Nr. made rounds.	최환성 Hwan Sung Choi
	mental : drowsy	
	pupil reflex + pin point./+ pin point	
	자극에 간헐적 눈뜨는 모습임. Intermittently opens eyes when stimulated.	
	O2 5L/min inhalation state via nasal prong.	
	self RR stable.	
	자극에 신음소리만 냄. Moans when stimulated.	
	Rt. side weakness remained.	
	-자극에 오른팔 움직임 없음, 오른발만 움찔하는 정도임. No movement of right arm and withdrawal of right leg when stimulated.	
	S.Z sign none.	
	vomiting (-) Use of restraint on left elbow and left leg maintained.	
	기구유지 및 침상안정위해 왼팔 팔꿈찌 억제대, 왼쪽다리 억제대 유지중임.	
	-혈액순환 확인함. Checked for blood circulation.	
	Elevation on Head(30°)유지중임.	
20-05-13 16:00	Position change & back care was done.	
20-05-13 17:25	NPO state.	이성범 Sung Bum Lee
20-05-13 19:00	Position change & back care was done.	최환성 Hwan Sung Choi
20-05-13 19:05	입에 객담 머금고 있음. Sputum in the mouth.	
	oral suction시행함. Proceeded with suctioning.	
	-secretion large & thick.	
20-05-13 20:30	I/O 700/550, DE I/O 1610/1200 check.	
20-05-13 22:00	Nr. rounded.	오태훈 Tae Hoon Oh
	mental : drowsy	
	eye opening well.	
	pupil : +/+(ovoid)	
	O2 5L inhalation state. via nasal prong	

Nursing Record
간 호 기 록 지

Printing Period 출력기간: 2020년05월11일 ~ 2020년05월20일

[redacted] F / 86 000114008 NS Dr. 김준학 Dr Joon Hak Kim 2020년05월11일

HD : 10 OP : 비지정 ICU-01-03

Address 주 소: [redacted] Phone 전 화 번 호: [redacted]

등록일/시 Date/Time	간호활동 Nursing Activities	
	self RR stable. freq. suction was done. secretion amount large. 자극에 신음소리만 내는 정도임. Moans when stimulated. motor : localizing Rt. side weakness sign remained. 오른쪽 팔, 다리 거의 못움직이는 모습임. Shows hardly any movement of right arm or leg. 왼쪽 팔 다리 억제대 유지중임. Use of restraints on left arm and leg maintained. -순환 상태 확인함. Checked for blood circulation. 지속적으로 소리 지르고있음. Constant screaming. Foley cath., L-Tube kept. Elevation on Head(30°) 유지중임.	
20-05-13 22:20	perineal care was done.	한보람 Boram Han
20-05-13 23:00	Position change & back care was done.	오태훈 Tae Hoon Oh
20-05-14 00:00	BT 37.5'c check.	오태훈 Tae Hoon Oh
20-05-14 01:00	자고 있음. Sleeping. BT 37.9'c check.	
20-05-14 02:00	BT 37.7'c check.	
20-05-14 03:00	Position change & back care was done. BT 37.4'c check.	
20-05-14 04:00	oral care & facial cleansing was done. gum bleeding sign none. BT 37.0'c check.	
20-05-14 06:00	I/O 800/550, Total I/O 2410/1750 (stool*0) check. 대변 3일째 없음. No defecation for 3 days. BT 37.1'c check.	
20-05-14 08:00	Nr. rounded. mental : drowsy pupil : +/+ eye opening well. self motor있으나 협조 안됨. Shows autonomous movement but is not cooperative. 왼쪽 손 억제대 유지중임. Use of restraint on left hand maintained. 혈액 순환 확인함. Checked for blood circulation. 오른쪽 손 살짝 구부리는 정도로만 움직임 가능함. Can slightly flex right hand. 오른쪽 다리 움직이지 못함. Cannot move right leg. 02 5L/min inhalation state. self respiration stable. spo2 91% check. 자극에 신음 소리만 냄. Moans when stimulated. L-tube feeding was done. before aspiration. dyspepsia, vomiting sign none. foley cath., L-tube kept. Elevation on Head(30°)유지중임.	이순화 Soon Hwa Lee
20-05-14 08:45	장태훈 부장님 회진함. Dr Tae Hoon Jang rounded.	
20-05-14 08:50	김준학 과장님 회진함. Dr Kim rounded. 자극에 신음 소리밖에 안됨을 알림. Informed Dr Kim that pt. only moans when stimulated. 답손은 보호자분이 원하시는데로 복용하자고 함. **Orders to give Dapsone according to guardian's wishes.**	
20-05-14 09:00	Position change & back care was done.	
20-05-14 09:30	bedside PT 시행함. Screening for bacterial pneumonia. Streptoccocal pneumonia antigen, urine (SPNEU).	
20-05-14 10:35	sputum Ordinary culture, Gram stain, 폐렴 원인균 선별검사, urine 폐렴 연쇄상구균 소변항원 , Legionella urinary Ag check.	
20-05-14 10:41	Levloxin 500mg 1BOT, Levloxin 250mg 1BOT add. Muteran 300mg 1AMP * 3 add.	
20-05-14 11:00	Position change & back care was done.	
20-05-14 12:30	freq. suction was done. L-tube feeding was done. before aspiration. dyspepsia, vomiting sign none.	

Radiology Report

영 상 의 학 결 과 지

Date of Admission

환자 ID : 000114008 환 자 명 : 조순 입 원 일 : 2020-05-11 병 동 : 응급--

성별/나이 : F / 86 부 서 : ER 주 치 의 : 이병국

Department

생년월일 : 19331209

처 방 일 : 20200511.504 처 방 의 : 김준학 판 독 의 : 김상흠(52584) Radiologist: Sang Heung Kim

처 방 명 : Chest AP 판 독 의2 : 김상흠(52584) Radiologist: Sang Heung Kim

접수일시 : 2020-05-11 15:46 판 독 일 : 2020-05-11 15:54

Date/Time of Reading

검사일시 : 2020-05-11 15:46

Date/Time of Exam

소 견 : No abnormality in both lung mediastinum.
Otherwise unremarkable.

Impression

Imp:Negative study.

대한병원

대한양·한방병원

Radiology Report

영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11 병동 Ward : 응급--

Gender/Age
성별/나이 : F / 86

Department
부 서 : ER

주 치 의 : 이병국
Referring Physician: Byeong Wook Lee

DOB
생년월일 : 19331209

Date of Order
처 방 일 : 20200511.509

Prescribing Dr.: Joon Hak Kim
처 방 의 : 김준학

판 독 의 : 김상흥(52584) Radiologist: Sang Heung Kim

Type of Exam
처 방 명 : B-MRI & MRA & Diffusion(급여)

판 독 의2 : 김상흥(52584) Radiologist 2: Sang Heung Kim

Date/Time of Reading
판 독 일 : 2020-05-11 15:50

Date/Time of Exam
접수일시 : 2020-05-11 14:53

검사일시 : 2020-05-11 14:53

Impression
소 견 : MRI of brain, noncontrast, DWI

T1 sagital, T2 axial, FLAIR axial, T1 axial , T2 coronal , Gradient FFE axial, DWI axial

clinical information :r/o cbr. infarction

Acute infarction in lt parietal white and gray matter and forceps major .
A few lacunar infarctions in bilat basal ganglia.

MRA, cerebral(brain) and carotid

Marked occlusion at lt M2 bifurction portion.
Mild stenosis at rt M1, M2, bilat P2, bilat distal vertebral a and rt proximal ICA.

[redacted] [redacted]

Radiology Report

영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11

Ward: ER
병 동 : 응급--

Gender/Age
성별/나이 : F / 86

Department
부 서 : ER

주 치 의 : 이병국
Referring Physician: Joon Hak Kim, MD

DOB
생년월일 : 19331209

Date of Order
처 방 일 : 20200511.511

Prescribing Dr.: Joon Hak Kim
처 방 의 : 김준학

판 독 의 : 김상흥(52584) Radiologist: Sang Heung Kim

Type of Exam
처 방 명 : Brain CT(Non contrast)

판 독 의2 : 김상흥(52584) Radiologist 2: Sang Heung Kim

Date/Time of Reading
판 독 일 : 2020-05-11 16:36

Date/Time of Exam
접수일시 : 2020-05-11 15:50

검사일시 : 2020-05-11 15:50

Impression
소 견 : A few lacunar infarctions in bilat basal ganglia.
Otherwise unremarkable.

[redacted] [redacted]

Radiology Report
영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11 병동 Ward : ICU-01-03

Gender/Age
성별/나이 : F / 86

Department
부 서 : NS

주 치 의 : 김준학
Referring Physician: Joon Hak Kim, MD

DOB
생년월일 : 19331209

Date of Order
처 방 일 : 20200512.28

Prescribing Dr.: Joon Hak Kim
처 방 의 : 김준학

판 독 의 : 김상흠(52584) Radiologist: Sang Heung Kim

Type of Exam
처 방 명 : Diffusion MR (단독 급여)

판 독 의2 : 김상흠(52584) Radiologist 2: Sang Heung Kim

Date/Time of Reading
판 독 일 : 2020-05-12 14:42

Date/Time of Exam
접수일시 : 2020-05-12 14:02
검사일시 : 2020-05-12 14:02

Impression
소 견 : Increased area of acute infarction in lt posterosup temporal lobe.

[redacted] [redacted]

Radiology Report

영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11 병동 Ward : ICU-01-03

Gender/Age
성별/나이 : F / 86 부 서 Department : NS 주 치 의 : 김준학
DOB
생년월일 : 19331209 Referring Physician: Joon Hak Kim, MD

Date of Order
처 방 일 : 20200512.14 Prescribing Dr.: Joon Hak Kim 처 방 의 : 김준학 판 독 의 : 김준학(87798) Radiologist: Sang Heung Kim
Type of Exam
처 방 명 : Perfusion MR (급여) 판 독 의2 : 김준학(87798) Radiologist 2: Sang Heung Kim
Date/Time of Reading
Date/Time of Exam
접수일시 : 2020-05-12 14:02 판 독 일 : 2020-05-13 09:58
검사일시 : 2020-05-12 14:02

Impression
소 견 : 2020.5.11 acute infarction, left PCA-MCA borderzone infarction (hypoperfusion infarction)으로 진단받음
.Brain MR angio에서 atheroscleosis change있어 perfusion state확인하기 위해서 perfusion MR을 시행함.
Perfusion MR to check perfusion status due to atherosclerotic change found on brain MR angiography.

CBF : Left Occipito-parietal, temporal area decreased
CBV : Left Occipito-parietal, temporal area decreased
MTT :Left Occipito-parietal, temporal area prolonged state
TTP :Left Occipito-parietal, temporal area prolonged state

[conclusion]
Decreased perfusion at left MCA and PCA territories.

[redacted] [redacted]

Radiology Report
영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11

Ward
병 동 : ICU-01-03

Gender/Age
성별/나이 : F / 86

Department
부 서 : IM

Referring Physician: Joon Hak Kim, MD
주 치 의 : 김준학

DOB
생년월일 : 19331209

Date of Order
처 방 일 : 20200513.36

Prescribing Dr.: Joon Hak Kim
처 방 의 : 장태훈

판 독 의 : 김상흠(52584) Radiologist: Sang Heung Kim

판 독 의2 : 김상흠(52584) Radiologist 2: Sang Heung Kim

Type of Exam
처 방 명 : CT Abd./ Pelvis[contrast]

Date/Time of Reading
판 독 일 : 2020-05-13 15:55

접수일시 : 2020-05-13 14:07

Date/Time of Exam
검사일시 : 2020-05-13 14:07

Impression
소 견 : CT of abdomen and pelvis, postcontrast

Mild dilatation of body and tail portion of P duct, R/o benign stensis, D/Dx IPMN.
No abnormality in liver, Gb, spleen and BK.
Otherwise unremarkable.

[redacted] [redacted]

Radiology Report

영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11

Ward
병 동 : ICU-01-03

Gender/Age
성별/나이 : F / 86

Department
부 서 : IM

Referring Physician: Joon Hak Kim, MD
주 치 의 : 김준학

DOB
생년월일 : 19331209

Date of Order
처 방 일 : 20200513.35

Prescribing Dr.: Joon Hak Kim
처 방 의 : 장태훈

Type of Exam
처 방 명 : Chest CT (contrast)

Date/Time of Exam
접수일시 : 2020-05-13 14:07
검사일시 : 2020-05-13 14:07

판 독 의 : 김상흥(52584) Radiologist: Sang Heung Kim

판 독 의2 : 김상흥(52584) Radiologist 2: Sang Heung Kim

Date/Time of Reading
판 독 일 : 2020-05-13 15:51

Impression
소 견 :
Patchy pneumonia in LLL.
R/o Minimal pneumonia in RLL.
A small calcified granuloma in LUL.
Dependent atelectasis in BLL.
Small lt pleural effusion.
Cardiomegaly.
R/o Pul arterial hypertention.

[redacted] [redacted]

Radiology Report
영 상 의 학 결 과 지

[redacted] [redacted]

Date of Admission
입 원 일 : 2020-05-11

Ward: Emergency
병 동 : 응급--

Gender/Age
성별/나이 : F / 86

Department
부 서 : ER

주 치 의 : 이병국

DOB
생년월일 : 19331209

Referring Physician: Byung-gook Lee, MD

Date of Order
처 방 일 : 20200511.504

Prescribing Dr.: Joon Hak Kim
처 방 의 : 김준학

판 독 의 : 김상흥(52584)

Radiologist: Sang Heung Kim

Type of Exam
처 방 명 : Chest AP

판 독 의2 : 김상흥(52584)

Radiologist 2: Sang Heung Kim

접수일시 : 2020-05-11 15:46

Date/Time of Exam
검사일시 : 2020-05-11 15:46

판 독 일 : 2020-05-11 15:54

Date/Time of Reading

Impression
소 견 : No abnormality in both lung mediastinum.
Otherwise unremarkable.

Imp:Negative study.

[redacted]

[redacted]

Microbiology Culture Report

GCLabs 검사결과보고서 CAP

의뢰기관	의료법인성화의료재단대한병원	기관기호	11101156	접수번호	20200514-112-5306
수진자명	조순	등록번호	00011400	채취일시	2020/05/14
진료과/병동	IM/ ICU	주민번호	331209-2******	접수일시	2020/05/14 18:08
주 치 의		성별/나이	F / 86	검사일시	2020/05/15
검체정보	비인후/인후도찰물	Specimen: Nasal & Oropharyngeal Secretion		보고일시	2020/05/15 06:40
임상정보/기타:	2005140105				

Date of Collection

Date of Reporting

오더코드	검사항목	Result 검사결과	단위	참고	References
D680104C	B. pertussis (폐렴 원인균 선별검사)	Negative		별지결과지 참조	Attached report
	C. pneumoniae (폐렴 원인균 선별검사)	Negative		별지결과지 참조	
	H. influenzae (폐렴 원인균 선별검사)	Positive (31.6)		별지결과지 참조	
	L. pneumophila (폐렴 원인균 선별검사)	Negative		별지결과지 참조	
	M. pneumoniae (폐렴 원인균 선별검사)	Negative		별지결과지 참조	
	S. pneumoniae (폐렴 원인균 선별검사)	Positive (36.6)		별지결과지 참조	
	M. pneumoniae A2063G mutation (폐렴 원인균 선별검사)	N/A		별지결과지 참조	
	M. pneumoniae A2064G mutation (폐렴 원인균 선별검사)	N/A		별지결과지 참조	

* 검사보고 완료입니다. *

[1/ 1]

본 검사실은 대한진단검사의학회(KSLM)의 신임인증을 받은 우수 검사실로서 결과의 정확성과 신빙도를 보증합니다.

의료법인 녹십자의료재단
검체검사기관기호: 41303059
GCL-AAAA-F09-01 (00)
경기도 용인시 기흥구 이현로 30번길 107
대표전화: 1566-0131
www.gclabs.co.kr
검 사 자: 오영주 M.T. (23780)
보 고 자: 이상곤 M.D. (671)
검체담당: 박준성

Cultured by: Y.J. Oh M.T.

Reported by: S.G. Lee M.D.

Medical Certificate

진 단 서

[redacted]

연 번 호 [redacted]

환자의 성명	[redacted]	주민등록번호	[redacted]
환자의 주소	[redacted] (전화번호 : [redacted])		
Diagnosis 병 명 Clinical Impression [■] 임상적 추정 [ ] 최 종 진 단	(주상병)급성 뇌경색 (Main diagnosis) Acute Brain Infarction (주상병)고혈압 (Main diagnosis) Hypertension		ICD 질병분류기호 I63.8 , I10.9
Onset 발병 연월일	2020 년05 월10 일	Diagnosis Date 진단 연월일	2020 년05 월11 일
Medical Opinion 치료 내용 및 향후 치료에 대한 소견	2020년 5월 10일 우측의 마비를 주소로 2020년 5월 11일 내원 및 입원함. 상기 병명하에 현재 중환자실 치료를 받고 있으며, 향후 안정가료 및 경과관찰 요함. 추가 증상 발생시 추가 진단명 기입 가능함 Right paralysis started on May 10th, 2020. Visited ER and admitted on May 11th, 2020. Currently being treated in the ICU and expected to stabilize further.		
용 도			
비 고	신경외과 영역임.		

「의료법」 제17조 및 같은 법 시행규칙 제9조1항에 따라 위와 같이 진단합니다.

2020 년05 월20 일

의료기관 명칭 : [redacted]

주소 : [redacted]

[■] 의사 [ ] 치과의사 [ ] 한의사 면허번호 제 87798 호

성 명 : 김준학 (서명 또는 인)

Dr Joon Hak Kim