Observation DateTime	March 25, 2022	**Status**	F
Reported Date:	April 09, 2022		

Summary Data

GAS-Final
*** Final Report ***

. Ambulatory Consult
Lenskyj, Adam Adolf
MRN: 203-1473
D.O.B. Dec-02-1940

Apr 09, 2022

PATIENT INFORMATION
Patient Identifier (MRN) 2031473
Patient Name LENSKYJ, ADAM
Gender M
Date of Birth (DOB) Dec 2, 1940
Encounter Date Mar 25, 2022
Attending Physician Mosko, Jeffrey
Primary Care Provider Welsh, Lauren emily
Staff Physician/Nurse Practitioner Mosko, Jeffrey
CC Physician 1 RAY, JOEL
CC Physician 2 WELSH, LAUREN EMILY
Virtual Meeting
Start Time
End Time

This meeting was a telephone consult. Informed verbal consent was obtained to communicate and provide care using virtual tools. This patient has been told about: risks related to unauthorized disclosure or interception of personal health information; steps they can take to help protect their information; that care provided through video or audio communication cannot replace the need for

physical examination or an in person visit for some disorders or urgent
problems; and that the patient must seek urgent care in an Emergency Department
as necessary.

ID: 81M

RFR: enlarging hepatic cyst with intrahepatic biliary dilation

PMHx:
1. Atrial fibrillation
2. CAD, NSTEMI 2013, c/b HfrEF 35-40%
3. CKD
4. Cataracts
5. Cholecystectomy
6. Gallstone Pancreatitis
7. MSSA bacteremia
8. PEA arrest 2021
9. Pruringo Nodularis
10. Scar-mediated V-tach, ICD in 2021
11. T2DM

Meds:
1. ATORVASTATIN 40 MG PO Once Daily

2. CLOPIDOGREL 75 MG PO Once Daily
3. APIXABAN 2.5 MG PO BID
4. AMIODARONE 200 MG PO DAILY 1000H
5. CARVEDILOL 12.5 MG PO/NG
6. LANSOPRAZOLE 30 MG PO daily
7. AMLODIPINE 5 MG PO daily
8. TRESIBA PENFILL 27 Units PARENTINJ QAM
9. INSULIN LISPRO RAPID 100 UNITS/ML CARTRIDGE FOR INJECTION 1-10 UNITS SC TI
D
AC
10. FERROUS FUMARATE 300 MG PO Q2Days

Allergies: metoprolol, PCN, ramipril-angioedema

Sohx:
This gentleman lives alone in community housing. He is a retired Engineer and has two adult children. One lives in Toronto the other is a physician in Vancouver. He manages all his ADLs/iADLs independently. He is a lifetime non-smoker. He denies any drug or substance use.

Family hx:
-no hx of liver or biliary disease

HPI:
-admitted Jan 15-17th to GIM for heart failure exacerbation and was noted to have RUQ pain at that time
-CT showed enlargement of a prior imaged hepatic cyst with associated intrahepatic biliary dilation
-liver enzymes during the admission were initially elevated however they seem to have been consistently mildly elevated since the last admission in July 2021 where he was diagnosed with CAP c/b PEA arrest and heart failure
-No pale stools, jaundice, RUQ pain, associated nausea, emesis, no fevers/chills, or GIB reported
-Patient currently reports severe sharp stabbing right shoulder pain radiating to right chest associated with a red spotted rash specifically confined to the right side of the back consistent with ?Shingles

Physical exam: Deferred as this is a virtual assessment.
Labs/Ix:
Jan 15 2022- 169, bili 50 (10-direct)>ALP 142, t bili 31>Jan 25 2022ALP 231 Tbili 13, ALT 63

CT abd/pelvis Jan 2022: Prior cholecystectomy. Unremarkable gallbladder fossa.
-Interval growth of the hepatic cyst in segment 4A, now 4.9 cm. New isolated right-sided intrahepatic biliary dilatation, possibly on the basis of external compression by the enlarging hepatic cyst. Liver: Measures 12.1 cm. Smooth contour. Increase in size of the segment 4A bilobed cyst now measuring 4.8 x 4.9 x 2.8 cm (previously 3.9 x 2.5 x 3.2 cm in July 2021). Biliary tree: New isolated right-sided moderate intrahepatic bile duct dilated, measuring 0.8 cm. Its communication to the common bile duct is not well seen. Nondilated common

bile duct measuring 0.4 cm.
Pancreas: Body normal, head and tail not well seen

A/P: 81M with hx of A-fib on apixaban and heart failure c/b cardiac arrest requiring ICD placement in 2021 referred for asymptomatic hepatic cyst in segment 4 with associated intrahepatic biliary ductal dilation without clinical evidence of biliary obstruction. ALP has been mildly elevated since 2021 though this is likely in the context of the PEA arrest during the July 2021 admission for CAP and congestive hepatopathy related to known heart failure currently. This cyst is quite small and is high unlikely to be affecting biliary drainage through the common bile duct.

However, it is reasonable to obtain an MRCP to ensure that there are no high-risk features to the cyst or intrahepatic stone disease that may be contributing to the reported dilation. We will request a booking. Of note, the patient's ICD is the Medtronic Evera model which is MRI-compatible. We would also ask that Dr. Welsh, his GP, repeat ALP and bilirubin 1-2 months to coincide with the MRI results. We will book follow up after the MRI is completed to review the results.

Sincerely,
Chandni Pattni, PGY4 GI
In service of Dr. Jeff Mosko

Automatically released by Digital Dictation System for Mosko, Jeffrey Apr 09, 2022 05:00 am

Jeffrey Mosko, MD Dictated by: Chandni Pattni, MDPGY3
Department of Medicine
Division of Gastroenterology

cc: Joel Ray, MD
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D: Mar-25-2022 03:27 P T: Mar-25-2022 EVR463129 Doc: 5645994