Discontinuing Oxygen Therapy in the Patient Who Smokes

An Ethical Dilemma

Harry E. Scher
Treating Patients who Smoke with Oxygen Therapy: An Ethical Dilemma

Bill Taryton is a 66 year-old male with a long-term history of tobacco use. His medical history indicates that he has smoked tobacco products for approximately 50 years. His complex medical history includes chronic obstructive pulmonary disease (COPD), coronary artery disease, hypertension, chronic systolic heart failure, obstructive sleep apnea and chronic kidney disease.

Mr. Taryton has been evaluated and treated by the pulmonary department in a large Veterans Health Administration (VHA) medical center. He is currently on long-term oxygen therapy prescribed by the pulmonary staff. His need for oxygen therapy has been well documented in his medical record. During his recent visit to the pulmonary department, it was noted that Mr. Taryton was found to be hypoxemic on room air as demonstrated by his arterial blood gas results. He also experiences significant shortness of breath when not using oxygen. It was noted at a recent clinic visit that Mr. Taryton experiences a significant oxygen desaturation when placed on room air for a brief period of time.

During his visit in May, 2013, Mr. Taryton informed the staff that he continues to smoke tobacco products. He was informed that in the event he continues to smoke, his oxygen therapy would be discontinued. Both staff nurses and medical providers have frequently encouraged Mr. Taryton to discontinue smoking cigarettes. Mr. Taryton expressed his sincere concerns regarding the fact that oxygen therapy may be discontinued. During numerous clinic encounters, Mr. Taryton has been informed of the risk of injury to himself and to others when using oxygen therapy while smoking. Even though he states he understands the risk of injury, he continues to
Smoke cigarettes. The pulmonology staff frequently checks urine nicotine levels to assist them in determining whether the patient continues to use smoke. Based on the evaluation of the patient’s current condition and the obvious anxiety brought on by the pending decision to discontinue oxygen therapy, the patient’s primary care physician requested that the institution’s multidisciplinary ethics committee review Mr. Taryton’s care for recommendations.

**The Ethical Dilemma**

**Risk**

Although a prescription of long-term oxygen therapy (LTOT) is often prescribed for patients who have COPD and continue to smoke, the risk of injury is significant. Over the past decade, there appears to be an increasing number of oxygen-related burn injuries (Robb, Hungness, Hershko, Warden and Kagan, 2003). Although oxygen therapy is generally safe, the potential for burns arises in patients who smoke while using oxygen. Patients who continue to smoke while receiving home oxygen therapy endanger themselves, family members, neighbors and fire fighters at a significant expense to society (Rastogi, 2013).

**Treatment Decisions**

Nurse practitioners as well as other medical providers will encounter frequent treatment challenges when requiring that patients on oxygen therapy stop smoking. In the primary care and pulmonary arenas, nurse practitioners often treat patients with COPD who have been prescribed long-term oxygen therapy. Even though most providers who prescribe oxygen attempt to educate oxygen users regarding risks related to burns, there continues to be significant injuries related to smoking while using oxygen. Shiner, Zaretsky, Mirali, Benzaray and Elad
(1997) reported that smoking cessation compliance with prescribed oxygen use was as low as 22%.

When considering the cessation of oxygen therapy for patients with COPD, providers are primarily concerned with the risk of injury. While considering the autonomy of the patient, providers must also consider the safety of family, friends, and neighbors. Protecting society from risk of preventable injury is of paramount importance.

The literature often suggests that medical providers should fully consider the risks versus the benefits of home oxygen before prescription (Litt, Ziesche, Happak, and Lumenta, 2012). It also recommends that prescribers carefully review a significant number of legitimate factors before considering the denial or withdrawal of oxygen therapy (Veterans Health Administration, 2010).

Review of Mr. Taryton’s case indicates that medical providers have frequently considered discontinuing oxygen therapy without completing a risk evaluation. The chart indicates that an unwritten policy developed by medical staff regarding oxygen cessation is being applied to Mr. Taryton’s case. Even though an active multidisciplinary ethics committee exists at the medical center, it should be noted that decisions were being made regarding oxygen cessation without input from the ethics consultation team. As stated by a report provided by the National Ethics Committee of the Veterans Health Administration (2010), “VHA clinicians should never stop a beneficial treatment without the strong justification that the treatment creates a serious enough risk to outweigh the benefit of this treatment to veterans” (p. 9). A VHA directive released and published in 2006 recommends that harm reduction strategies include fire risk assessment, ongoing education for patients, families and friends, installation of smoke
detectors and frequent counseling for patients who continue to smoke (Veterans Health Administration, 2010).

The Science of Risk and Benefits

Providers’ perception of risk is not always congruent with the actual risk associated with prescribing LTOT for smokers. Without conducting risk and ethical assessments, most clinicians will likely take an approach that is somewhat conservative based on perceived risk.

Perception of Risk versus Actual Risk

As stated by the Veterans Health Administration report (2010),

An inherent psychological bias in risk perception may lead providers and patients to differ in their assessment of the true risks. People tend to perceive less risk when they control the situation and more risk when they do not. However, it should be noted that smoking at home substantially increases the risk for home fire, but the presence of oxygen in a smoker’s home further increases the risk of fire only slightly (p. 3).

Benefits of Oxygen Therapy

The number of individuals receiving LTOT is increasing with the world prevalence’s reaching about 280 per 100,000 people. LTOT is generally considered beneficial; it reduces hypoxemia and alleviates hypercapnia to increase survival and reduce hospitalization (Litt et al., 2012). Therapeutic modalities effective in reducing COPD related impairments have received attention, often in randomized trials. Such is the case for home oxygen therapy (Lacasses, LaForge and Maltais, 2006). In patients with hypoxemia, oxygen supplementation improves survival, pulmonary hemodynamics, exercise capacity, and neuropsychological performance. It
may also decrease the oxygen cost of breathing and improve the quality of sleep (Tarpy and Celli, 1995).

**Stakeholders**

In Mr. Taryton’s case, there are numerous stakeholders. The primary stakeholders are the patient and his family. The medical treatment team is also an important group of stakeholders in this case. The patient’s refusal to consider tobacco cessation places the patient, his family and society at risk for harm. As evidenced by the case presented here, medical providers including pulmonologists and primary care providers are involved in a prescribed treatment in which they have profound moral and ethical concerns. Other stakeholders include society and the legal system. There is significant concern that other members of society may be harmed. American culture and law make significant contributions in defining the value of human life. The legal community may be concerned that the medical system performs in a way that will prevent harm to the patient and to society while preventing excessive health care costs related to oxygen therapy injury.

**Ethical Considerations**

In the treatment arena, medical providers are going to be guided by treatment protocols that are widely accepted treatment guidelines by the field of medicine. Protocols used to treatment COPD include the use of oxygen therapy. Based on scientific data, one could argue that even though he continues to smoke, the use of oxygen therapy is appropriate in Mr. Taryton’s case. While applying the ethical principle of beneficence, the prescription of oxygen therapy is indeed acting in the best interest of the patient and does provide a net benefit to the patient (Lo, 2013).
In the light of safety concerns, discontinuing oxygen therapy for a patient who continues to smoke could be considered a harmful action. The patient may be concerned that his care is being negatively affected due to addiction to tobacco. An ethical question in Mr. Taryton’s case could ignite concern regarding principles of justice. When considering that principle, the patient may easily contend that he is not being treated with fairness (Lo, 2013). While the principle of justice often refers to the equitable distribution of resources and care, it applies to this case in that the patient may see discontinuing oxygen as an unfair decision or act of his medical team.

The ethic of caring is yet another theoretical concern in Mr. Taryton’s case. Even though there may be a significant concerns regarding injury risk related to oxygen use, by continuing oxygen therapy, the prescriber is responding to the needs and welfare of the individual, which may be viewed as more important than acting in accord with abstract standards (Lo, 2013). Once again, numerous studies have demonstrated that Mr. Taryton may live longer and experience a reduction in hospitalizations as a result of oxygen use (Litt et al., 2012).

As his history reveals, Mr. Taryton has been smoking for more the 50 years. Tobacco use has long been a part of this patient’s life. When considering both policy application and treatment issues, patient autonomy is a concern of paramount importance in this case. As the staff considers the wishes of the patient, the theory of liberalism may guide our thinking as we reject the philosophy of paternalism and weigh ethical considerations based on patient autonomy (Daniels, 1992). Mr. Taryton understands the risks involved with smoking and oxygen therapy. However, he has chosen to continue to smoke and use oxygen. Allowing Mr. Taryton to continue receiving oxygen therapy will certainly reject paternalistic thinking and allow Mr. Taryton to make major decisions regarding the treatment of his chronic lung disease.
The primary care provider in this case was concerned that the oxygen therapy department was proceeding to make decisions without fully evaluating issues related to injury risk and benefit. The Veterans Health Administration has published guidelines that encourage providers to make oxygen therapy decisions based on an extensive evaluation of the patient’s individual situation. According to Mr. Taryton’s chart, the pulmonary staff planned to discontinue oxygen therapy after having documented two elevated urine nicotine levels on two separate occasions. The ethics document developed by the VHA related to this issue cites important data. “Almost 20% of all residential fire resulting in death are due to smoking, but only 7% of fatalities, when smoking started the fire, involve medical oxygen” (Veteran Health Administration, 2010). A review of this data further supports the philosophy that every effort should be made to provide ongoing risk evaluation, intensive patient education related to oxygen use.

While prescribing oxygen therapy for smokers, providers are aware of the risks for harm to the patient. Application of the principle of nonmaleficence can easily be applied to Mr. Taryton’s situation. That principle is consistent with the most ancient moral maxim of medicine, stated in the Hippocratic oath. Another Hippocratic imperative states that the provider will “be of benefit and do no harm” (Johnson, A. R., Siegler, M., and Winslade, W. J., 2010). In reviewing data related to oxygen related injury in Massachusetts in 1997, the Department of Fire Services reports that there were 31 fire deaths, 57 serious injuries and 7 firefighter injuries (Massachusetts Department of Fire Services, n.d.) This type of data demands the upmost respect when considering how patients should be protected in the event that they are at high risk for behavior that may lead to injury. In reviewing the data presented by the Massachusetts
Department of Fire Services, prescribers of oxygen therapy can clearly see that patients are not the only people at risk for injury. To some degree, the entire community is at risk. Children, neighbors and firefighters are all too frequently the victims of these cruel fires.

Communitarianism, as an alternative ideology focused more on the common good and the public interest than on autonomy could easily lead the discussion for support of discontinuing Mr. Taryton’s oxygen therapy (Callahan, 2003). In an effort to protect all potential victims from increased risk, the pulmonary staff should document the care plan objective which will promote risk reduction for the community as well as for the patient. The pulmonology provider has, at the risk of escaping the principles of patient-centered care, made decisions that are paternalistic. Paternalism is often linked to the ideas of beneficence and is engaged and justified when decisions are related to a benefit and the avoidance of harm for the patient (Grace, 2009).

Helping professions operate and exist using a theoretical framework of the Ethic of Caring. While Mr. Taryton’s providers are confronted with difficult decisions regarding the use of oxygen therapy, they are making treatment decisions that consider the needs and safety of the patient. The theory of caring leads medical providers to provide care that is compassionate. The care ethic also leads providers to respond to the needs and welfare of the patient (Lo, 2013). Even though somewhat paternalistic in nature, the unilateral decision to discontinue the prescription of oxygen for this patient who continues to smoke is done so in a caring manner so as to reduce risk of injury for him and the community.

Legal Issues

In an attempt to make sound ethical decisions regarding care, providers may be seen as making decisions that are not in the best interest of the patient. As in the case of Mr. Taryton, he
and his family may see discontinuing oxygen as unethical and immoral. In the event that the patient’s condition deteriorates following oxygen therapy cessation, family and friends may perceive the decision to discontinue oxygen in smokers as a quality of care issue. They may also see this event as an opportunity to file a malpractice lawsuit.

The literature reveals that the number one cause of malpractice lawsuits against nurse practitioners is related to treatment (Miller, 2013). In order to provide patients with reassurance that decisions regarding discontinuing oxygen therapy are made using ethical support and clinical guidelines, it is important to involve patients such as Mr. Taryton in the decision-making process. In the eyes of some patients, discontinuing oxygen therapy on a patient chronic obstructive disease is a malpractice issue. Some patients may consider the act as negligence on the part of a medical provider. As stated by Berg (2013), medical professionals have a duty to their patients, to provide treatment that is in line with the medical standard of care, which is usually defined as the level and type of care that a reasonably competent and skilled health care professional. Reassuring Mr. Taryton that decisions regarding therapy are being made based on both standards of care and ethical concerns will lead to understanding and assist in avoiding accusations that the provider is acting in a negligent manner.

**Personal Decision and Summary**

The task of evaluating treatment risk and benefit is always a significant challenge when dealing with a potentially dangerous substance such as oxygen. The goal of care rendered must be to provide compassionate, safe care while preserving the autonomy of the patient. Mr. Taryton’s smoking behavior has given his caregivers significant cause for concern.
As the nurse practitioner in charge of Mr. Taryton’s care, I would focus on how to preserve his autonomy while integrating the principle of nonmaleficence. Issues related to safe, prudent care such as the one reviewed here should be evaluated on an individual basis while avoiding the application of strict, rigid rules. Mr. Taryton should be allowed to continue oxygen therapy while an ethical consult team reviews his case. Every precaution should be taken to keep the patient and the community safe. Oxygen therapy should be discontinued only when it is determined by providers in conjunction with the Interdisciplinary Ethics Consultation Service that Mr. Taryton is not following oxygen safety guidelines and is jeopardizing both his safety and the safety of those in his home and in the community.
References


Grace, P. (2009). *Nursing ethics and professional responsibility.* Sudbury: Jones and Bartlett


Rastogi, P. (2013). *Prescribing long-term oxygen therapy to patients who smoke.* Unpublished manuscript, Department of Internal Medicine, University of Texas Southwestern Medical School, Dallas, Texas.


Step 1: Personal Responses

As a nurse practitioner frequently faced with ethical challenges, I am concerned that in the case of Mr. Taryton, the health care system may be applying undocumented, unpublished clinical decisions that do not possess a sound ethical framework. In a large health system such as the one involved in caring for Mr. Taryton, there seems to be a tendency to form and apply blanket, undocumented policy regarding difficult health care issues. As Mr. Taryton is a unique patient with a complex medical history, his treatment plan related to oxygen therapy should include referral to the institution’s interdisciplinary ethics committee requesting that they provide recommendations and a framework for making decisions in his case.

Step 2: Facts of the Case

Mr. Taryton is a 66 year-old male with a complex medical history who is currently treated at a Veterans Health Administration system in Dallas, Texas. His multiple medical issues include tobacco use, chronic obstructive pulmonary disease, obstructive sleep apnea, supraventricular cardiac arrhythmias, elevated prostatic specific antigen, stage III chronic kidney disease, chronic systolic heart failure, hypertension and depressive disorder. Mr. Taryton has been prescribed oxygen therapy to treat chronic hypoxia related to COPD. Mr. Taryton has been counseled regarding the importance of tobacco cessation on numerous occasions. Although he reports that he understands the risk and dangers of oxygen use when smoking, he continues to smoke on a daily basis. The pulmonology medical staff has referred him for tobacco cessation classes and treatment. They have also informed him that if he continues to smoke and his
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medical record contains documentation of three positive urine samples, his oxygen therapy will be discontinued. At a recent visit to the clinic, testing revealed that discontinuing of oxygen while in the clinic resulted in immediate oxygen desaturation with an oxygen level of 78 to 80%. Mr. Taryton’s urine nicotine on September 3, 2013 was 14, which indicated he is continuing to smoke.

**Step 3a: Clinical/Psychological Issues Influencing Decision**

A significant number of medical oxygen related deaths in smokers occur annually. The literature also includes information regarding data related to injuries experienced by families, communities and firefighters. The incidence of injury in smokers who use oxygen is not insignificant. In Mr. Taryton’s case, his clinical condition related to smoking and COPD clearly indicates the need for chronic oxygen therapy. The medical community recognizes the benefits of oxygen therapy in patients who continue to smoke. My decision to continue the prescription of oxygen in the future is based on the plan of care that will include ongoing patient and family education, risk assessments conducted in the home frequently and the receipt of recommendations from the Interdisciplinary Ethics Committee.

**Step 3b: Initial Plan**

The initial plan will include provisions of an on-going prescription for oxygen therapy. Mr. Taryton will be referred to the Tobacco Cessation Program. He will be encouraged to use tobacco outside the home after having stopped its use 15 minutes prior to smoking a tobacco product. Mr. Taryton will be requested to sign an oxygen therapy contract that stipulates the ways in which oxygen may be used in a safe manner. The plan should also include having a sprinkler system installed in the home. It should also include having Mr. Taryton and those who
live in the home with him attend an Interdisciplinary Ethics Committee meeting at which time his case will be reviewed and discussed.

**Step 4: Policies and Ethical Code Directive**

The American Nurses Association (ANA) Code of Ethics statement has established a framework which informs the profession that the nurses primary commitment is to the patient, whether an individual, family, group or community (American Nurses Association, 2001). In documenting concerns and evaluation the plan, it is clear that providers are concerned about the safety of the patients and the community. Prior to an ethics committee consultation request, it was noted that the pulmonary staff were making unilateral decisions related to oxygen therapy in patients who smoke. The staff continues to make oxygen therapy treatment decisions without the assistance of the ethics committee. The report by the National Ethics Committee of the Veterans Health Administration documents a directive that states that

All patients who fail to comply with oxygen therapy and smoking safety guidelines are referred to a multidisciplinary clinical committee or the facility Ethics Consultation Service for review to determine appropriateness of continued oxygen therapy, and how such therapy will be provided in ongoing care (Veterans Health Administration, 2010).

As a member of the Interdisciplinary Ethics Consultation Service, I recommend that all difficult cases be referred to the ethics consultation service for careful consideration of clinical recommendations.

**Step 5: Ethical Principles Analysis**

Discussion of ethical principles including autonomy, nonmaleficence, and beneficence were discussed and applied to this case.
Step 6: Possible Legal Issues

Negligence, malpractice
Appendix B

Case Consultation B

Plan and Implementation Strategy

- Strict adherence to ethical guidelines and protocols documented in the report by the National Ethics Committee of the Veterans Health Administration.
- Refer Mr. Taryton’s case to the Interdisciplinary Ethics Consultation Service.
- Request that the patient and all members of his household sign an oxygen therapy agreement that documents education and understanding of the practices related to safe oxygen use.

Advance Clinical/Psychological Interests

- Determine risk for injury by analyzing history of previous incidents in the home related to oxygen therapy
- Schedule risk assessment visits in the home every three months to insure and document the safe use of oxygen in a patient who smokes.
- Encourage all providers, including primary care and pulmonary providers and oxygen supply staff to conduct oxygen risk assessments at each encounter with Mr. Taryton.
- Determine risk of injury of those who dwell in the patient’s home including of dependents, incapacitated residents or those living in a multi-family dwelling.

Adheres to Agency Policies and Professional Ethics Codes

- As specified in the American Nurses Association Code of Ethics, provider will respect for inherent worth, human rights and dignity of every individual (ANA, 2001
Provider will follow national guidelines delineated in the document entitled Ethical Considerations that Arise when a Patient on Long Term Oxygen Therapy Continues to Smoke

Minimizes Harm and Maximizes other Ethical Principles to the Extent Possible for the Client and Relevant Others

• Provider will encourage patient participation in an ethics consultation conference in an effort to promote trust and understanding regarding decisions made related to oxygen therapy.

• Honor the patient’s autonomy when making decisions regarding his care.

Allows You to Operate Within the Law

• Based on American Nurses Association guidelines and the federal medical system in which I am employed, Mr. Taryton’s plan of care meets requirements that allow me to function within the law.
John J. Taryton
AMB CARE NOTE
The patient was identified by having them respond to their name and then by the patient stating their full Social Security number.

66 year old GROUP 5 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER MALE with a prior history of Care involving other physical therapy (ICD-9-CM V57.1)
Obstructive Sleep Apnea (Adult) (Pediatric) (ICD-9-CM 327.23)
Supraventricular Arrhythmias (ICD-9-CM 427.32)
Hypersomnia with Sleep Apnea, unspecified (ICD-9-CM 780.53)
Elevated Prostate Specific Antigen (PSA) (ICD-9-CM 790.93)
Chronic Kidney Disease, Stage III (Moderate) (ICD-9-CM 585.3)
Male erectile disorder (ICD-9-CM 302.72)
Hypogonadism, Male (ICD-9-CM 257.2)
Hyperglycemia (ICD-9-CM 790.29)
Lumbar Radiculopathy (ICD-9-CM 724.4)
Major Depressive Disorder, Single Episode, Severe, without Psychotic Features (ICD-9-CM 296.23)
Migraine, unspecified, without mention of Intractable Migraine (ICD-9-CM 346.90)
Chronic Systolic Heart failure (ICD-9-CM 428.22)
Atherosclerosis of Arteries of the Extremities W/Intermittent Claudication (ICD-9-CM 440.21)
Other and unspecified hyperlipidemia (ICD-9-CM 272.4)
Tobacco Use Disorder (ICD-9-CM 305.1)
COPD (ICD-9-CM 496.)
Coronary Artery Disease (ICD-9-CM 414.9)
Hypertension (ICD-9-CM 401.9)
Depressive Disorder Nec (ICD-9-CM 311.)
Active Outpatient Medications (excluding Supplies):

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<thead>
<tr>
<th>Active Outpatient Medications</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ALBUTEROL 3/IPRATROP 0.5MG/3ML INHL 3ML TAKE 3ML IN NEBULIZER BY INHALATION EVERY 6 HOURS AS NEEDED FOR BREATHING</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>2) ASPIRIN 325MG EC TAB TAKE ONE TABLET BY MOUTH EVERY DAY TO REDUCE THE RISK OF STROKE &amp; HEART ATTACK</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>3) BUDESONIDE 160/FORMOTER 4.5MCG 120D INHALE 2 PUFFS INHALATION TWICE A DAY FOR BREATHING <em>REPLACES FORMOTEROL/MOMETASONE INH</em></td>
<td>ACTIVE</td>
</tr>
<tr>
<td>4) CHOLECALCIFEROL (VIT D3) 1,000UNIT TAB TAKE TWO TABLET BY MOUTH TWICE A DAY FOR VITAMIN D DEFICIENCY</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>5) DIGOXIN 0.25MG TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR YOUR HEART</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>6) DILTIAZEM (TIAZAC/INWOOD) 240MG SA CAP TAKE ONE CAPSULE BY MOUTH EVERY DAY TO REDUCE BLOOD PRESSURE</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>7) FLUTICASONE PROP 50MCG 120D NASAL INHL INSTILL 2 SPRAYS IN NOSE DAILY IN EACH NOSTRIL FOR ALLERGIES</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>8) FUROSEMIDE 40MG TAB TAKE TWO TABLETS BY MOUTH EVERY MORNING FOR BLOOD PRESSURE &amp; FLUID REDUCTION</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>9) HYDROCODONE 5/ACETAMINOPHEN 500MG TAB TAKE 2 TABLETS BY MOUTH FOUR TIMES A DAY AS NEEDED</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>10) IPRATROPIUM BR 17MCG/Spray Aerosol,INHL INHALE 2 PUFFS BY MOUTH FOUR TIMES A DAY FOR COPD</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>11) KETOTIFEN FUMARATE 0.025% OPH SOLN INSTILL 1 DROP BOTH EYES TWICE A DAY AS NEEDED FOR EYE ALLERGIES</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>12) LISINOPRIL 20MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY DAY FOR BLOOD PRESSURE</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>13) NICOTINE POLACRILEX 2MG LOZENGE DISSOLVE 1 LOZENGE IN BY MOUTH EVERY 2 HOURS AS NEEDED FOR SMOKING CESSATION</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>14) NITROGLYCERIN (NITROSTAT) 0.4MG SL TAB DISSOLVE ONE TABLET UNDER THE TONGUE EVERY 5 MINUTES UP TO MAXIMUM 3 TABLETS FOR ANGINA.</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>15) OMEPRAZOLE 20MG SA CAP TAKE TWO CAPSULES BY MOUTH EVERY DAY FOR REFLUX OR STOMACH ULCERS. TAKE 30 MINUTES PRIOR TO A MEAL.</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>16) SENNA 8.6MG (AS SENNOSIDES) TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR CONSTIPATION (TAKE AT BEDTIME)</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>17) SIMVASTATIN 20MG TAB TAKE ONE-HALF TABLET BY MOUTH AT ACTIVE BEDTIME FOR CHOLESTEROL</td>
<td>ACTIVE</td>
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### Active Non-VA Medications

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<th>Status</th>
<th>Active Non-VA Medications</th>
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<tr>
<td></td>
<td>1) Non-VA ASPIRIN 81MG CHEW TAB 81MG BY MOUTH</td>
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<tr>
<td></td>
<td>2) Non-VA CETIRIZINE HCL 10MG TAB 10MG BY MOUTH EVERY DAY</td>
</tr>
<tr>
<td></td>
<td>3) Non-VA FUROSEMIDE 40MG TAB 80MG BY MOUTH EVERY MORNING</td>
</tr>
</tbody>
</table>

20 Total Medications

**Reason for Exam**
Here for scheduled visit regarding management of hypertension, CAD, COPD, supraventricular arrhythmias and other medical problems. Here with wife.

**Review of Systems**
Persistent abdominal pain for the last 6 months; not worse with eating. Pain is diffuse.

The following past medical, social, and family history elements taken from past notes were reviewed with the patient and updated SEP 03, 2013 as necessary:

**Past Medical History:**
1. 4 vessel CABG on 11 June 2002; had LVEF of 50% then.
   - 10/2005 Cancelled echo and dobutamine stress, stated did not want to reschedule
   - 06/03/2003 Echocardiogram: Concentric LVH, dilated LA Moderately depressed LV systolic function (est EF 30-40%). Regional wall motion abnormalities.
   - 06/29/06 Exercise echo technically difficult due to lung disease. Worsening of baseline wall motion abnormality (septal) c/w inducible ischemia. Mildly depressed LVSF.
   - 7/8/2009 Echocardiogram: Mildly dilated aortic root, mildly dilated left atrium, mild to moderately depressed LV systolic function (est LVEF 40%), mitral inflow and tissue Doppler c/w diastolic dysfunction.
2. Hypertension for several years before CABG
3. Hypercholesterolemia diagnosed in 2001
5. Left ankle fracture around 1975, non-compliant with treatment and doctors stopped recasting it after five casts removed by patient
6. COPD due to smoking
   - 08/04/2004 PFTs: Obstructive pattern, moderate impairment.
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Cannot rule out concomitant restriction or air-trapping.
Significant bronchodilator response. FEV 1.43L to 1.64L 
(40 to 46% of predicted), FEV/FVC 48 to 46%.

7. Depression and insomnia - has been tried on citalopram, paroxetine, 
sertraline, mirtazapine, trazodone without success.
8. OSA - has CPAP, has problems using due to nasal congestion, sleeps well 
when able to use.
9. Chronic lumbar, leg and hip pain (mainly legs and hips) 
   03/02/07 Lumbar MRI at Nydic  
   Impression: 
   1. Bilateral pars defects at L5 with Grade-I spondylolisthesis  
   Stopped gabapentin due to ineffectiveness.
10. Hypogonadism  
    01/13/2010 Normal FSH, LH, prolactin  
    01/25/2010 Normal pituitary/sellar MRI
11. Patient refuses colonoscopy.
12. ED

SOCIAL HISTORY   Lives with wife (married Sept 1966)  
Has not worked since 18 May 2005 due to medical conditions. 
+ Tobacco, 100pkyr. Had been smoking 3ppd according to wife on one  
   visit, was down to about a pack every 3 days, currently down to  
   about 2-3 packs a week. 
+ ETOH (ism) years ago, quit 30y ago 
- IVDA, - BTs, - Tattoos  
Receiving disability through Social Security.  
Has also started playing bass (has 1962 model) and  
mandolin (has an Ovation & 2 others), recently doing more guitar  
than anything else.

FAMILY HISTORY  
- Dad 1st MI @ 59s, CAD  
- Brothers x2 c CABG & MIs in late 40s  
No known family history of colon cancer or colon polyps

Lab:  
09/03/2013 WBC: 10.9 ;  
09/03/2013 HGB: 16.3 ;  
09/03/2013 HCT: 50.4 ;  
09/03/2013 SODIUM: 142 ;  
09/03/2013 POTASSIUM: 3.7 ;  
09/03/2013 UREA NITROGEN (BUN): 8 ;  
09/03/2013 CREATININE: 1.05 ;
DISCONTINUING OXYGEN THERAPY

09/03/2013 GLUCOSE: 136 H;
07/12/2013 CHOLESTEROL: 140 ;
07/12/2013 TRIGLYCERIDE: 65 ;
07/12/2013 LDL Chol,Calc.: 79.0 ;
07/12/2013 HDL: 48 ;

09/03/2013 HGB A1C: 6.2 H;
05/29/2013 Microalbumin: 394.5 H;

05/29/2013 .PROSTATIC ANTIGEN: 3.2 ;

VITALS:
Pulse: 40 (09/03/2013 14:45)
Blood Pressure: 113/64 (09/03/2013 14:45)
Weight: 243.1 lb [110.5 kg] (09/03/2013 14:45)
Height: 72 in [182.9 cm] (06/07/2013 18:12)
Temp: 95.7 F [35.4 C] (07/22/2013 09:29)
Pain Level: 0 (09/03/2013 14:45)
BMI: 33*

ALLERGIES:
SERTRALINE, TRAZODONE, MIRTAZAPINE, FLUNISOLIDE, CITALOPRAM,
CIPROFLOXACIN
BUPROPION

EXAMINATION:
  General: No apparent distress, ambulating with oxygen
  tank and nasal cannula.
  Pulmonary - Chest clear to auscultation today. No labored respirations.
  Cardiac - regular bradycardia, normal S1 & S2. No murmur, gallop
  or rubs heard.
  No masses, hepatosplenomegaly or bruits.
  Ext: only trace ankle edema today.
  Neuro-Alert & oriented x 3.

DIAGNOSIS/PLAN:
1. CHF - lung and heart exam good and weight stable, cough and shortness of
   breath at baseline.
2. Atrial fibrillation - will decrease diltiazem
2. COPD - still wrestling with Home Oxygen unit here about their disinclination
   to follow national directives and recommendations.
3. Fatigue/hypogonadism/depression - mood OK lately on no meds, but quite sleepy
   - will continue to monitor. May be due to hypogonadism but see #4. Did have CPAP
DISCONTINUING OXYGEN THERAPY

mask adjusted since last visit with me.
4. Hypogonadism - unable to continue testosterone replacement due to elevated hemoglobin, which is likely due to hypoxia.
5. Allergic rhinitis and conjunctivitis - adequate control on nasal steroid and allergy eye drops.
6. Back and hip pain - stable
7. Hyperlipidemia excellently controlled on simvastatin when last checked - will plan to recheck at next visit.
8. Smoking - will continue to work on this. Has had good luck with lozenges. Less than one cigarette daily on average.
9. Hypertension - doing well on current regimen.
10. ED - VED worked well for patient.
10. Abdominal pain - unknown etiology - will continue to monitor.

Patient received education about his above listed medical conditions and patient verbalizes understanding of these educational instructions.

ORDERS:

<table>
<thead>
<tr>
<th>Item Ordered</th>
<th>START DATE</th>
<th>STOP DATE</th>
<th>ENTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYRINGE/NEEDLE, DISPOS</td>
<td>NOV 09, 2012</td>
<td>SEP 03, 2013</td>
<td>NOV 07, 2012@08:57</td>
</tr>
<tr>
<td>HYDROCODONE 5MG/ACETAM</td>
<td>SEP 03, 2013@15:39</td>
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<tr>
<td>Text Order: Return to DALLAS PC WIXTROM CL#14 clinic</td>
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<tr>
<td>When: 3 months before 1030</td>
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<tr>
<td>Test(s) on arrival: cmp, cbc, HgbA1c, testosterone, lipids</td>
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<tr>
<td>Diagnosis and Clinical History: hyperglycemia, headaches</td>
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<tr>
<td>Special Instructions: fasting</td>
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<tr>
<td>DILTIAZEM (TIAZAC/INWO</td>
<td>SEP 03, 2013@15:37</td>
<td>SEP 03, 2013</td>
<td>SEP 03, 2013@13:14:52</td>
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<tr>
<td>POC ANC PANEL</td>
<td>SEP 03, 2013</td>
<td>SEP 03, 2013</td>
<td>SEP 03, 2013@13:14:52</td>
</tr>
</tbody>
</table>

PREVENTIVE MEDICINE INITIATIVES
V17 P At Risk for Wandering Screen:
This patient does not meet "at-risk" for wandering criteria and does not have one or more of the following:

1. Is not legally committed; or
2. Does not have a court appointed legal guardian; or
3. Is not considered dangerous to self or others; or
4. Is not gravely disabled due to a mental disorder; or
5. Does not lack cognitive ability (either permanently or temporarily) to make relevant decisions; or
6. Does not have physical or mental impairments that increase their risk of harm to self or others (dementia, sedated, intoxicated, etc).