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SUPREME COURT
STATE OF WASHINGTON

NO. 88307-6

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IN THE SUPREME COURT OF THE STATE OF WASHINGTON BY RONALD E. CARPENTER

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Court of Appeals No. 30098-6-III

RODOLFO ANAYA-GOMEZ,
as personal representative of the estate of Christina Palma-Anaya,
deceased

Petitioner,

v

MARK F. SAUERWEIN, M.D. and THE YAKIMA VALLEY FARM
WORKERS CLINIC, a Washington corporation,

Respondents.

RESPONSE TO PETITION FOR REVIEW

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I. IDENTITY OF RESPONDING PARTY

Respondents, Mark F. Sauerwein, M.D. and the Yakima Valley Farm Workers Clinic, request denial of the Petition for Review.

II. COURT OF APPEALS DECISION

On December 11, 2012, the Court of Appeals, Division III, unanimously affirmed the decision of the Trial Court that dismissed the informed consent claim as a matter of law.

III. COUNTER-STATEMENT OF THE FACTS

Contrary to the assertion by Plaintiff-Petitioner, the facts stated in the Petition for Review are partially disputed. For the ease of the Court, a replication of the timeline used as a demonstrative exhibit at trial is attached as Appendix A. This timeline was first used in Defendants' opening statement starting at RP 6/7/11, page 28:577; throughout trial; and in Defendants' closing statement starting at RP 6/14/11, page 35: 763. The medical records that support each line item in the timeline are also attached in Appendix A.

Plaintiff's claim against Dr. Sauerwein is exclusively based on the medical decision-making that occurred on August 24, 2006. On August 24, 2006, the Yakima Valley Farm Workers Clinic received a telephone call that the preliminary result of a blood test was positive for yeast. Dr. Sauerwein was concerned and puzzled by this information, and did not

know the implications. RP 6/10/11, page 76: 1512-1516. He called John Moran, M.D. an internist, because Dr. Moran had more experience with infectious disease, and Dr. Moran treated Ms. Anaya during her hospitalization on August 20 and 21, and therefore had "eyes on" the patient. RP 6/10/11, page 82: 1617-1623, and page 77-78: 1539-1544.

Dr. Sauerwein and Dr. Moran engaged in shared decision making, and jointly decided that Dr. Sauerwein would find out how the patient was doing. If she were sick, then further action would be taken; if she was not sick, then they would wait because this laboratory result was a probable contaminant. RP 6/10/11, pages 79-82: 1575-1629.

Dr. Sauerwein had a nurse contact the patient. He learned the patient had been to the Emergency Room the previous day because she could not empty her bladder and had been catheterized, but she was not admitted to the hospital. RP 6/10/11, page 83: 1641-1647; page 85: 1683-1688. The patient reported feeling better, she had been taking her antibiotics as prescribed, and she did not have a fever. RP 6/10/11, page 85: 1689-1690; page 86: 1691-1692 and 1706-1707. Dr. Sauerwein was advised by his nurse of these reassuring indications from the patient. RP 6/10/11, page 87: 1712-1715.

Dr. Sauerwein determined in consultation with Dr. Moran that the positive blood culture for yeast was a probable contaminant. Dr.

Sauerwein directed the nurse to contact the patient to schedule her for an appointment earlier than the appointment that had previously been made (August 30, rather than September 5). RP 6/10/11, page 93: 1831-1842.

The final culture report from the laboratory that the species of yeast was *Candida glabrata* was not known until Saturday, August 26, 2006. *See*, RP 6/10/11, page 70-71, lines 1401-1406. However, the final culture was not reported to or received by the Yakima Valley Farm Workers Clinic. *See*, RP, 6/10/11, page 71, lines 1407-1421.

IV. ARGUMENT

The Supreme Court of Washington should deny the Petition for Review. The theory of a failure to obtain informed consent does not apply in this case for the following reasons: 1) this is a misdiagnosis case, 2) no duty to inform arose because this is a misdiagnosis case, and 3) there was no evidence at trial establishing proximate causation.

1. This Is A Misdiagnosis Case and Dr. Sauerwein Is Not Subject To An Action Based On Failure To Secure Informed Consent.

Plaintiff tried this case to the jury on the theory that Dr. Sauerwein **misdiagnosed** a preliminary laboratory result in determining that the positive blood culture for yeast was a contaminant. Plaintiff presented evidence that Dr. Sauerwein's misdiagnosis constituted a violation of the standard of care. As articulated by the Supreme Court in *Backlund v.*

University of Washington, 137 Wn.2d 651, 975 P.2d 950 (1999), with a misdiagnosis case, informed consent does not apply.

A physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, **may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent.**

Id., at 661 (emphasis added).

In this case, stated simply, the allegation against Dr. Sauerwein was that he misdiagnosed the patient's condition. Accordingly, pursuant to *Backlund*, Dr. Sauerwein may properly be subject to a negligence action for breaching the standard of care by misdiagnosing the condition, but not also subject to an action based on failure to secure informed consent based on the same set of facts used to claim a violation of the standard of care.

A. **Preliminary Test Results Are Not Necessarily Valid.** The telephone call from the Yakima Regional Medical Center laboratory on August 24, 2006 reported a preliminary laboratory result that must be compared with the clinical picture presented by the patient.

MS. MURPHY: Now, so the jury understands um, a lab result, is there, we've talked about **preliminary and final. But what is the difference between those things?**

DR. SAUERWEIN: Preliminary and final um, would be probably be a couple of categories for, in a, in an example of a culture, **preliminary culture is the, the first indication that something is growing and then it takes time to further identify what that is. In the realm of um, specialized tests, um, that are not related to**

infection, there could be an example of um, um, a positive result for a particular condition and then further information is generated as the lab runs it through their machines.

MS. MURPHY: And in this case, **you didn't get any kind of piece of paper or document relative to Christina Anaya and the um, abnormal lab result, correct?**

DR. SAUERWEIN: At that time, **no I did not.**

MS. MURPHY: It was simply a telephone call from the lab?

DR. SAUERWEIN: **It was a telephone call.**

RP 6/10/11, page 70: 1387-1398.

Plaintiff's family practice expert, Howard Miller, M.D., agreed that a preliminary report from a laboratory is merely a **possibility** of a result, and not a probability.

MS. MURPHY: Dr. Miller let me ask you this with regard to your comments about treating a lab result that comes back positive blood culture for yeast. **You would agree with me would you not that on the 24th of August with that information Candida [yeast] was simply a possibility. Correct?**

DR. MILLER: **Uh, that is correct.**

RP 6/7/11, page 104: 2058-2061.

B. Contamination Happens. Humans have yeast all over their bodies. Peter Hashisaki, M.D. (misspelled throughout the Report of Proceedings) is a specialist in infectious disease and explained to the jury that yeast is present on the body of every person at all times.

MS. MURPHY: Before getting to your opinions in this, can you explain to the jury about yeast?

DR. HUSHISAKI: So, I'm, I'm gonna say that for the purposes of this discussion that yeast and fungus are pretty much you can think of them as being similar or the same. So, they are very common. So probably **everybody in the world has a small amount of yeast in your mouth. And every woman in the world has yeast in their [sic**

- her] vagina. They're just part of everybody's flora. We all have bacteria in our body and we all have a little bit of yeast.
RP 6/10/11, page 109: 2153-2158.

As a result of having yeast all over our bodies, which is more likely to flourish in certain areas, like the folds of our arms at our elbows where blood draws are taken, contamination of blood draws can occur. This was explained by family practice physician Walter Balek, M.D. (misspelled throughout the Report of Proceedings).

DR. BALICK: In other words, if, if she had this yeast growing in her blood stream and it's, and it's, and it's increasing and increasing, I would think that she would be sicker through that week. Um, I think, usually blood cultures are, positive blood cultures are always taken very seriously. I don't mean to say that, that's [sic - that it is] a test to be taken lightly. It's a very serious finding to have something growing in the blood stream. But in, you know something that grows in the plate is not necessarily in the blood stream it could of come off the skin. And I think a contaminate[d] specimen, that's what we, that's when we say a contaminated specimen that's what we're talking about. That the organism is grown in the test is not really in the blood stream. Came from, from the needle poking through the skin and carrying some organisms into the sample and then they grew, Um, so I, you know I, it is a positive blood culture an, and emergency, um, in a sick patient yes. At this time it doesn't, although she wasn't a healthy woman by any means I'll say, but she wasn't getting sicker in the since [sic - sense] that one would with an infection in their blood stream.

RP 6/9/11, page 108-109: 2168-2182 (emphasis added).¹

¹ Dr. Balek also testified as follows: "I think that looking at the, at the yeast thing and knowing the [sic - that] diabetics are highly prone to have yeast infections, not necessarily in the blood stream but on the surface. And in this case vaginally or on the skin, anywhere skin folds you can, yeast likes a moist, warm site[s] basically. So it's more common in the growing areas, under the armpits, under the breasts in woman [sic - women]. Any place skin folds then I, I, I would, I, I don't know where they does [sic - did] these blood cultures, but usually they're drawn from the, from the fold in the arm. And that's again a skin fold area where, where the skin is a little more moist, a little more, little warmer. So I think that, that was probably something in my mind that

Dr. Sauerwein testified that contaminated laboratory results occur on weekly basis in his practice.

MS. MURPHY: Ok. Have you encountered contaminates in lab data before?

DR. SAUERWEIN: Yes.

MS. MURPHY: K. How often do you see that?

DR. SAUERWEIN: Contamination um, is, is a frequent event depending on, on the specimen or [sic – of] what you're looking at. But, it's, on a weekly basis, we see a contamination in a specimen of some sort.

MS. MURPHY: K. So you see it weekly?

DR. SAUERWEIN: Yes, I do.

MS. MURPHY: K. So the lab will report data to you that is later confirmed to be wrong?

DR. SAUERWEIN: It's confirmed to [be] inaccurate or clinically not important or in some cases, the laboratory error.

RP 6/10/11, page 82: 1630-1640.

C. Confounding Clinical Picture. Laboratory results must be compared with the clinical presentation of the patient. This is especially true when a preliminary test result, which may be a contaminated sample, presents as confusing and puzzling information given the clinical picture of the patient. A patient with yeast in the blood would normally be severely and critically ill. Primary care internist, Daniel Doornink, M.D.,

it would, it would make you think that contamination would be more likely then and, and I think seeing that also that she'd been better, its not five days from the time of the, I'm sorry, four days from the time of the culture being obtained, she's, she's basically better then [sic] when the culture was taken back up here. And, and during that time she did not have any antifungal, anti yeast type of treatment. And I think the, the assessment that was arrived at was based on I think the diabetic issue, the fact that she was better. The assessment being that the culture was a contaminant. Um, I think that was arrived at by, by those, through that mechanism through those, those thoughts." The full question and answer are at RP 6/9/11, page 105-106: 2103-2130.

testified about the circumstances in which a physician would typically encounter a positive blood culture for yeast.

MS. MURPHY: Dr. Doornink, what is the typical clinical picture of a patient who has yeast in her blood?

DR. DOORNINK: So **a patient with yeast in their blood, which is also termed Candidemia, that patient is usually sick and usually in the hospital and most of the time is in the intensive care unit.** They take, typically would have had surgery, they typically would have a central line in so they'd have a, they'd have a big IV in a big vein either in their neck or under their, their clavicle here. Um, they've usually been on antibiotics for a long period of time. Um, many times they have um, cancer or they're otherwise compromised in reference to their immune system. So, that would be the, that would be **the typical patient usually with low blood pressure um, maybe on a ventilator, on multiple medications.**

MS. MURPHY: **Someone who is seriously ill?**

DR. DOORNINK: **Really, really sick.**

MS. MURPHY: What does Nosocomial mean?

DR. DOORNINK: Nosocomial means that you acquired it in the hospital. So Nosocomial infections would be infections that are acquired generally after 72 hours in the hospital.

MS. MURPHY: **With Christina Anaya, did um, she acquire the yeast infection from being in the hospital?**

DR. DOORNINK: **No, she did not.**

MS. MURPHY: Would she be considered a Nosocomial patient?

DR. DOORNINK: No.

RP 6/13/11, page 12-13: 235-253.

In comparison to the typical patient with yeast in the blood, Christina Anaya was "better" and without fever despite the fact that she had never had any therapeutic intervention to treat yeast in the blood. This logically is incompatible with a patient who had a progression of yeast in the blood.

MR. THORNER: Now we know from the, from the sequence of events, that after he spoke with Dr. Moran he wrote in the records, unless she is currently ill, it is a probably [sic] contaminant. K. Do you have an opinion as to that, whether that was reasonable and appropriate under these circumstances?

DR. BALICK: Ya, typically people who have organisms growing in their blood, whether [it] be a bacteria or fungus, typically those people are, are, I would say in most cases seriously ill at the time and, and unless their [sic] being treated for that specific thing, an appropriate treatment for the specific organism, their [sic] probably gonna continue to be sicker during that time. And I think that knowing that she had the culture, blood culture obtained on the 20th, and here it is on the 24th now, um, he doesn't yet know her health status, how she's doing because they're going to make a phone call. But at that point, I think he, he appropriately had the patient call[ed] to find out how she's doing. Because if certainly she had a, a bacterial or I believe again, I'm not like I say a [sic] fungus infections in the blood stream are very rare, but, but clearly if someone had a pathogen, an organism, a bacteria or fungus in the blood stream, typically I think they would be getting sicker unless the appropriate treatment was being done right at the time. In this case, she actually got better, she was better here. When in with [sic] different reasons here, no fever at this point in time, went in the hospital with more bladder retention which I'm sure made her very uncomfortable. And again was discharged, evaluated by a doctor this night and discharged again to her home. It, it would seem unlikely given that, just that information without talking to her about how she's doing that next day, this day, the 24th, it would seem that even with that, that would sort of [be] incompatible with, for progressive blood stream infection of whatever organism.

RP 6/9/11, page 103-104: 2051-2069.

In addition to doing better, this patient had been seen by an Emergency Room physician on August 23, 2006, who did not hospitalize her within hours of the report of the positive blood culture for yeast. RP 6/9/11, page 114: 2288-2297.

All of the issues discussed above relate to whether Dr. Sauerwein committed an act or omission that constituted medical negligence in his misdiagnosis of a contaminant. The evidence is related to the standard of care, not a duty to inform. Based on the Supreme Court's decision in *Backlund*, informed consent is not applicable in this misdiagnosis case.

2. **No Duty To Inform Had Arisen**. Dr. Sauerwein concluded after discussing this case with Dr. Moran and obtaining reassuring information from the patient, that the positive blood culture was a probable contaminant. Plaintiff-Petitioner is arguing that Dr. Sauerwein had a duty to inform the patient that his determination that this laboratory result was a contaminant could be wrong. However, Plaintiff cannot meet the burden of proof on an informed consent claim because there is no evidence that there was any choice to be made at that time on the part of the patient. Until the final result was processed and confirmed by the laboratory as to the type of organism, no effective treatment could have been started. Therefore, there was no decision for the patient to make.

Justice Hicks' opinion in *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980) is the majority decision on the issue of informed consent. Referencing the reasoning of the *Keogan* Court of Appeals on the issue of informed consent, Justice Hicks, and the Supreme Court of Washington held:

The Court of Appeals held that no duty to inform had yet arisen in this case because when “there is no diagnosis nor diagnostic procedure involving risk to the patient, there is nothing the doctor can put to the patient in the way of an intelligent and informed choice.” *Keogan v. Holy Family Hosp.*, 22 Wash.App. 366, 370, 589 P.2d 310 (1979). Under the circumstances of this case, I agree with the Court of Appeals....

Angina pectoris did cross Dr. Snyder’s mind as a possible cause of Keogan’s chest pain. After taking a history and examining Keogan, however, the doctor settled upon costochondritis as a probable cause of the chest pain.

Id., at 330.

Similar to the facts presented in *Keogan*, Dr. Sauerwein was concerned about the positive blood culture for yeast, but after consulting with Dr. Moran and jointly devising a plan that was dependent upon how the patient was doing, Dr. Sauerwein learned that the patient was better and without fever. Dr. Sauerwein settled upon contamination as being the probable cause for the laboratory result. Therefore, pursuant to the holding of *Keogan*, no duty had yet arisen that required Dr. Sauerwein to inform the patient.

MS. MURPHY: Did the standard of care required [sic] Dr. Sauerwein to put this patient on antifungal medications?

DR. DOORNINK: No. It did not.

MS. MURPHY: Why?

DR. DOORNINK: Well I think their determination in their shared decision making between Dr. Moran and Dr. Sauerwein, that thought it was a contaminant and so the patient was clinically doing better and so they determined that they didn’t need to treat it because it was a contaminant.

MS. MURPHY: Did the standard of care require Dr. Sauerwein to inform the patient of a positive blood culture for yeast?

DR. DOORNINK: This was, the clinical significance of this was still in question and so he wasn't required to notify the patient regarding this, no.

RP 6/13/11, page 25-26: 494-505.

As held by the Court in *Bays v. St. Lukes Hospital*, 63 Wn.App. 876, 825 P.2d 319 (1992)

A physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform the patient. ... Here, it is undisputed Dr. DeWitt did not diagnose the condition of thromboembolism in Mr. Bays. Ms. Bays' action for medical negligence is based on Dr. DeWitt's failure to diagnose the thromboembolism which manifested itself in the early morning hours of September 6 and resulted in the sudden fatal pulmonary embolism.

A failure to diagnose a condition, as we have indicated above, is a matter of medical negligence. We decline to create a second or alternate cause of action on informed nonconsent to a diagnostic procedure predicated on the same facts necessary to establish a claim of medical negligence.

Id., at 882-883 (citations omitted) (emphasis added).

Similarly, in *Thomas v. Wilfac, Inc.*, 65 Wn.App. 255, 828 P.2d 597 (1992), the Court of Appeals held

Dr. Plumely diagnosed Ms. Thomas as suffering from asthma, not Malathion poisoning. He did not treat her for Malathion poisoning. Therefore, he did not have a duty to inform her of the time frame for administering an antidote or her future risk of developing organophosphate-induced neurotoxicity....

Failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform a patient. *Bays v. St. Luke's Hosp.*, 63 Wash.App. 876, 881, 825 P.2d 319 (1992). Informed consent and medical negligence are alternate theories of

liability. *Burnet [v. Spokane Ambulance]*, 54 Wash.App. [162,] at 169, 772 P.2d 1027 [(1989)]. Here it is undisputed Dr. Plumely did not diagnose Malathion poisoning. Ms. Thomas has not established that Dr. Plumley failed to inform her of a material fact relating to treatment.

Id., at 260-61 (citations omitted) (emphasis added).

In conformance with these holdings, no duty to inform had arisen for Dr. Sauerwein.

MR. THORNER: Ok. The question is this, I'll try to restate it. Did Dr. Sauerwein based upon, re, restate myself. **Under the circumstances of the information that Dr. Sauerwein had, as reflected in the records, require under these circumstances to meet the standard of care, was he required to tell the patient or have the nurse tell the patient on his behalf that she had [a] yeast infection on this date?**

DR. BALICK: Ok. Given the information that he had I think that the, I guess **once he had made the determination this is a contaminated sample and therefore not a valid tests [sic], I, I don't think it's a required [sic] to, to give a patient what you have now come to the clinical conclusion is that it is [an] invalid test before the result.** Um, so I would say that, that it wouldn't have been required based on, on the information at that point and, and knowing or not knowing, I'll just say making the decision, that this is a, a contaminated sample because she is better.

MR. THORNER: K. Now, does a reasonably prudent family practitioner tell a patient of all abnormal lab results that he or she receives during the course of caring for a patient?

DR. BALICK: I would say that almost never happens. And the, the reason for that is because there's a lot of abnormal lab results that really are not pertinent not only to the patient's care but just plain aren't pertinent.

RP 6/9/11, page 111-112: 2233-2247.

In *Burnet v. Spokane Ambulance*, 54 Wn.App. 162, 772 P.2d 1027 (1989), *review denied*, 113 Wn.2d 1005, 777 P.2d 1050 (1989), the Court

held:

In response to Dr. Graham's liability, Thomas T. Reiley, M.D., an expert called on behalf of the Burnets, stated Dr. Graham was unaware of the risk of brain herniation and subsequent injury. **The trial court determined that the issues presented were confined to negligence and misdiagnosis rather than a violation of the informed consent law. We agree; informed consent is an alternative method to impose liability.** Thus, a high risk method of treatment rendered in a non-negligent manner, but without an informed consent of the patient, may result in liability. That is not the situation here. **It is undisputed Dr. Graham was unaware of Tristen's condition which implicated risk to her, so he had no duty to disclose.** See *Nicholson [v. Deal]*, 52 Wn. App. [814], 821, 764 P.2d 1007 [(1988)]. **The Burnets' claim relates solely to issues of failure to meet the standard of care and diagnosis.**

Id., at 168-169 (emphasis added). Plaintiff's claim against Dr. Sauerwein relates solely to issues of failure to meet the standard of care for his misdiagnosis.

3. **No Evidence Supporting Proximate Causation.** Proving proximate causation is a necessary element of an informed consent claim. RCW 7.70.050. The evidence presented at trial did not demonstrate the required causal connection. The primary underlying cause of Christina Anaya's death was her uncontrolled diabetes. Fluconazole, the typical medication used to treat yeast infections, is not effective against the organism that infected Ms. Anaya, *Candida Glabrata*. Moreover, even if she had been treated with the medication used to treat *Candida Glabrata*, Amphotericin B, the outcome would not have changed.

A. Christina Anaya Died From Uncontrolled Diabetes.

Petitioner asserted that Christina Anaya died of preventable fungal sepsis because of the delay in treatment. This is not correct as confirmed in the Death Certificate.²

MR. THORNE [sic]: Yes, thank you kindly, Your Honor. Dr. McCowen, would you mind grabbing that microphone please and stepping over here for just a moment. I wanna just cover one thing with you. This is the Exhibit 8, page 1 in this case and it is the Washington State Certificate of Death pertaining to Christina Palma-Anaya. You've reviewed this document?

DR. McCOWEN: I have.

MR. THORNER: And it indicates that the immediate cause of death, final disease or condition resulting in death is cardiac arrhythmia and then it says sequentially list conditions, if any, leading to the cause listed on Line A. Enter the underlying cause (disease or injury) that initiate[d] the events resulting in the death/last [sic]. K. And that would be in this spot here presumably D, correct?

DR. McCOWEN: Correct. ...

DR. McCOWEN: What is [sic – it] says, it says this is the background date. It says here [“]cause of death[“], and this, this is set up where [there] is a chain of events. “Disease, injuries or complications to [sic – that] directly cause[d] of [sic – the] death. [“]Do not enter terminal events such as cardiac arrest, respiratory arrest[”]. So what they're interested in and what, this is consistent with what I was saying earlier. And I had informed [sic – formed] that opinion long before I'd look[ed] at the, at the death certificate is that [the] immediate cause was a cardiac arrhythmia. These are intermediate causes and down here, **[“]enter the underlying cause (disease or injury) that initiated the events resulting in death[”] as the last entry. And the last entry reads; type 2 diabetes melotis [sic – mellitus].** And this is, I believe consistent with what I was saying, is that, **that there is a cascade of events that once, once it starts down that road where the body cannot deal with infections, and the immune system is just completely overwhelmed, that initiated the cascade that we're seeing.** And it's consistent with what I, what I believe and what I testified to.

² Attached as Appendix C to the Petition for Review is the Certificate of Death.

RP 6/10/11, page 44: 881-890 ... 897-907.

David McCowen, M.D. was the only endocrinologist to testify at trial. His opinions were not disputed or refuted.³ The evidence at trial was that this woman's body was so compromised by her years of uncontrolled diabetes that she would not have survived even if she had been treated for the yeast infection, as will be further discussed below.

B. Fluconazole Is Not Effective Against Candida Glabrata. To establish proximate causation, there must be something that could have been done effectively to change the outcome. Petitioners argue that if Christina Anaya had been diagnosed with yeast in her blood, without knowing the organism, Fluconazole (Diflucan is the brand name for Fluconazole) could have been administered. However, even if Fluconazole had been administered starting on August 24, this would not have changed the outcome, as agreed by all experts. In cross examination of Plaintiff's infectious disease expert, Dr. Dreyer confirmed:

MR. THORNER: Alright. **Now to be clear, diflucan is not is, is [not] responsive to Candida Glabrata, correct?**

³ Plaintiff called Jerrold Dreyer, M.D., an infectious disease doctor, who deferred questions on how uncontrolled diabetes would impact Christina Anaya to an endocrinologist:

MR. THORNER: Alright. Would you defer to an opinion of an endocrinologist as [to] her life expectancy due to her diabetes and related co-morbidities?

DR. DREYER: I'm not, I'm not....

MR. THORNER: On that subject?

DR. DREYER: **I'm not an expert in life expectancy so I would defer to an expert in that field.** RP 6/9/11, page 60: 1161-1165.

DR. DREYER: That's correct.

MR. THORNER: Alright. It's not therapeutic? It doesn't eliminate the fungi from the blood stream, correct?

Dr. Dreyer: Correct.

RP 6/9/11, page 50: 967-972.

Similarly, Defendant's infectious disease expert Dr. Hashisaki testified that Fluconazole would not have helped:

MS. MURPHY: Dr. Hushisaki, Candida Glabrata, is that susceptible to fluconozal [sic]?

DR. HUSHISAKI: It's usually no [sic – not] susceptible to fluconozal [sic].

MS. MURPHY: And so in this case um, can you explain to the jury how an antifungal agent, like fluconozal [sic], would work?

DR. HUSHISAKI: So, antibiotics and antifungal agents work pretty similar[.] The idea is that they disrupt growth of the fungus or the[y] disrupt [growth] of the bacteria. They usually attached [sic – attach] to the cell wall of the fungus and that's [sic] prevents them reproducing and they, they die. Most of the time though, antibiotics and antifungal agents, don't kill all of the fungus and they don't kill all the bacteria. All they are, all they can really do is kill enough of the fungus or enough of the bacteria to let your own immune system kill off the rest of the bacteria.

MS. MURPHY: So, it's really the human response that is what resolves, the body's natural response that resolves the bacterial or fungal infection?

DR. HUSHISAKI: Correct. It's your own body, it's your own immune system that does the majority of the work.

MS. MURPHY: If this patient has [sic – had] been started on fluconozal [sic] on August 24th, would that have changed to, would that have been affective [sic] at combating Candida Glabrata?

DR. HUSHISAKI: No, that really wouldn't have done anything.

MS. MURPHY: Why not?

DR. HUSHISAKI: Because Candida Glabrata is resistant to fluconozal [sic].

PR 6/10/11, page 116-117: 2296-2304.

It is undisputed that the primary therapeutic agent to treat yeast in the blood, Fluconazole, would not have helped Christina Anaya.

C. Amphotericin B Would Not Have Changed The Outcome.

Amphotericin B is a highly toxic drug that damages the kidneys, and is not administered unless there is a serious problem, and a determination of the type of yeast infection has been confirmed. RP 6/10/11, page 118: 2337-2343, and page 119: 2356-2360. Again, in this trial, the only endocrinologist that testified, and to whom Plaintiff's experts deferred, was Dr. McCowen. Dr. McCowen testified that even if this patient had received Amphotericin B, the outcome would not have changed.

MR. THORNER: Now let's assume that the patient is in a medical facility or taken to a medical facility, and report, let's assume she went to the Toppenish Hospital, as, as, as part of this, sent to the hospital or in the hospital. And that report comes in. And let's assume that medicine known as Anphotericin B [sic] is started. Are you familiar with that medicine?

DR. McCOWEN: I am.

MR. THORNER: K. **Do you have an opinion as to whether the outcome in this case would have been different with this patient, had medication been started on the 26th of August?**

DR. McCOWEN: No. **Unfortunately I do not believe it would have made a difference at that point.**

MR. THORNER: Why?

DR. McCOWEN: Again, the main infection fighters in the body, that are only aided by antibiotics are the white blood cells. And they're called granular cites [sic - granulocytes] or neutrophils. And the process is called chemotaxis, that they detect and then devour and fraise, they eat whatever is invading, bacteria, viruses, fungi. And, and, and I guess my point is, that **if her blood sugar would have been under really good control, she would not had the infection to begin with. And therefore she did have the infection, it was obvious that**

her immune system was completely overwhelmed. These organisms grow an[d] expand very, very rapidly in an immune compromised host because there isn't anything there to stop them. And unfortunately, [h]as a progressive down course. Now, also we can say well, if we make her blood sugars normal, is that going to help. And the answer is yes, but it takes some time for that to happen. That's does not happen overnight. This is a catastrophe. I mean this is, this is physiologic Armageddon. **What was happening here [was] because of [a] very, very long history of, of high blood sugars that ultimately in this very unfortunate lady, lead to her demise.**
RP 6/10/11, pages 42-43: 839-870.

The evidence presented at trial did not support proximate causation in the context of an informed consent claim. (The jury did not reach the question of whether or not there was proximate causation because they did not find a violation of the standard of care.)

4. **Gates v. Jensen Is Distinguishable.** Even if not abrogated or limited to its facts, or overruled sub silentio, *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) is distinguishable. In *Gates*, for two years the patient had high pressure in both eyes, was at increased risk for glaucoma due to other medical conditions, and there were two diagnostic tests for glaucoma that were simple, inexpensive, and risk free. *Id.*, at 248. In comparison, Dr. Sauerwein was not aware of an abnormality because the clinical picture of the patient was inconsistent with someone who had yeast in her blood, which indicated that the preliminary blood culture was a probable contaminant as agreed by Dr. Moran. Also, Dr. Sauerwein's involvement with this patient was only for part of one day.

In *Gates*, the Court disagreed with the defendant-doctor's contention that informed consent did not apply to questions of appropriate diagnostic procedures. *Id.*, at 250. This is distinguishable from Dr. Sauerwein's case in which there was nothing to do except wait for the final laboratory result because without that information, there was no effective treatment available on August 24, 2006.

V. CONCLUSION

This is a misdiagnosis case in which informed consent does not apply. The Trial Court properly dismissed the informed consent claim. The Court of Appeals properly affirmed that decision. These decisions conform to opinions of the Supreme Court and the Court of Appeals. Plaintiff-Petitioner has not presented a proper basis for acceptance of the Petition for Review under RAP 13.4(b)(1) or (4). The decision of the Court of Appeals is not in conflict with the relevant decisions of the Washington Supreme Court. This case does not present as a case of substantial public interest especially in light of the evidentiary facts as summarized herein.

Respectfully submitted this 6th day of February 2013.

THORNER, KENNEDY & GANO P.S.
Attorneys for Defendants- Respondents

By: 

David A. Thorner WSBA 4783
Megan K. Murphy WSBA 31680

Appendix A

August 20 – 29, 2006

Sunday 08/20/06 – Christina Anaya went to the Emergency Department of Toppenish Community Hospital with complaints of nausea, vomiting, and weakness. She had been ill for 2-3 days and had not been taking her anti-diabetic medications for the last 3 days. Her temperature was 102.8. Her glucose (blood sugar) was 332. Lab tests were ordered – urine and blood samples collected. Assessment

1. Pyelonephritis,
2. Diabetes mellitus out of control,
3. Normocytic anemia,
4. Dehydration with mild acute renal insufficiency.

She was admitted to the medical floor

Monday 08/21/06 – Christina Anaya was discharged stating she felt significantly better. Final diagnosis:

1. Pyelonephritis,
2. Uncontrolled diabetes mellitus, type 2,
3. Iron deficiency anemia.

She was sent home with antibiotic. She was to return to the hospital if symptoms worsened and had a scheduled follow-up appointment with the YVFWC on 9/5 at 8:45 a.m.

Tuesday 08/22/06 – A urine culture confirmed *Klebsiella pneumoniae*.

Wednesday 08/23/06 – Christina Anaya went back to the Emergency Department of Toppenish Community Hospital. She indicated that she was there because she was seeing blood in urine, feeling bloated and had diarrhea now somewhat dark in color. Her blood sugar was low at 41. Blood and urine samples were taken to be cultured. Her bladder was drained by catheter of clear yellow urine and she had leg swelling and discomfort. She was discharged with normal temperature of 97.7 degrees with instructions to increase clear liquids, eat a meal before bed tonight, take Pepto-Bismol, and continue taking her antibiotic and other medications.

Thursday 08/24/06 –

- 11:57 a.m. – Yakima Valley Farm Workers Clinic received a telephone call from the Yakima Regional laboratory that there was a blood culture positive for yeast relative to blood collected on 8/20/06.
- 2:33 p.m. – Dr. Sauerwein had the History and Physical narrative report from the 08/20 – 21 hospitalization, some laboratory reports, and did not have the Discharge Summary. He reviewed the case with Dr. Moran, who cared for Ms. Anaya on 08/20 and 21. Dr. Sauerwein stated that this was a probable contaminant unless Ms. Anaya was currently ill. He requested a nurse contact Christina Anaya to see how she was doing.
- 2:53 p.m. – A nurse spoke with Christina Anaya by telephone. Ms. Anaya told the nurse she had gone to the ER the previous night because she had not been feeling well and could not empty her bladder. A catheter was used to drain her bladder. She said she felt much better now. She was taking ABX (antibiotics). She did not have a fever and had a follow-up appointment on 9/5. She reported feeling just a little tired and that she was a diabetic.
- 6:50 p.m. – Dr. Sauerwein requested a nurse contact Christina Anaya to schedule an earlier appointment because 9/5 was too far out.

Friday 08/25/06 12:13 p.m. – A nurse with Yakima Valley Farm Workers Clinic scheduled an appointment with Christina Anaya to be seen on Wednesday, 08/30/06.

Saturday 08/26/06 13:53 p.m. – *Candida glabrata* was identified by the Yakima Regional laboratory in the blood collected on 08/20/06. *Candida glabrata* was identified in the urine collected on 08/23/06.
*This information was not provided to Dr. Sauerwein and the Yakima Valley Farm Workers Clinic.

Tuesday 08/29/06 – Christina Anaya went to the Emergency Room at Yakima Valley Memorial Hospital and was admitted.

TOPPENISH COMMUNITY HOSPITAL

502 West 4th Avenue
 Toppenish, WA 98948
 (509) 865-3105

ADMISSION RECORD

ACCOUNT NO. 5005344 MEDICAL RECORDS NO. 0000329427

ADMIT DATE / TIME 08/20/2006 10:37	ROOM NO. 0205 2	PT I1	FC D	AGE 32	DATE OF BIRTH 06/14/1974	SEX F	RA 4	MB M	LOCATION	PROGRAM	
PATIENT NAME & ADDRESS ANAYA, CHRISTINA 42 EAST 3RD AVE TOPPENISH WA 98948 US		SS NUMBER 535-72-3676		PATIENT EMPLOYER UNEMPLOYED			EMPLOYER PHONE NO.				
		PHONE NUMBER (509) 985-5337					COUNTY YAKIMA				
RESPONSIBLE PARTY & ADDRESS ANAYA, CHRISTINA 42 EAST 3RD AVE TOPPENISH WA 98948 US		SS NUMBER 535-72-3676		RESPONSIBLE PARTY EMPLOYER UNEMPLOYED			EMPLOYER PHONE				
		PHONE NUMBER (509) 985-5337					RELATIONSHIP TO PATIENT PATIENT IS G				
EMERGENCY CONTACT NAME PALMA, ALMA		EMERGENCY CONTACT PHONE (509) 985-5659			EMERGENCY CONTACT RELATIONSHIP TO PATIENT MOTHER						
COMMENTS DARNOTES				MBP <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	MED. KEY <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	PRIVACY	NPTI Y	ADMIT. BY CG2			
PRIVACY											

INSURANCE	1	PAYER BB9	PLAN TIPS	POLICY NUMBER 1	DATE OF BIRTH 04/27/1973
	INSURANCE CO. NAME & ADDRESS TRUSTED PLAN SERVICE PO BOX 1894 TACOMA WA 98401 (800) 426-9786			INSURED'S NAME ANAYA, RODOLFO G	
	GROUP NUMBER 45965		GROUP NAME GLACIER FISH		
	AUTHORIZATION				
INSURANCE	2	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
	INSURANCE CO. NAME & ADDRESS			INSURED'S NAME	
	GROUP NUMBER		GROUP NAME		
	AUTHORIZATION				
INSURANCE	3	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH
	INSURANCE CO. NAME & ADDRESS			INSURED'S NAME	
	GROUP NUMBER		GROUP NAME		
	AUTHORIZATION				
MISC	DR. ATTENDING / ADMITTING MORAN, JOHN K			DR. FAMILY / PRIMARY CARE HEISEY, KYLE L	
	DIAGNOSIS / SIGNS & SYMPTOMS PYELONEPHRITIS, VOMITING, DM			ACCIDENT	ACCIDENT DATE
PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).					DISCHARGE DATE/TIME Home 8-21-06

COMPLICATIONS

COMORBIDITY(IES)

PRINCIPAL PROCEDURE

Apdy
OP
 8/24
 AUG 24 2006

A0001A

5005344

0000329427

MEDICAL RECORDS COPY

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2-207

ATTENDING PHYSICIAN: JOHN K MORAN, MD

DATE OF ADMISSION: 08/29/2006

Actual Date 8/20/06 - see below

PRESENTING COMPLAINT: Nausea, vomiting, and weakness.

HISTORY OF PRESENT ILLNESS: The patient is a 32-year-old woman who presents to the emergency department with the above named complaints. She has been ill for the past two to three days. She has also had symptoms of back pain, but specific denies any bladder symptoms such as dysuria, frequency, urgency. She has had no prior history of urinary tract infection that she is aware of.

PAST MEDICAL HISTORY: Significant for diabetes mellitus type 2. She is on Glucotrol XL 10 mg two every day and metformin 500 mg one to two tablets every morning.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: She is married with two children. She does not work outside the home. She denies alcohol, tobacco, or drug use.

FAMILY HISTORY: Significant for extensive diabetes mellitus.

PAST SURGICAL HISTORY: She has had cataract extraction bilaterally.

REVIEW OF SYSTEMS: She denies history of seizure, stroke, syncope. She denies chest pain or palpitations. She denies chronic cough or hemoptysis. She denies gastrointestinal or genitourinary complaints.

PHYSICAL EXAMINATION:

VITAL SIGNS: On examination, temperature is 102.8, pulse rate 104, respiratory rate 20, blood pressure 100/57.

GENERAL APPEARANCE: The patient is pleasant young woman who is somewhat tired.

HEENT: There is a shallow ulcerated area in the right preauricular area with some superficial yellow crust, minimal erythema. Extraocular muscles are intact. Pupils are equal, round, and reactive to light and accommodation. Oropharynx is not inflamed.

Toppenish Hospital 504 W. 4th Ave Toppenish, WA 98948

=====
Name: ANAYA, CHRISTINA DOB: 06/14/1974
Acct#: 5005344 MR#: 000329427
Physician: JOHN K MORAN, MD
Room: 0105 I
Date Of Admit: 8/20/2006 HISTORY AND PHYSICAL
=====

CONTINUED ON PAGE 2

0000004

2-208

NECK: No jugular venous distention, thyromegaly, or adenopathy. No carotid bruits.

LUNGS: Clear to auscultation.

CARDIOVASCULAR: Regular rate and rhythm with a normal S1, S2.

ABDOMEN: Bowel sounds present. There is minimal left lower quadrant tenderness to palpation, some left flank discomfort as well.

EXTREMITIES: No edema.

NEUROLOGICAL EXAMINATION: Nonfocal.

LABORATORY DATA: Hemoglobin and hematocrit 10.5, 31.2. White blood count 10,000, 71 polys, 17 bands, 18 lymphs. Sodium 130, potassium 4.7, chloride 91, CO2 28. Glucose 332, BUN 24, creatinine 1.6. Total bilirubin 0.4, alkaline phosphatase 173, SGOT 19, SGPT 36. Serum pregnancy negative. Urinalysis 2+ leukocyte esterase and greater than 100 WBC, packed bacteria.

ASSESSMENT:

1. Pyelonephritis.
2. Diabetes mellitus out of control.
3. Normocytic anemia.
4. Dehydration with mild acute renal insufficiency.

PLAN:

1. Admit to medical floor.
2. Intravenous fluids rehydration.
3. Intravenous ceftriaxone.
4. Insulin by sliding scale.
5. Continue Glucotrol and metformin.
6. Iron studies and monitor hemoglobin and hematocrit.

cc: Kyle Heisey, M.D.

Toppenish Hospital 504 W. 4th Ave Toppenish, WA 98948
=====

Name:	ANAYA, CHRISTINA	DOB:	06/14/1974
Acct#:	5005344	MR#:	000329427
Physician:	JOHN K MORAN, MD		
Room:	0105 1		
Date Of Admit:	8/20/2006	HISTORY AND PHYSICAL	

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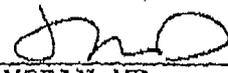
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2-209

ATTENDING PHYSICIAN: JOHN K MORAN, MD

Signed: _____



JOHN K MORAN, MD

DD: 8/20/2006 16:30
DT: 8/21/2006 15:44
JM/mlg 18724
CC:

JOB#: 987382

Toppenish Hospital 504 W. 4th Ave Toppenish, WA 98948

Name: ANAYA, CHRISTINA

DOB: 06/14/1974

Acct#: 5005344

MR#: 000329427

Physician: JOHN K MORAN, MD

Room: 0105 1

Date Of Admit: 8/20/2006 HISTORY AND PHYSICAL

CHART COPY

PAGE 3 OF 3

0000006

2-210

ATTENDING PHYSICIAN: JOHN K MORAN, MD

DATE OF ADMISSION: 8/20/06

DATE OF DISCHARGE: 8/21/06

FINAL DIAGNOSIS:

1. Pyelonephritis.
2. Diabetes mellitus, type 2.
3. Iron deficiency anemia.

HISTORY OF PRESENT ILLNESS: The patient is a 32-year-old woman who presented to the Emergency Department with a history of nausea, vomiting, weakness, fever, and back pain. She denied any bladder symptoms. She had no prior history of urinary tract infection.

There is a past history of diabetes mellitus.

PHYSICAL EXAMINATION: VITAL SIGNS: Temperature 102.8; pulse 104; respirations 20; blood pressure 100/57. GENERAL APPEARANCE: She is a pleasant young woman in no distress. HEENT: Unremarkable. LUNGS: Clear to auscultation. HEART: Regular rate and rhythm. Normal S1, S2. ABDOMEN: Bowel sounds present. There is some left abdominal and left flank discomfort, as well as some suprapubic discomfort. EXTREMITIES: No edema.

LABORATORY DATA: URINALYSIS: 2+ leukocyte esterase; greater than 100 white blood cells. URINE CULTURE: Is growing a Gram-negative rod. CHEMISTRY: Sodium 130; potassium 12.7; chloride 91; CO2: 28; glucose 332; BUN 24; creatinine 1.6. CBC: H&H 10.5 and 31.2; white blood cell count 10,000 with 71 polys, 17 segs, 18 lymphs. The H&H the following morning is 9.7 and 28.6; MCV 84.5; white blood cell count is down to 9.3. IRON STUDIES: %saturation 2; serum iron 3; iron binding capacity 159.

HOSPITAL COURSE: The patient was admitted and begun on intravenous Ceftriaxone, intravenous fluids, sliding scale insulin coverage. By the following morning she feels significantly better. She is tolerating a P.O. diet without difficulties. She is anxious to go home.

Iron studies show %saturation of 2. Serum iron 3. Iron binding capacity 159. The H&H the following morning is 9.7 and 28.6; MCV is 84.5; white blood cell count is down to 9.3. The urine culture is growing a Gram-negative rod. BUN and

Toppenish Hospital 504 W. 4th Ave Toppenish, WA 98948

Name: ANAYA, CHRISTINA DOB: 06/14/1974

Acct#: 5005344 MR#: 000329427

Physician: JOHN K MORAN, MD

Room:

Date Of Admit: 8/20/2006 DISCHARGE SUMMARY

creatinine are up to 22 and 1.4 and the blood sugar is 95.

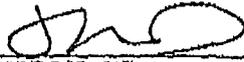
PLAN:

1. To discharge her home on Cipro 500 mg P.O. twice a day x 9 days.
2. Iron sulfate is started 325 mg twice a day x 3 months.
3. She is to continue Glucotrol 10 mg, 2 daily; Metformin 500 mg, 1-2 daily.

FOLLOW-UP: With Dr. Heisey in about 2 weeks, with a urinalysis.

She should return to the hospital sooner as needed for worsening of symptoms.

cc: Dr. K. Heisey

Signed: 
JOHN K MORAN, MD

DD: 8/21/2006 12:48
DT: 8/25/2006 14:21
JM/bin 18828
CC:

JOB#: 988041

Toppenish Hospital 504 W. 4th Ave Toppenish, WA 98948

=====
Name: ANAYA, CHRISTINA DOB: 06/14/1974
Acct#: 5005344 MR#: 000329427
Physician: JOHN K MORAN, MD

Room:
Date Of Admit: 8/20/2006 DISCHARGE SUMMARY

=====
CHART COPY

PAGE 2 OF 2

0000008

2-212

PATIENT: ANAYA, CHRISTINA
 I.D.#: 05005344
 DISCHARGED: 08/21/06

MRN: 00000329427 LOC: TMED-0105-1
 DOB: 06/14/1974 AGE: 32 SEX: F
 ORDERED BY: JEROME, JEROME

M I C R O B I O L O G Y

SOURCE: Urine
 ORDER#: 44200194
 ANTIBIOTICS AT COLLECTION :
 ORDER ENTRY COMMENTS:

COLLECTED: 08/20/06 11:15
 RECEIVED : 08/20/06 11:19

Culture Urine

08/21/06 Total Colony Count: Greater than 100,000 CFU/mL
 Organism 01 Klebsiella pneumoniae
 * FINAL 08/22/06 06:59 Site: M
 08/22/06 06:58 JHP

Organism	01-klepne		COST
	MIC	Int	
Ampicillin	>=32	R	1
Ampicillin/sulbactam	16	I	4
Cefazolin	<=4	S	1
Ceftriaxone	<=1	S	4
Cefuroxime	2	S	2
Ciprofloxacin	<=0.25	S	4
Gentamicin	<=1	S	1
Levofloxacin	<=0.25	S	2
Nitrofurantoin	64	I	
Piperacillin	32	R	
Piperacillin/tazobactam	<=4	S	5
Meropenem	<=8	S	4
Vancomycin	<=1	S	2
Trimethoprim/Sulfa	<=20	S	

S=SUSCEPTIBLE I=INTERMEDIATE R=RESISTANT MIC=Minimum Inhibitory Concentration (ug/ml)

* COMPARABLY PRICED ANTIBIOTICS ARE GROUPED ACCORDING TO COST TO THE PHARMACIST.

1 = LEAST EXPENSIVE 5 = MOST EXPENSIVE

KEY FOR RESULTS: * - NEW RESULT ** - RESULT WAS MODIFIED AFTER FINAL STATUS SET SITE CODE H-YAKIMA O-TOPPENISH

ATT.PHYS.: MORAN, JOHN
 ADM.DATE: 08/20/06

MRN: 00000329427 LOC: TMED-0105-1
 PATIENT : ANAYA, CHRISTINA

M I C R O B I O L O G Y

0000032

2-236

TOPPENISH COMMUNITY HOSPITAL

502 West 4th Avenue
 Toppenish, WA 98948
 (509) 865-3105

AUG 2 3 2006

ADMISSION RECORD

ACQUISITION NO. 5006618 MEDICAL RECORDS NO. 0000329427

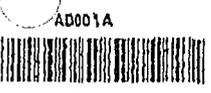
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PATIENT NAME & ADDRESS ANAYA, CHRISTINA 42 EAST 3RD AVE TOPPENISH WA 98948 US		SS NUMBER 535-72-3676		PATIENT EMPLOYER UNEMPLOYED			EMPLOYER PHONE NO.				
RESPONSIBLE PARTY & ADDRESS ANAYA, CHRISTINA 42 EAST 3RD AVE TOPPENISH WA 98948 US		SS NUMBER 535-72-3676		RESPONSIBLE PARTY EMPLOYER UNEMPLOYED			EMPLOYER PHONE				
		PHONE NUMBER (509) 985-5337					COUNTY YAKIMA				
		PHONE NUMBER (509) 985-5337					RELATIONSHIP TO PATIENT PATIENT IS G				
EMERGENCY CONTACT NAME PALMA, ALMA		EMERGENCY CONTACT PHONE (509) 985-5659			EMERGENCY CONTACT RELATIONSHIP TO PATIENT MOTHER						
COMMENTS				MSP <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	MED. KEY <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	PRIVACY		NPP Y	ADMIT. BY GLG		
PRIVACY											

INSURANCE	1	PAYER BBB	PLAN TPS	POLICY NUMBER 836496390	DATE OF BIRTH 04/27/1973	
	INSURANCE CO. NAME & ADDRESS TRUSTEED PLAN SERVICE PO BOX 1894 TACOMA WA 98401 (800) 426-9786			INSURED'S NAME ANAYA, RODOLFO G		
				GROUP NUMBER 45965	GROUP NAME GLACIER FISH	
UNION	2	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH	
	INSURANCE CO. NAME & ADDRESS			INSURED'S NAME		
				GROUP NUMBER	GROUP NAME	
NCE	3	PAYER	PLAN	POLICY NUMBER	DATE OF BIRTH	
	INSURANCE CO. NAME & ADDRESS			INSURED'S NAME		
				GROUP NUMBER	GROUP NAME	
MISC	DR. ATTENDING / ADMITTING CLIPPINGER, MARK S			DR. FAMILY / PRIMARY CARE HEISEY, KYLE L		
	DIAGNOSIS / SIGNS & SYMPTOMS HEMATURIA				ACCIDENT	ACCIDENT DATE
PRINCIPAL DIAGNOSIS (The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care).					DISCHARGE DATE/TIME	

COMPLICATIONS

COMORBIDITY (IES)

PRINCIPAL PROCEDURE

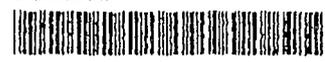


5006618



MEDICAL RECORDS COPY

0000329427



0000058

2.264

PHYSICIAN ASSESSMENT FORM

Oppenish Community Hospital

Room: 4

Patient: ANAYA, CHRISTINA

PH#: 5005818

Urgency: Urgent

DOB: 06/14/1974

AGE: 32YRS Sex: F

MR#: 0000329427

DATE: 08/23/2006

EDP: CLIPPINGER, MARK S

PCP: HEISEY, KYLE L

Worker's Comp:
Emp. Referred:

Presentation Time: 17:42

Triage Time: 18:03

Arrival Mode: AMB - POV

Height: Weight: lbs. kgs. LMP: Last Tetanus: Acc By:

Chief Complaint: HEMATURIA

Vital Signs
T: 99.7 PO
P: 114 regular
R: 16 unlabored
BP: 094/069
O2: 100% RA
Pain Intensity Scale: 0 / 10
Pain Location: denies pain

History of Present Illness: C/O SCANT BLEEDING W/ URINATION, ONSET TODAY, WAS SEEN HERE 2 DAYS AGO AND DX WITH KIDNEY INFECTION AND ANEMIA. ALSO C/O RUNNY, DARK STOOLS.

NOCTURNAL URINATION NO
VURIA NO
HEMATEMESIS NO
HEMOPTYSIS NO
FEVER NO
PAIN IN FLANKS NO
PAIN IN GROIN NO
PAIN IN LOWER BACK NO
PAIN IN BUTTOCKS NO
PAIN IN THIGHS NO
PAIN IN LEGS NO
PAIN IN FEET NO
PAIN IN HANDS NO
PAIN IN FINGERS NO
PAIN IN TOES NO
PAIN IN NECK NO
PAIN IN SHOULDER NO
PAIN IN ELBOW NO
PAIN IN WRIST NO
PAIN IN ANKLE NO
PAIN IN FOOT NO
PAIN IN HEEL NO
PAIN IN TOE NO
PAIN IN NAIL NO
PAIN IN SKIN NO
PAIN IN MOUTH NO
PAIN IN THROAT NO
PAIN IN EAR NO
PAIN IN NOSE NO
PAIN IN EYE NO
PAIN IN EAR NO
PAIN IN NOSE NO
PAIN IN EYE NO

Medications: PAIN MEDS
Allergies: NKDA

Medical History: "PAIN PILL", "RED PILL FOR ANEMIA", ABX FOR KIDNEY INFECTION, GLUCOTROL, METFORMIN

Hasern

HLC

RM 5 1835

Rev 04/12/04

0000062

2-265

Toppenish Community Hospital

(Instructions: circle positive - backlash negative, provide additional pertinent information.)

NAME: ANAYA, CHRISTINA PH: 5006618 DATE OF SERVICE: 8/23/2008
 DOB: 6/14/1974 Age: 32 Yrs. 0 Mos. 0 Wks MR#: 0000328427 Pres. Time: 17:42
 Sex: F Wt: KG Ht: Triage Time: 19:06
 Chief Complaint: HEMATURIA T: 99.7 PO
 Medicines: "PAIN PILL", "RED PILL FOR ANEMIA", ABX FOR KIDNEY INFECTION, GLUCOTROL, METFORMIN P: 114 regular
 Allergies: NKDA RI: 13 unlabored
 BP: 094/069
 SaO2: 100% Normal / Hypoxia
 EDP: CLIPPINGER, MARK S PCP: HEISEY, KYLE L Arrival Mode: AMB - ROV Pain Scale: 0

HISTORY OF PRESENT ILLNESS

EXAM TIME: 19:08 Hx by: Patient Family EMS NH Translator Interpreter ALOC Intoxication Severity Dementia
 C/C/HPI: (Narrative): ENTALAN Medical Specialist Emergent Non-Emergent

It seen here 8/20 to UTI / anemia. Here because she is seeing blood in urine. Also, sensation of "gaining weight" / feeling bloated. Diarrhea for some time, now somewhat dark in color.

Timing: Sx started suddenly / gradually 3 min. / hrs. / days / wks. ago: continuous / intermittent
 Duration: Sx last 3 min. / hrs. / days / wks. at a time: present / absent
 Location: flank R/L breast R/L pelvic R/L vaginal
 Quality: cannot describe pain rash lesions vaginal discharge dysuria hematuria
 Severity: mild moderate severe 1-10 scale
 Context: none menstruating sexually active trauma abn. menses?
 Exacerbated by: nothing movement urinating Relieved by: nothing rest OTC meds
 Assoc. Signs & Symptoms: none abd. pain dysuria hematuria flank pain vaginal discharge bleeding

REVIEW OF SYSTEMS

Constitutional: fever chills weakness diaphoresis Limited Due To ALOC Intoxication Severity Dementia
 ENT: sore throat ear pain facial pain Neurological: HA seizures weakness confusion
 Eyes: pain visual changes Psychological: anxious depressed
 Cardiovascular: C.P. palpitations DOE PND Hematological: polyuria polydipsia
 Respiratory: S.O.B. cough congestion Infectious: rashes pruritis lesions
 GI: N/V diarrhea / constipation pain melena hematemesis Hematological: anemia bleeding disorders transfusion
 GU: flank pain dysuria hematuria frequency Allergy/Immunology: frequent infections allergies hives
 Musculoskeletal: joint pain neck / back pain ext. pain
 All Other Systems Reviewed And Are Negative Agree With Nursing Assessment

MEDICAL AND SOCIAL HISTORY

Current: CAD HTN IDDM / NIDDM kidney stones breast CA PID HIV Reviewed
 Past Med. Hx: DM Reviewed
 Meds: "PAIN PILL", "RED PILL FOR ANEMIA", ABX FOR KIDNEY INFECTION, GLUCOTROL, METFORMIN Reviewed
 Allergies: NKDA Reviewed
 Surgeries: none Append Chole Hyster tubal ligation
 Family Hx: negative breast CA R/L Handed Lives Alone: Y/N
 Social Hx: Tobacco: Y/N ___ Packs/Day ___ Years ETOH: Y/N ___ Drinks/Wk. Drugs: Y/N
 Immunizations: Up-to-date: Y/N Last Tetanus:
 LMP: 1/2 weeks ago G P AB

NAME: CHAYLA, CHRISTINA

MR#: 5095618

MR#: 0000329427

PHYSICAL EXAM

GENERAL: (N) mild/moderate/severe distress

VITALS: T 99.7 P 114 R 16 BP 094/069

HEENT: (S) PERLA (E) JVD (S) Strals

(R) (M) murmurs /6 svs /dys

(R) (C) gallops S3/S4

RESP: lungs (C) clear/equal bilateral esp. effort (N) distress

(S) (M) wheezes

GI: (S) (D) distended bowel sounds (N) / ABN (M) max RLO

(S) (N) non-tender guarding rebound rigidity

(S) (N) clubbing cyanosis edema

(S) (S) symmetrical discharge masses tenderness (M) max

(S) (N) diaphoretic rashes

(S) (S) 2/2 JVP DTRs equal/symmetrical

(S) (S) mood/affect (N)

(S) (N) (M)

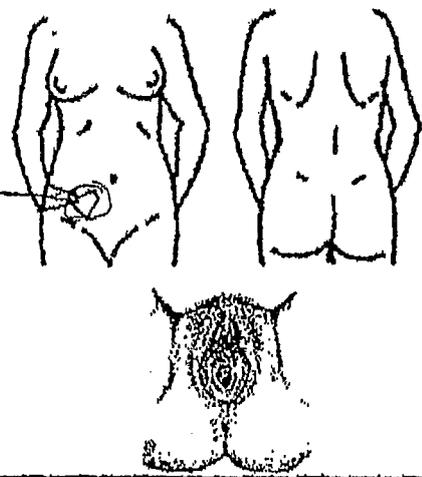
GU: (S) (N) (M) cervix (N) / discharge

(S) (N) tender/mass uterus (N) / enlarged

(S) (N) tenderness

Other: U/S -> large bladder

Location/Description of Symptoms:



MEDICAL DECISION MAKING

LABS AND STUDIES: X-Ray: MEDS:

13 ribs rovicwed and are negative 9.5

13/100 336 84 29

DIFF NL (ABN) DIFF

EKG: NSR no acute disease

Pulse Ox: % NL / hypoxia

UA: (S) (N) TRBCs / WBCs (S) (N) bacteria

DCR: (S) (N) cervicitis ovarian cyst mastitis breast abscess UTI kidney stones (S) (N) UP ectopic pregnancy STD menstrual cramping tubo-ovarian cyst

RE-EVAL: Time:

IVF: FOLEY: 850 cc urine removed Less swelling Discomfort

RE-EVAL: Improved Same Worse

Critical Care: 30-74 / 75-90 / 91-104 / 105-120 121-134 / 135-164 Minutes Excl. billable proc.

CLINICAL IMPRESSION(S)

- 1. Resolving UTI
2. GE
3. Anemia
4. Hypoglycemia

DISCHARGE INSTRUCTIONS

Discharged to: Home Nursing Home Family
Follow-up with Patient's Dr. in 2 days.
Other Instructions:
1. cal lig, Eat a meal before bed tonight.
Rx: Pyltor Bismol
Prescriptions Given:
Cont. Cipro, FeSO4

DISPOSITION

DISPOSITION

Discharge Time Out:
Admit: OBS ICU PCU Floor Tele. OR
Transfer:
AMA:
DOA:
Condition: Improved (Stable) Deceased

Discharge Time Out:
Admit: OBS ICU PCU Floor Tele. OR
Transfer:
AMA:
DOA:
Condition: Improved (Stable) Deceased

RETURN TO ER IF CONDITION WORSENS.

See procedure form attached

MD/DO Record Complete

PA/ARNP

Handwritten signature of the provider.

**EMERGENCY DEPARTMENT
PRIMARY NURSING ASSESSMENT**

Name: ANAYA, CHRISTINA

Toppenish Community Hospital

Age: 32 YRS DOB: 08/14/1974

Sex: F

PH#: 5005618

MR#: 0000329427

EDP: CLIPPINGER, MARK S

PCP: HEISEY, KYLE L

Date In: 8/23/2006

Time: 1835

Subjective Notes:

Pain

Location: _____ Quality: Sharp Dull Cramping Burning Aching Severity Scale: _____ Onset: _____
Provocation: _____ Other: _____ Aggravating Factors: _____
Radiating: No Yes (specify) _____ Constant Intermittent Relieving Factors: _____

Psychosocial

Appearance: Clean Unkempt Other _____ Environment: No steps Few steps Many steps
Mood / Affect / Behavior: Appropriate Depressed Anxious Nutritional status: Normal Cachectic Obese
 Tearful Other _____ Religious / Cultural preference: None (specify) _____
Caregiver: Self Family member Significant Other Group home Best learn by: Verbal Written Return demo
Activity level: Ambulates independently Requires assistance Non-ambulatory Learning Barriers: TDD phone Interpreter Yes
 Performs ADL's independently Requires assistance with ADL's Other: _____

Neurological

Alert Oriented X 3 Cooperative Awake but Comatose
 Uncooperative Combative Agitated Restless
Responds: To Verbal To Pain Unresponsive
Posturing: No Decorticate Decerebrate
Pupils: Brisk Sluggish Fixed Pinpoint Dilated

Extremities:

	RUE	LUE	RLE	LLE

Movement: 0=None 1=Barely Breaks Gravity 2=Weak 3=Strong
Sensit.: n: NR=No response DP=Deep pain MP=Mod pain LT=Light touch

GI/Gastrointestinal

Abdomen: Soft Flat Rigid Distended
 Non-Tender Tender (Area) _____
Bowel Sounds: Present Decreased Absent
Elimination: Normal Constipation Diarrhea # of Stools: _____

Urological

Urine: Colorless Yellow Red Brown Cloudy
 Anuria Dysuria Hematuria Frequency Urgency
Vaginal D/C No LMP: _____
Penile D/C Yes Type: _____

Cardiovascular

Skin: Warm Cool Moist Diaphoretic
Color: Pale Ashen Flushed Cyanotic Jaundiced
Capillary Refill: < 2 Secs (Normal) > 2 Secs (Delayed)
Turgor: Normal Decreased
Pulses:

	R	L
Carotid		
Brachial		
Radial		
Femoral		
Distal		

S=Strong W=Weak D=Doppler A=Absent

Wounds

Lacerations / Abrasions / Contusions
Location: _____
Size: _____
Bleeding: Absent Present Scant Moderate Heavy Pulsating
ROM: WNL Decreased Absent
Edema Absent 1+ 2+ 2+ Deformity Yes No
Scars: Yes No Distal pulses: Absent Present

Respiratory

SpO2: Normal Other _____
Cough: Unlabored Labored Mildly Severely
 Retractions Stridor Nasal Flaring
Sputum: None Productive Non-Productive
Lung Sounds:

	R	L
Crackles		
Wheezing		
Hyperinflation		
Diminished		
Normal		

Respiratory

CPR PASG Not Inflated Legs Inflated Abd Inflated
 Intubated
 Ambu-Assist
 Mask C-Collar
 Nasal Cannula Backboard
 O2 @ _____ lpm _____ % Traction
 Splint

Medication	Amt	Route

0.7 P: 114 regular R: 16 BP: 094/089

Nurse Signature: *[Signature]*

0000065

Rev. 03/05/04

2-268

**EMERGENCY DEPARTMENT
ONGOING NURSING ASSESSMENT**

Name: **ANAYA, CHRISTINA** P#: 5005818
Age: 32YRS DOB: 06/14/1974 Sex: F MR#: 0000329427
EDP: CLIPPINGER, MARK S PCP: HEISEY, KYLE L

Date: 8/23/2006

Oppenish Community Hospital

NURSING DIAGNOSIS (Number in order of priority) (Each patient may have more than one diagnosis)

<input type="checkbox"/> Airway Clearance, Ineffective	<input type="checkbox"/> Communication Impaired	<input type="checkbox"/> Infection, Potential	<input type="checkbox"/> Self Care Deficit
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coping, Ineffective	<input type="checkbox"/> Injury, Potential	<input type="checkbox"/> Skin Integrity Impairment
<input type="checkbox"/> Breathing Patterns, Ineffective	<input type="checkbox"/> Fluid Volume, Alteration in	<input type="checkbox"/> Knowledge Deficit	<input type="checkbox"/> Thought Processes, Impaired
<input type="checkbox"/> Cardiac Output, Decreased	<input type="checkbox"/> Gas Exchange, Impaired	<input type="checkbox"/> Mobility Impaired	<input type="checkbox"/> Thought Processes, Alteration in
<input checked="" type="checkbox"/> Comfort, Alteration in	<input type="checkbox"/> Hyperthermia (Fever)	<input type="checkbox"/> Non-Compliance	<input type="checkbox"/> Tissue Perfusion, Alteration in
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

The GOAL / PLAN for this patient is to assist in meeting identified needs and to intervene as needed.

<input type="checkbox"/> PAIN CONTROL <input type="checkbox"/> VITAL SIGN CONTROL <input type="checkbox"/> AIRWAY CONTROL <input type="checkbox"/> BREATHING CONTROL <input type="checkbox"/> ANXIETY CONTROL <input checked="" type="checkbox"/> COMFORT CONTROL	<table border="1"> <tr><th colspan="3">Not Met</th></tr> <tr><th>Met</th><th>Met</th><th>Int</th></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>	Not Met			Met	Met	Int																												<input type="checkbox"/> IMMOBILIZATION / PROPER ALIGNMENT <input type="checkbox"/> DECREASE / PREVENT SWELLING <input type="checkbox"/> MAINTAIN STABLE HOMEOSTASIS <input type="checkbox"/> MAINTAIN SKIN / TISSUE INTEGRITY <input type="checkbox"/> PREVENT FURTHER INJURY <input type="checkbox"/> MAINTAIN / IMPROVE CIRCULATION <input type="checkbox"/> INFECTION CONTROL	<table border="1"> <tr><th colspan="3">Not Met</th></tr> <tr><th>Met</th><th>Met</th><th>Int</th></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>	Not Met			Met	Met	Int																												<input type="checkbox"/> IMPROVEMENT OF BREATHING <input type="checkbox"/> STABILIZE PATIENT IN DISTRESS <input type="checkbox"/> MEET ENVIRONMENTAL NEEDS <input type="checkbox"/> MEET PSYCHOSOCIAL NEEDS <input type="checkbox"/> MEET SELF CARE ABILITY NEEDS <input type="checkbox"/> MEET EDUCATIONAL NEEDS <input type="checkbox"/> Other _____	<table border="1"> <tr><th colspan="3">Not Met</th></tr> <tr><th>Met</th><th>Met</th><th>Int</th></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>	Not Met			Met	Met	Int																											
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Int: N = documentation in nurses notes, other 'codes' per Hospital Policy.

Nurses Progress Notes & Reassessment

2115	1 ED cath inserted into bladder. 825ml of clear yellow urine drained from bladder. Pt tolerated well. NPO																			
2147	Pt states "I feel my sugar is low." CBG checked 44mg/dl. Dr aware. Pt given apple juice & 2 packets of sugar. Pt drank all. CBG will be rechecked in 10 min (2157)																			
2157	CBG 57mg/dl. Dr. aware NPO																			

Disposition: _____

Discharged in care of: self Amb W/C Stret Carried

Discharge instructions given to self Verbalized understanding

Admit: Room #: _____ to Dr. _____ Ready for Room Time: _____

Report called at _____ and given to _____

Transferred to _____ Transfer Verified

Report called at _____ and given to _____

Left without treatment Left Against Medical Advice

Condition at Disposition: Improved Stable Serious Expired

Pain Scale: 0 Pain Location: denies pain

Patient reports that pain is: Improved Unchanged Worse

Disposition Vitals: T 97.7 P 110 R 16 BP 100/71 O2 100%

Disposition Date: 8/23/06 Time: 2057 Nurse: R. Brown

**ORDER PROCEDURE FORM
GENITOURINARY EMERGENCIES**

Oppenish Community Hospital

Name: ANAYA, CHRISTINA

PH#: 5005618

Age: 32 YRS DOB: 06/14/1974

Sex: F

MR#: 0000329427

EDP: CLIPPINGER, MARK S

PGP: HEISEY, KYLE L

Date In: _____

Time: _____

Order Time	Order Sent	By	Religion	Diagnosis
<input checked="" type="checkbox"/> CBC	1919	RFB		Acute Abdominal Series
BMP CMP				KUB
Amylase Lipase				Kidney Ultra Sound
				Testes Ultra Sound
PT/PTT				
Type & Screen or Cross # Units				
<input checked="" type="checkbox"/> UA Urine Culture	1800	HC		EKG
Beta HCG				ABG
				O2 LPM
Misc. Orders				
Previous Medical Records				
Physical Therapy - Eval & Tx				

Weight: _____ Allergies: NKDA

Order Time	Medication / Dosage / Route	VO	Resp	Back	Abdominal	Gen	Other	Improved	Worse	Unchanged
		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Order Time	IV Solution / Added Medication	Start Time	Device	Start Time	Device	Start Time	Device
	<input type="checkbox"/> KVO Device:						
	<input type="checkbox"/> IV Fluids:						

Procedures / Nursing Assistance:

<input type="checkbox"/> Cardiac Monitor Rate _____ Rhythm _____	<input type="checkbox"/> Specimen Collection
<input type="checkbox"/> NIBP Monitor	<input type="checkbox"/> Continuous Bladder Irrigation
<input type="checkbox"/> Pulse Oximetry	<input type="checkbox"/> Peritoneal Dialysis
<input type="checkbox"/> Urinary Catheter Insertion # _____ Fr.	

Discharge Instructions

Physician's Signature: <i>HC Haseln</i>	Initials/Signature:	Initials/Signature:	Initials/Signature:
JARRN:	Physician's Signature: <i>gus</i>		

Rev. 06/14/04

0000067

2-270

Clinical Message

Anaya, Christina Pat ID: 14852 DOB: 6/14/1974 33.5 yr F

[NKA]

MRN: 14852

Home Phone: (509) 985-5659

Work Phone:

Category: Clinical Message

Send To:

Priority: Routine

Copy To:

Received By: Sarah Gott, RN

Received Date: 08/24/2008 11:54 AM

Caller:

Provider: TOPPENISH, FP NURSE

Return Phone:

Messages: Sarah Gott, RN 8/24/2008 11:57:49 AM
received /o from Yak Reg microbiology. Pts blood cultures positive for yeast. Pt was discharged on 8/21/08. Obtained hospital information but discharge summary not available. Information placed on your workstation.

Mark Sauerwein, MD 8/24/2008 2:33:51 PM
please call patient to see how she is,
unless she is currently ill, it is a probable contaminant
I reviewed the case with dr moran who took care of her in the hospital

Mary Sifuentes, LPN 8/24/2008 2:53:59 PM
spoke to christina she said went to er last nite was not feeling well at all was not to empty out her bladder so they cath her she said
feels much better now she is taking abx and has f/u appt on 8/5 not fever just a little tired pt is a diabetic.

Mark Sauerwein, MD 8/24/2008 6:50:40 PM
have her come in next week please , 8/5 is too far out

Sarah Gott, RN 8/25/2008 11:00:27 AM
Will contact.

Mary Sifuentes, LPN 8/25/2008 12:13:29 PM
APPT GIVEN FOR WED 8/30

Entered By: Sarah Gott, RN	8/24/2008 11:57:49 AM
Closed By: Mark Sauerwein, MD	8/25/2008 1:17:39 PM
Approved: Mark Sauerwein, MD	8/25/2008 1:17:00 PM

PATIENT: ANAYA, CHRISTINA
D.#: 05005344
DISCHARGED: 08/21/06

MRN: 00000329427 LOC: TMED-0105-1
DOB: 06/14/1974 AGE: 32 SEX: F
ORDERED BY: JEROME, JEROME

M I C R O B I O L O G Y

SOURCE: Blood Left Arm
ORDER#: 44200226

COLLECTED: 08/20/06 12:20
RECEIVED : 08/20/06 12:49

ANTIBIOTICS AT COLLECTION :

ORDER ENTRY COMMENTS: VOMITING AND DIARRHEA--ADULT (MILD)

..... C O M M E N T S

VOMITING AND DIARRHEA--ADULT (MILD)

Culture Blood

* FINAL 08/26/06 13:54 Site: 0

08/21/06 .

08/24/06 ** Aerobic Bottle: POSITIVE after 3.3 days incubation.
** Patient discharged.

** Report called to Sara RN at Farmworkers Toppenish taking calls
** for Dr.K.Haisey 08/24/2006 11:27 rb/th

08/26/06 ** Anaerobic Bottle: No growth after 5 days.

Organism 01 Candida glabrata (T. glabrata) 08/26/06 13:54 CJL

KEY FOR RESULTS: * - NEW RESULT ** - RESULT WAS MODIFIED AFTER FINAL STATUS SET SITE CODE M-YAKIMA O-TOPPENISH

ATT.PHYS.: MORAN, JOHN
ADM.DATE: 08/20/06

MRN: 00000329427 LOC: TMED-0105-1
PATIENT : ANAYA, CHRISTINA

M I C R O B I O L O G Y

PRINTED 08/27/2006 03:15

Page: 1 of 2

0000031

2-235

CHIEF COMPLAINT: Swelling in feet and legs.

HISTORY OF PRESENT ILLNESS: This is a 32-year-old lady who comes in with increasing pain in her lower extremities and her abdomen as well as her back, increasing swelling in her lower extremities. She had been admitted to Toppenish Community Hospital twice within the last 8 days, treated with intravenous antibiotics and fluids for pyelonephritis. She had done a little better and then went home. In the last 3 days she has had increasing swelling in her lower extremities, increasing weakness and fatigue. She is febrile today and has been febrile intermittently over the past week and a half. She is known to be diabetic, previously diet controlled and now on metformin and glipizide to try to control her blood sugar. She was released from the hospital on ciprofloxacin and has taken about 3 days' worth of outpatient antibiotics at this point in time. She complains of pain to the middle of her back and increasingly so on the right side. She appears ill and very uncomfortable.

PAST MEDICAL HISTORY: Diabetes, not previously treated with insulin and recently placed on oral agents. Recently discovered anemia, thought to be iron deficiency when she was in the hospital in Toppenish within the last week.

PAST SURGICAL HISTORY: Cesarean section about 5 years ago.

SOCIAL HISTORY: Denies the use of alcohol, tobacco or drugs. She lives with her husband who had just come home from a fishing boat near Alaska where he has been working for the past couple of weeks.

MEDICATIONS: Ferrous sulfate; metformin; glipizide; ciprofloxacin.

ALLERGIES: NONE.

REVIEW OF SYSTEMS: HEENT: Denies ear pain, sore throat, sinus pain or drainage. She has not had a headache. **Neurologic:** Otherwise negative. **Psychiatric:** Negative. **Cardiac:** No complaints. **Pulmonary:** Dyspneic with exertion. Otherwise no complaints. No cough or chest congestion. **Gastrointestinal:** Some nausea and nonspecific abdominal pain radiating into her back. No diarrhea. No hematemesis, hematochezia or melena. **Genitourinary:** Pain over her flanks, especially on the right side. No pain or burning with urination. **Extremities:** Moderate diffuse weakness. No numbness or tingling anywhere. **Neurologic:** Nothing else specific.

PHYSICAL EXAMINATION: Vital signs: Blood pressure 99/63, pulse 103, respirations 18, temperature 38.8 degrees Celsius orally. Pain level 8 over 10. Saturation 98% on room air. **General:** Ill, moderately toxic-appearing 32-year-old woman in no respiratory distress, awake, alert and seems to be well oriented. **Skin:** Warm, dry and very pale. **HEENT:** Scalp and face are atraumatic. Tympanic membranes, nasal and oropharyngeal mucosae without acute or obvious abnormalities. Mucous membranes are somewhat dry. **Neck:** Good range of motion without apparent pain. **Chest:** Nontender.

1 of 4

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

EMERGENCY ROOM REPORT

ORIGINAL

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
BILLING #: 25388968
PCP: Kyle Helsey, MD
DOS: 08/29/2006
Michael J. Hauke, MD

0000001

Normal excursion. Nonlabored respirations. **Lungs:** Clear and equal bilaterally with good breath sounds. **Heart:** Regular rate and rhythm, without apparent murmurs, bruits or gallops. **Abdomen:** Bladder is obviously enlarged with evidence of urinary obstruction on physical examination. Mild nonspecific abdominal tenderness on palpation. Normoactive bowel sounds. **Back:** Mild tenderness over the right flank and low back. Otherwise benign. Fair range of motion with mild pain. **Extremities:** Good range of motion. There is 4+ bilateral pedal edema in the feet and going up to the knees. Good distal pulses. Somewhat slowed capillary refill with some bluish discoloration to the feet but good capillary refill and good pulses. **Neurologic:** Seems to be intact. **Rectal:** A rectal evaluation here showed guaiac-negative stool and no gross blood.

LABORATORY EVALUATION: B-type natriuretic peptide is somewhat elevated at 282. INR is elevated at 1.56. PTT at 46.6. Complete blood count shows an elevated white blood cell count of 14,100; hemoglobin 7.5; hematocrit 22.2. Within the last week her hemoglobin at Toppenish Community Hospital was 9.5, so she has dropped 2 gm within a week. A rectal evaluation here showed guaiac-negative stool and no gross blood. Platelet count is 393,000. Differential shows 90% neutrophils on her automated differential. The manual differential shows 67% neutrophils and 22% bands, 8% lymphocytes. A note is made that blood cultures x2 were obtained. Amylase and lipase are normal. Metabolic panel shows a calcium of 7.7, glucose 237, BUN 54, creatinine 3.7, total protein 6.0 and albumin of 1.7. Alkaline phosphatase is 287, sodium 121, CO₂ is very low at 10. Complete blood count and differential show evidence of infection and probably bacterial. Metabolic panel is indicative of acute renal failure, significantly worsened just in the last few days and indicated in part by her peripheral edema. Her glucose is elevated compared to what it has been. Her alkaline phosphatase is elevated for reasons that are unclear. Her CO₂ is significantly low, probably due to some form of nephropathy. Urinalysis shows the following abnormalities: Leukocytes on dipstick are 2+. Total protein is trace. Occult blood is 3+. White blood cells are only 2 to 4 on microscopic, but there is 3+ yeast on the microscopic examination. A culture is ordered and pending. Sedimentation rate is very high at greater than 140. A chest x-ray shows no indications of an infiltrate or other apparent abnormality. Electrocardiogram shows a normal sinus rhythm, heart rate of 95. Normal PR interval, QRS duration and QT interval. Precordial R wave progression is normal. No pathological Q waves are seen. No signs of acute ST or T wave abnormalities. The machine reads a possible chronic pulmonary disease pattern. I think this is an over read. I see no indications of an obvious acute abnormality here.

This patient has numerous and severe worsening problems. She appears acutely ill and requires admission for further evaluation of her problems. At this point in time I cannot obviously justify calling this a urinary tract infection. She is already on ciprofloxacin PO. I spoke with Dr. Richard B. Boyd, on-call for medical admissions, and discussed the case at length with him. At the very least this lady has acute renal failure, uncontrolled diabetes, severe anemia, an elevated D-dimer of unclear significance at this point in time. She does not show signs of respiratory failure. Her sedimentation rate is very high. The elevated D-dimer may indicate a coagulopathy of some sort, especially since her INR and PTT are

2 of 4

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

EMERGENCY ROOM REPORT

ORIGINAL

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
BILLING #: 25388968
PCP: Kyle Helsey, MD
DOS: 08/29/2006
Michael J. Hauke, MD

0000002

3-4

on the rise. Her troponin-I is borderline at 0.06. Her electrocardiogram does not show any signs of acute ischemia. The B-type natriuretic peptide is somewhat elevated at 282, which might potentially

indicate some degree of congestive heart failure but her chest x-ray does not bear out any indications of right heart failure. In addition to this, the reason for her elevated alkaline phosphatase is not clear and exactly where she is losing her bicarbonate is not clear. I am cautious and hesitant about overloading more fluids too rapidly considering the fact that she is retaining fluid and is in renal failure. Dr. Richard B. Boyd and I discussed all of these points. We will admit her to a telemetry bed. He will come and see her, probably consult nephrology and try to figure out where to start with this lady. I am not certain exactly what form of infection process I may be treating here, if any, or if this is all an autoinflammatory problem and potentially something like a glomerulonephritis.

After discussion with Dr. Richard B. Boyd, it was decided to get an ultrasound of her kidneys. Her left kidney is significantly enlarged compared to the right with evidence of mild pyelocaliectasis. The right kidney also has mild pyelocaliectasis, but no frank hydronephrosis is seen on either side. The bladder otherwise appeared grossly normal, but I previously had a catheter placed because of some seeming urinary retention. The patient's bladder had been enlarged on examination and she had a total of some 1300 mL out after catheterization.

DIAGNOSES

1. Acute renal failure.
2. Fluid overload.
3. Electrolyte abnormalities.
4. Severe anemia.

Note is made that I had a type and crossmatch for 3 units initiated and that we initiated the first units of transfusion in the emergency room.

5. Elevated B-type natriuretic peptide.
6. Elevated D-dimer.
7. Elevated sedimentation rate.
8. Febrile illness, etiology unclear.

PLAN: Admission to a telemetry bed to Dr. Richard B. Boyd for further care.

3 of 4

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

EMERGENCY ROOM REPORT

ORIGINAL

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
BILLING #: 25388968
PCP: Kyle Heisey, MD
DOS: 08/29/2006
Michael J. Hauke, MD

0000003

3-5

MJH:brn

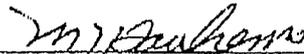
D: 08/29/2006 7:09 P

T: 08/30/2006 9:07 A

000097817

cc: Kyle Heisey, MD

Signature



Michael J. Hauke, MD

4 of 4

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

EMERGENCY ROOM REPORT

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0000004

CERTIFICATE OF SERVICE

I certify under penalty of perjury of the laws of the State of Washington that on February 6, 2013, I caused a true and correct copy of the foregoing Response to Petition for Review to be delivered U.S. Mail, with postage fully affixed and/or hand delivery as follows:

Richard R. Johnson
DELORIE-JOHNSON, P.L.L.C.
917 Triple Crown Way Suite 200
Yakima, Washington 98908
(Hand Delivery)

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Benjamin Gould
Isaac Ruiz
Harry Williams, IV
KELLER-ROHRBACK, L.L.P.
1201 Third Avenue Suite 3200
Seattle, Washington 98101
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Colette Franklin
Secretary to Megan K. Murphy