KAISER PERMANENTE

LOCATION	
SUNSET	
LAST NAME, FIRST: SCHNEIDER, DALE	MED. REC. NO.: 200 21 46 — 10/2/86
PHYSICIAN OR SURGEON: DAVID S. ROSENFELD, M.D.	ASSISTANT OR REFERRING PHYSICIAN: REF: MORRIS E. FREEDLAND, M.D., IMP. CC: JOHN ROWLAND, M.D.

PATIENT PROFILE: 29-year-old right-handed Caucasian male referred by Dr. Freedland of Imperial Clinic for evaluation of sleep disorder.

Historian patient; outpatient Kaiser chart reviewed.

HISTORY OF PRESENT ILLNESS: This was the first Kaiser Sunset Neurology Clinic-Sleep Disorders consultation for this patient. The patient's chief complaint is that of excessive daytime somnolence. He has also had witnessed apnea by his wife with whom he sleeps in the same bed. He has had a three hour daytime nap polysomnogram which demonstrated brief episodes of mixed and obstructive sleep apnea of brief duration. This study had very poor ill-sustained sleep and hence an eight hour study was requested. Patient had this study approximately one week ago and the results are pending.

The patient states that he has been a loud snorer for several years. He also feels that his daytime somnolence has also been present for a significant period. The patient states that he is oftentimes irritable and has difficulty concentrating at work because of his afternoon sleepiness. He oftentimes goes to bed at 8 to 9 in the evening and wakes up at approximately 5 to 6 AM in the morning. He states that oftentimes, no matter how much he sleeps, he is not particularly refreshed. Patient prefers to sleep on his back. He himself realizes that sleeping on his back makes both his snoring and apnea worse. The apnea, according to the wife, as well as snoring, have been worsened in the supine position.

The patient also feels that he is somewhat depressed during the daytime which he attributes to the possible apnea.

The history is negative with regard to significant paroxysmal sleep attacks or cataplexy.

The patient does not abuse either stimulant or sedative hypnotic medications. He states that "I have to drink two very strong cups of coffee to get going in the morning." There is no history of illicit drug abuse.

The patient's past medical history is rather unremarkable. He is not known to suffer from any significant chronic medical disease such as stroke, myocardial infarction, diabetes mellitus or hypertension.

The patient has never had a tonsillectomy. Surgery has been limited to inguinal hernia repair as well as bilateral popliteal cyst repair in childhood.

The patient has put on a modest amount of additional weight in the last year. His weight is now approximately 185 pounds and he is 5'7" tall.

Continued/ttg

TYPE OF REPORT

OUTPATIENT NEUROLOGY CLINIC-SLEEP DISORDERS CONSULTATION

KAISER PERMANENTE

LOCATION	
SUNSET	
LAST NAME, FIRST: SCHNEIDER, DALE	MED. REC. NO.: 200 21 46 — 10/2/86
PHYSICIAN OR SURGEON: DAVID S. ROSENFELD, M.D.	ASSISTANT OR REFERRING PHYSICIAN: REF: MORRIS E. FREEDLAND, M.D., IMP. CC: JOHN ROWLAND, M.D., ENT

The patient denies any symptoms of nasal congestion or sinusitis. He has never suffered a nasal fracture.

PHYSICAL EXAMINATION: General physical examination showed a mildly obese Caucasian male in no apparent distress and no lethargy was noted. Blood pressure 158/90 recorded in the right upper extremity in the sitting position. Respirations 16 and regular. Neck; patient had a thick neck without palpable adenopathy, thyromegaly, bruits or thrills. Mouth; no evidence of definite oropharyngeal compromise. A brief screening neurological examination revealed normal mental status, coordination, motor and gait.

DIAGNOSTIC FORMULATION: The patient's history is entirely compatible with that of obstructive sleep apnea. I suspect that the majority of his symptoms, including his excessive daytime somnolence, daytime irritability, depression, as well as possible hypertension, are related to obstructive sleep apnea. I doubt that the patient has some other sleep disorders such as narcolepsy.

PLAN: (1) Patient was told to avoid sleeping on his back. Sleeping on his side is the preferable position. (2) Patient should attempt losing approximately 15 to 20 pounds. (3) An ENT consultation will be done with Dr. John Rowland of ENT to consider the possibility of UPP surgery. (4) Consideration will not be given at the present time to possible pharmacological therapy or mechanical therapy with CPAP. (5) The patient will be followed up by myself in six weeks time. He was instructed to contact me before then should he have any questions or problems. I personally believe that UPP surgery is perhaps the best single therapy for this gentleman.

The above diagnostic and therapeutic considerations were explained in some detail to the patient who appeared to understand and accept same.

DAVID S. ROSENFELD, M.D.
Department of Neurology

DSR:ttg
d 10/03/86
t 10/07/86

TYPE OF REPORT

OUTPATIENT NEUROLOGY CLINIC-SLEEP DISORDERS CONSULTATION - PAGE TWO

KAISER PERMANENTE

LOCATION	
SUNSET	
LAST NAME, FIRST: SCHNEIDER, DALE	MED. REC. NO.: 313 29 64
PHYSICIAN OR SURGEON: JOHN ROWLAND, M.D.	ASSISTANT OR REFERRING PHYSICIAN:

1-13-87

PREOPERATIVE DIAGNOSIS: OBSTRUCTIVE SLEEP APNEA

POSTOPERATIVE DIAGNOSIS: SAME

OPERATION: TONSILLECTOMY AND UVULOPALATOPLASTY

PROCEDURE: The patient was brought to the operating room, placed supine on the operating table, and given general endotracheal anesthetic without incident. The table was turned and a shoulder roll placed. The patient was then sterilely toweled in the usual manner. A Crowe-Davis mouth gag was used to expose the tonsils and the palate. This was suspended from a Mayo stand. The left tonsil was removed first. The tonsil was grasped with Allis clamp and an incision made in the anterior tonsillar pillar using a #12 blade. The posterior pillar was also incised with a #12 blade. Using sharp and blunt dissection, the tonsil was removed from the tonsillar bed down to the inferior pole. The inferior pole was removed with a tonsillar snare. A tonsillar pack was placed to control bleeding. The right tonsil was then removed in exactly the same manner. The tonsil was grasped with an Allis clamp and pulled medially. Using a #12 blade, the anterior tonsillar mucosa was incised. Using sharp and blunt dissection including using Metzenbaum scissors, the tonsil was removed down to the inferior pole. The inferior pole was removed with a tonsillar snare. This side was also packed. Hemostasis was then achieved in the tonsillar beds using Bovie cautery. The tonsillar packs were removed.

The palate was evaluated. The uvula was folded forward. The area where the tonsil had creased was marked. There was also a red area on the palate which easily showed a demarcated area. Using a #15 blade, this portion of the palate was removed down to the tonsillar beds on each side. Hemostasis was achieved with Bovie cautery. The tonsillar pillar mucosa was then examined and measured in order to remove the folds across the posterior pharyngeal wall. Millimeters of mucosa were excised on each side. These areas were then carefully sutured using 4-0 Vicryl suture. The sides were carefully measured during the suturing process in order to ensure that the mucosa was stretched correctly.

A nasal airway was placed at the end of the case and the patient extubated without difficulty. The patient was sent to the recovery room in good condition. Final sponge and needle counts were correct. Estimated blood loss was 150 cc.

JOHN ROWLAND, M.D.
Department of Otorhinolaryngology

JR:ttm
d 01/13/87
t 01/19/87

TYPE OF REPORT

OPERATIVE REPORT

12-5361 (8-83)

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