Dr. Randy MacKinnon Professional Corporation

RANDY MACKINNON, B.Sc., M.D., C.C.F.P., F.C.F.P
FAMILY PHYSICIAN, QUEEN STREET MEDICAL CENTRE (EXTENSION)
418 Queen Street, Suite 3, Charlottetown, PE C1A 4E7
902-566-1229

June 16, 2023

RE: Kevin Gallant
DOB: 03-10-1976

Dear Ms. Seymour,

This is in response to your letter dated June 14, 2023.

Please find enclosed a copy of Mr. Kevin Gallant's chart from May 27, 2022 to present, as requested.

If you have any further questions, please call (902)566-1229.

Yours Sincerely,

Randy MacKinnon, M.D., C.C.F.P., F.C.F.P.

RM/ep

DATE / VITAL SIGNS SUBJECTIVE OBJECTIVE ASSESSMENT PLANS

B.P. April 11/22 Percocet = 1 q 2 days
H W B
T T M
I
P T °
Seems his usual self.
c/o some numbness ↓ 4E'S.
insurance Co is asking re: 3rd party consult → OK
still has some LBP + numbness R > L foot. There is nothing surgical on the CT.
I suggest he cont. massage + P.T. + core strengthening.

Rx Revised RTW May 24

May 24/22 Rev
the massage Rx was helping, 1x/wk
since it was stopped, it is back to using percocet i tab bid ☹!
to have medical assessment by Dr Koshi
Jun 13th.

Rx Revised RTW Aug 22.
Refill Percocet i bid prn (60)
6/52

B.P.
H W B
T T M
I
P T °

May 26/22 Vit B12 1mL IM Ⓡ deltoid ——— MBS LPN

June 28/22 Rx refill ①

July 7/22. Walk in ~~Chest pain~~ several times - been to emerg several times - heart burn - tired ++
cardiac w/u ⊖ x several times ? Collum.
Sx's suggestive of GERD, ↑ Sx's
but VBAD ⊖
tender epigastrium

Rx Zantac 150² (180)
pt to reschedule

OFFICE VISITS Kevin Gallant

NAME [illegible]	MARITAL STATUS S M W D SEP	INSURANCE #	
ADDRESS		PHONE (H)	(O)
OCCUPATION / EMPLOYER		DATE OF BIRTH	AGE
MEDICATIONS			
DRUG ALLERGIES		DIAGNOSIS	REFERRED BY

Formedic

PAGE # CHART #

DATE / VITAL SIGNS | SUBJECTIVE | OBJECTIVE | ASSESSMENT | PLANS

B.P. Aug 8/22
HT WT BMI
P T °

~~40~~ 45 yo

Chrons

↳ waiting to see GI Sept

5 years remission

COVID — Home test
July 18th 5/7

Significant symptoms
Cough - hemoptysis. Pain [?]
Fatigue Sore throat
Vomit Diarrhea
muscle aches
→ ø [illegible]

14 lb lost

Symptoms continue. ø Nosebleeds

Vaccines x2

Ae = Ae
tight cough
SpO2 97% HR 110 · RR 22.

Postcard [illegible]
Azithro 500mg 5/7
CXR
BW. See in AM
ED if worse

[signature]

B.P.
HT WT BMI
P T °

Fasting bloods as per order + Vit B12 inj 1cc IM (L) Delt [illegible]

Aug 9/22. Appears well
?-Δ in symptoms.
↓ hemoptysis.
Continue plan. F/u Labs.
See next week
↳ ?CT.

[signature]

CXR - ø A/A
?congestion
bronchial

Bronchitis
?[illegible]

DATE / VITAL SIGNS | SUBJECTIVE | OBJECTIVE | ASSESSMENT | PLANS

Formedic

B.P. aug 15/22
HT WT BMI
P T °

151/109
HR 110.

SOB. cough
Hemoptysis ∅
[illegible]
chest pain
SOB [illegible] | [illegible]

chest clear
Labs reviewed

Query PE → VQ Scan?
Spoke c ED Tuesday
[illegible] present for assess

Aug 29/22. Follow-up. ∅ hemoptysis > 2wks
Requesting refill Percocet, Vit B_{12}.
↑ pain 2° to having work more.
this is primarily MSK pain.

OK, refill Percocet
[illegible] B_{12}
I cautioned pt. re: ongoing use.

B.P.
HT WT BMI

Sept 7/22. long discussion re: Alex (22) → learning disability + sig. anxiety.
I provided support + answered all his questions.

* disappointed with his visit to Orkoshi
all he did O/E was ✓ my knee reflexes + palpated the ant. shoulder, nil else!

OFFICE VISITS

NAME Kevin Gulhart	MARITAL STATUS S M W D SEP	INSURANCE #	
ADDRESS		PHONE (H)	(O)
OCCUPATION / EMPLOYER		DATE OF BIRTH	AGE
MEDICATIONS			
DRUG ALLERGIES		DIAGNOSIS	REFERRED BY

PAGE # CHART #

DATE / VITAL SIGNS | SUBJECTIVE | OBJECTIVE | ASSESSMENT | PLANS

B.P. HT WT BMI P T °

Sept 6/22 long discussion
support provide re: dysability

Forms filled out re: legal trouble and insurance
needs PT/OT/ massage.
Pain - he does not like percocet but feels stuck

? Dr F.tzpatrick re: the plan. pain. in short term
MR radicular pain Ⓡ side
further consultance injury
F/u in short term if needing further
support

B.P. HT WT BMI P T °

Oct. 3/22 Rev
⊕ answered further questions from the lawyers office.

Oct 2922 Vit B_{12} 1000mcg/mL 1mL IM Ⓡ delt — LO, LPN

Nov 9/22 Rx refill ①. Percocet i bid-qid prn (60)
liq N_2 Ⓡ thumb. c Wart.
Seen by a specialist (by Zoom) from
Vancouver → report pending

Nov. 16/22. Walk in - c/o Ⓡ eye ? infection - red, swollen, sore x 4 days.
(conj vs stye inf, medial Ⓡ lid)
(1) Fucithalmic i bid x10d
warm compresses
Clavulin 875 bid x10d

OBJECTIVE ASSESSMENT PLANS

B.P. H T W T B M I P T °

Nov. 24/22 Review report from Dr. Post
As per his recommendations ① MRI L-spine + EMG's
② MRI/MRA brain.
1) C: Heather Williams.

Jan 3/23 c/o abd pain x 10 days - to emerg twice
T 37.1 °C
143/84.
bowels moving, passing gas, ∅ vomiting
in the past, Pred has worked well. ⊕ mucus + pain with BM's
abd is soft, some tenderness Ⓝ BS's.
⊕ pressures at home to take his wife home to Mexico → she is to have surgery there.
P) Pred 50 x 10 d, then ↓ by 5 mg q 1 wk until finished
fecal calprotectin
2

March 7/23

B.P. H T W T B M I P T °

Ongoing Ⓛ abd pain
↓ appetite, N, weak, tired.
lost 18 lbs since Jan!
liq BM's, 6-7 x 1d, burns.
⊕ connected to GI clinic to have repeat scopes
on Pantoloc 40 bid
the pred took all the pain away
O) tender Ⓛ abd
soft BS ⊕ (-ext) tender
P) • Bloods.
Pred 50.00 x 7d then 10.00
1/12

Mar 23/23 Left sided abdo pain since dec 25/22. Had a scope and nothing was found. was told to see fam. doc. as states has nothing to do w̄ Crohn's. Pt. ?s if this could be a S/E pantoloc as it started @ the same time.
soft
Ⓝ BS's
⊕ mass
(-x) area of pain
sharp, burning
(P) d/c Pantoloc
Zantac 150 2.
To have GI scope
await reports
2

PROGRESS NOTES

PAGE #: CHART #:

NAME kevin Gallant   MARITAL STATUS S M W D SEP   DATE OF BIRTH   AGE

DIAGNOSIS

Rx   DRUG ALLERGIES

DATE / VITAL SIGNS	SUBJECTIVE / OBJECTIVE / ASSESSMENT / PLANS
B.P. apr 20/23 HT WT BMI P T	review test results from scope saw NP at dr. khan office, she said possible umbilical hernia. Been sleeping upright in chair, hurts to cough, sneeze. ++ tender ⊖ evidence for infn A) no hernia no other P) CT.
may 2/23	Rx refills for zantac x B_{12} still having unbearable abdominal pain. See bloods (N). on CT, there is no obvious hernia Dr Gaswell feels that much of the pain is 2° to adhesive disease. He will not operate He was given Percocet - helps but no a long term option. P) Tramadol 50 1-2 qid prn (100)
B.P. HT WT BMI P T	

QUEEN ELIZABETH HOSPITAL
PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY
Date of birth: 03-Oct-1976
Accession: 4704886
Exam: (QEH) CTABDPELVI - CT ABDOMEN,PELVIS WITHOUT CONTRAST -A
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2023-Apr-20

Requesting Provider: KAUL, THOMAS, MD
Attending Provider: MACKINNON, RANDY J MD

Extra Report Sent To:

FINAL

Findings: Reference is made to unenhanced CT of the abdomen and

pelvis dated December 29, 2022. Patient with history of allergy to intravenous contrast. Patient refused oral contrast. Due to lack of oral and intravenous contrast, the scan has reduced diagnostic sensitivity.

Previous right hemicolectomy redemonstrated. Satisfactory appearances of the ileocolic anastomosis. No suggestion of recurrent inflammatory bowel disease in the neoterminal ileum. Otherwise grossly unremarkable remnant colon.

A small bowel anastomosis is noted in the central abdomen anteriorly. Multiple small bowel loops are in direct apposition with the anterior abdominal wall, particularly in the vicinity of the umbilicus similar to previous. No significant umbilical hernia appreciated. No evidence of obstruction, perforation or collection, no ascites. Fat planes of the abdomen and pelvis are clear.

The liver has slightly low attenuation throughout, no focal lesion is seen within the liver, previous cholecystectomy appears to have been performed, no biliary dilation. The spleen is not enlarged. Grossly unremarkable pancreas, adrenals and kidneys, no hydronephrosis on either side.

No para-aortic, mesenteric, iliac or inguinal adenopathy. The prostate is not enlarged.

Included lung bases are clear. Bone windows do not show an aggressive lesion. No evidence of sacroiliitis.

Impression: There is evidence of extensive adhesions with direct apposition of multiple small bowel loops with the anterior abdominal wall - particularly deep to the umbilicus. No evidence of obstruction. Satisfactory appearances of the right hemicolectomy. No CT evidence of acute inflammatory bowel disease. No significant ventral hernia appreciated.

RECEIVED
JUN 2 0 2023

INVOICE
#2104

Patient: Kevin H. Gallant
DOB: 03-10-1976

Billed to: MacGillivray Injury & Insurance Law
5777 West St.
Halifax, NS B3K 1H9

Item/Service	Fee
Chart Request	$100
Date: June 16, 2023	**Total: 100.00**

Signature: _____

Date exam taken: 2023-Apr-20
Transcriptionist date: 2023-Apr-20
Finalized date: 2023-Apr-20

Interpretating Radiologist: HELPERT, CLAUDIUS RAD
Transcriptionist : User, Interface
Radiologist(s) sign off: HELPERT, CLAUDIUS

MACKINNON, RANDY J, MD
Queen Street Medical Centre

Q74-01
2023-Apr-21 8:15AM

QUEEN ELIZABETH HOSPITAL
PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY
Date of birth: 03-Oct-1976
Accession: 4704883
Exam: (QEH) DABD2V - DIAGNOSTIC ABDOMEN 2 VIEWS -A
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2023-Apr-20

Requesting Provider: FOLEY, MARK G, MD
Extra Report Sent To: MACKINNON, RANDY MD
Attending Provider: UNKNOWN PHYSICIAN, PHYSICIAN MD

FINAL

Abdominal radiographs

History: Crohn's with numerous surgeries and recurrent pain. Rule out small bowel obstruction.

Findings:

There is gas throughout the small bowel and colon to the level of the rectum. There is no pneumatosis or pneumoperitoneum. Short air-fluid levels are noted on the upright view.

The patient has subsequently undergone further assessment with CT abdomen and pelvis. Please refer to accession 4704886.

Date exam taken: 2023-Apr-20
Transcriptionist date: 2023-Apr-21
Finalized date: 2023-Apr-21

Interpretating Radiologist: KILCUP, MICHAEL RAD
Transcriptionist : User, Interface
Radiologist(s) sign off: KILCUP, MICHAEL

MACKINNON, RANDY J, MD
Queen Street Medical Centre

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 23-110-01955

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Rafiq,Tahir,MD

Copy For: MacKinnon,Randy J,MD

Location: Queen Elizabeth Hospital
Emerg QEH

Biochemistry

Routine Biochemistry

Collected Date	2023/Apr/20		
Collected Time	15:28		
Procedure		Reference Interval	Units
Sodium Level	140	[135-145]	mmol/L
Potassium Level	4.3	[3.5-5.1]	mmol/L
Chloride	105	[98-107]	mmol/L
Total CO2	26	[21-30]	mmol/L
Anion Gap	9	[4-12]	mmol/L
Glucose Random	5.9	[4.2-11.0]	mmol/L
Creatinine	95	[63-106]	umol/L
eGFR (CKD-EPI)	83 ^1	[>=60]	mL/min/1.73m^2
Total Protein	67	[64-83]	g/L
Albumin Lvl	40	[35-50]	g/L
Bilirubin Total	9.7	[<=21.0]	umol/L
ALT	34	[5-56]	mU/mL
AST	23	[<=50]	mU/mL
GGT	16	[<=50]	mU/mL
Alkaline Phosphatase	71	[40-120]	mU/mL
Lipase Level	99	[23-300]	mU/mL

Interpretive Data
^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 23-110-01955

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Rafiq,Tahir,MD

Copy For: MacKinnon,Randy J,MD

Location: Queen Elizabeth Hospital
Emerg QEH

Immunology

Immunology

Collected Date	2023/Apr/20		
Collected Time	15:28		
Procedure		Reference Interval	Units
CRP	0.8 ^2	[<=8.0]	mg/L

Interpretive Data
^2: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 23-110-01955

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Rafiq,Tahir,MD

Copy For: MacKinnon,Randy J,MD

Location: Queen Elizabeth Hospital
Emerg QEH

Hematology

CBC

Collected Date	2023/Apr/20		
Collected Time	15:28		
Procedure		Reference Interval	Units
WBC	5.30	[4.50-11.00]	x10^9/L
Hgb	149	[130-170]	g/L
Platelet	359	[140-400]	x10^9/L
RBC	4.91	[4.50-6.20]	x10^12/L
Hct	0.443	[0.420-0.520]	L/L
MCV	90.1	[80.0-100.0]	fl
MCH	30.3	[25.0-35.0]	pg
MCHC	336	[310-370]	g/L
RDW	13.2	[11.0-17.0]	%
Neut #	3.50	[1.50-8.50]	x10^9/L
Lymph #	**1.20** L	[1.50-4.00]	x10^9/L
Mono #	0.50	[0.00-1.00]	x10^9/L
Eos #	0.10	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc

Queen Elizabeth Hospital
60 Riverside Drive PO Box 6600
Charlottetown, PE C1A 8T5

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976

Encounter Number: 08634799
Location: Endoscopy QEH

DOB: 1976/Oct/03 **Age:** 46 years **Sex:** Male
Address: 106-55 CHESTNUT STREET
CHARLOTTETOWN, PE C1A1Z7

Admit Date: 2023/Mar/17
Discharge Date: 2023/Mar/17

Phone: 9022181335

Document Copy For: MacKinnon,Randy J,MD

Physician Surgical Documentation

Document Status: Auth (Verified)
Document Type: Ambulatory Procedure Record
Event Date: 2023/Mar/17 17:24
Performed By: Khan,Rajal,MD (2023/Mar/20 15:15)

Ambulatory Procedure Record
PROCEDURE DATE: 2023/Mar/17
PRIMARY CARE PROVIDER: Randy J. MacKinnon MD
PROCEDURE PERFORMED: Gastroscopy with biopsies. Colonoscopy to the neoterminal ileum with biopsies.

PREPROCEDURE DIAGNOSIS: Crohn's disease. To assess for active disease. Reflux esophagitis on last gastroscopy. To document healing on PPI.

POSTPROCEDURE DIAGNOSIS: Persistent esophagitis as described. Relatively normal colonoscopy to the neoterminal ileum as described.

CLINICAL NOTE: Kevin is a 46-year-old gentleman with Crohn's disease. He also has reflux esophagitis. I have seen him last for gastroscopy and colonoscopy in September. He saw Laurie Thomas, IBD nurse practitioner on several occasions since that time. He has been having worsening symptoms over the past several months. His fecal calprotectin was actually very reassuring. However, he complains of persistent symptoms despite the fact that there was not much disease on his colonoscopy back in September. He now complains of black stools as well as a lot of abdominal pain. He has also had symptoms in his legs as well as fevers and chills. He was urged to go to the Emergency Department by Laurie but he did not present to the Emergency Department. Instead, it seems that he was given steroids by his family physician despite the fact that he had infectious-type symptoms with a fever. He actually asked Laurie for steroids and she had not prescribed them him given the infectious symptoms, I am not sure what changed when he was prescribed the Prednisone.

In any case, I am really not convinced that his symptoms are related to active Crohn's disease. For this reason, we decided to repeat the colonoscopy to see if there is any difference between the colonoscopy in September and now given that he has worsening symptoms and new black stools. Again, his fecal calprotectin was very reassuring.

I discussed the gastroscopy and colonoscopy procedures including the risks of bleeding and perforation again today with Kevin. He understood the procedures and the risks and decided to proceed with the gastroscopy and colonoscopy. We have obtained informed consent.

PROCEDURE: The patient was transferred to the procedure area and placed in the left lateral decubitus position. He was placed on continuous blood pressure, heart rate and oxygen saturation monitors. He was administered intravenous sedation with a total of 8 mg of Midazolam and 200 mcg of Fentanyl, which were given in a gradual fashion. We began with the gastroscopy. A bite block was placed.

The gastroscope was introduced from the mouth and into the esophagus. The esophagus appeared normal in the proximal and mid portions. In the distal esophagus there was persistent esophagitis. I would still call it LA classification B. There is a small hiatus

hernia. It is difficult to assess the Z-line given that there is inflammation here. I think that the esophagitis may be slightly improved from previously, but has certainly not healed completely.

I advanced the scope into the stomach. The body of the stomach appears normal as does the antrum. Between the antrum and the body, there was a lesion that appeared to be a submucosal lesion. It does not appear worrisome. I took some biopsies of this today, but I do not think they are going to show anything as I think it is a submucosal lesion. I did not take any biopsies from the antrum and the body as we have taken these before. In the antrum, I retroflexed the scope. There is a small hiatus hernia. There are no other abnormalities here.

I straightened the scope and advanced it into the duodenum. The duodenal bulb appeared normal. In the second portion of the duodenum there was some very mild erythema. The third portion of the duodenum appeared normal. I decided to take some biopsies from the duodenum to rule out any pathology here given the erythema. He did have mild duodenitis in the past and this is likely related to the same, but we took some biopsies today anyway.

I withdrew the scope completely from the patient. The patient tolerated the procedure reasonably well.

We then repositioned the patient for colonoscopy. Rectal examination was performed and this was normal. There was no perianal disease.

The colonoscope was introduced from the anus into the rectum. It was advanced through the rectum, sigmoid colon, descending colon, transverse colon, and into the ascending colon remnant. Here, I came to the anastomosis with the small bowel. The anastomosis itself actually appears very healthy. It appears very similar to before. There are two small ulcerations in the area of the anastomosis, but the anastomosis was widely patent and I was able to pass the scope into the neoterminal ileum with no difficulty at all. The neoterminal ileum was intubated for a distance of about 10 cm. It all appears completely normal. There were no signs of inflammation here. I did take multiple biopsies from the neoterminal ileum. Again, the anastomosis has some very minor changes with two small aphthous ulcers here, but it is very patent. The changes here are very mild.

I withdrew the scope back into the colonic side of the anastomosis. The Boston bowel preparation score for today's examination was 5. From the cecum, I slowly withdrew the scope and carefully examined the mucosa. There are no signs of Crohn's disease anywhere in the colon. I did take multiple biopsies from throughout the colon, but the appearance is completely normal.

I withdrew the scope completely from the patient. The patient tolerated the procedure quite poorly. The withdrawal time was 14 minutes.

IMPRESSION AND PLAN: Again, there is really not much in the way of active disease here. It really looks about the same as last time. His fecal calprotectin was also reassuring. I really cannot blame Kevin's symptoms on active Crohn's disease. He really does not have any evidence of active Crohn's disease. His fecal calprotectin was also reassuring. I do wonder whether some of his symptoms may be functional in nature. Laurie has discussed this with him in the past as well. Given the fact that his preparation was less than ideal today and the fact that he did take the whole preparation, I wonder whether some of his symptoms may be in keeping with constipation. This can certainly cause abdominal pain and dark stools. He should make sure he is drinking lots of water between 2 and 3 liters per day and slowly increase his fiber up to 25 to 30 g per day. There is not much active Crohn's disease, so I do not think it will be a problem for him to slowly increase his fiber. He should do this.

Of course, as he has been having fevers and other symptoms, then this is likely not functional. If he truly had fevers I think he should be worked up for other causes of his symptoms. He did also describe leg symptoms at one point as well as fevers. I really cannot blame this on his GI tract. I will leave it up to his primary care team to work him up for other causes of these symptoms. Again, he really does not have much in the way of Crohn's disease. I do not think we can blame any of his symptoms including abdominal pain on Crohn's disease. If they are not felt to be due to functional GI disease, then I would leave it up to his primary care provider to work

him up for other causes. We will see him back in the office to go over the biopsies, but I am not sure they will look good as things looked really good.

There may be some advantage to treating Kevin to prevent complications from his disease in the future. However, I really do not think that treating him at this point is going to make much difference to his symptoms and I want that to be very clear.

As far as the esophagitis this is persistent. His PPI was increased to twice daily by Laurie. He should continue on twice daily PPI therapy. He should avoid any NSAIDs. We will book him for repeat gastroscopy again in 3 months after taking the PPI twice daily for 3 months to document healing of the esophagitis. In the meantime, he will follow up with Laurie regarding the biopsies from today and the overall situation.

Rajal Khan, MD
Copies To: Randy J. MacKinnon, MD
Laurie A. Thomas, NP

DD: 2023/Mar/17 17:24:27
DT: 2023/Mar/20 15:14:00
T: vlg
Job: 7673467/13250087

Electronically Authenticated By: Khan, Rajal, MD
Date and Time: 09-Apr-2023 11:28 AM

12th April 2023

Dr. Khan - Polyclinic
199 Grafton St.
Suite 103
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email: kcgallant@hotmail.com
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin was seen for consultation 2023-04-12

Dear Dr. MacKinnon,

I saw your patient, Kevin Gallant, in the office today in follow-up for his Crohn's disease.

As you know, Kevin has been complaining of vague abdominal pain for the past several months. His blood work has been unremarkable, his CT scan has been unremarkable, and bidirectional endoscopy in September and March were unremarkable. His most recent EGD showed some esophagitis so Dr. Khan had recommended continuing with pantoprazole 40 mg daily to twice daily and repeating the EGD in 3 months.

Kevin tells me he is actually stopped taking his pantoprazole 2 weeks ago. He felt this was contributing to his ongoing abdominal pain. He says within 4 to 5 days of stopping pantoprazole he noted improvement in his symptoms. He says he is having less pain, less bloating, and less abdominal swelling. He does tell me that he continues to have pain just left of his umbilicus when he eats. He also says that his pain is worse with walking and laying in a prone position.

He is having 3-4 liquid bowel movements daily with occasional rectal bleeding and mucus. He is not having stool accidents or nocturnal bowel movements. He has some urgency. He has no nausea, vomiting, or perianal symptoms. He has no fevers, chills, or night sweats. His weight is stable and his diet is normal.

Physical exam: Kevin appears well and in no acute distress. He is not pale or jaundiced. His abdomen is soft and he has tenderness just just to the left of his umbilicus. I could not palpate any abnormality today. There is no obvious hernia. Bowel sounds are present and there is no

12th April 2023

Dr. Khan - Polyclinic
199 Grafton St.
Suite 103
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

hepatosplenomegaly.

The patient was diagnosed with: Crohn'S Disease (Disorder)

Impression plan: Kevin is a 46-year-old man who was diagnosed with Crohn's disease around 2000. He said multiple surgeries for this has not been on medical therapy for more than 7 years.

He is having ongoing issues with vague abdominal pain that he feels have improved somewhat since stopping his pantoprazole. He says he is drinking a special tea made note of tree bark that helps his reflux. He also takes Zantac every 2 to 3 days.

I explained to Kevin that his Crohn's disease is well controlled. He had an unremarkable CT scan, a reassuring fecal calprotectin, no elevation in inflammatory markers on blood work, and unremarkable bidirectional endoscopies in March and September.

I wonder if his abdominal pain is related to something like hernia although I cannot palpate any abnormality today. I have asked him to follow-up with you to investigate causes for his abdominal pain as I do not feel this is related to inflammatory bowel disease.

I have recommended he go to the emergency department if he is having severe abdominal pain.

I have given him a requisition in a container to repeat his fecal calprotectin in September. We will plan for follow-up visit in September as well.

He knows to return to the office at any time if he has a change in his symptoms

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

ANATOMIC PATHOLOGY REPORT

Provincial Laboratory Services - Health PEI

Queen Elizabeth Hospital
60 Riverside Drive
Charlottetown, PE C1A 8T5
Phone: (902) 894-2300 Fax: (902) 894-2385

Prince County Hospital
65 Roy Boates Avenue
Summerside, PE C1N 6M8
Phone: (902) 438-4280 Fax: (902) 438-4281

Patient: GALLANT, KEVIN HENRY **Lab No: QH-23-02686**
MRN: 000825976
DOB: 1976/Oct/03 **Age: 46 years** **Sex: Male**

Ordering Physician: Khan,Rajal,MD **Location: Queen Elizabeth Hospital**

Primary Provider: MacKinnon,Randy J,MD **Copy For: MacKinnon,Randy J,MD**
Additional Copies:

Surgical Pathology Report

Collected Date:	Received Date:	Accession Number:	Pathologist:
2023/Mar/17 14:04	2023/Mar/17 14:04	QH-23-02686	Shogan,Ahmad,MD

Surgical Pathology Final Report – 2023/Mar/24 11:17

Clinical Summary

Hx of Crohn's Dz + reflux esophagitis. Increased symptoms of IBD + to check for __ at esophagitis on PPI. A) R/O Celiac Dz. B) R/O Adenoma. C) R/O IBD. D) R/O IBD, R/O dysplasia.

Diagnosis

A Duodenum, Endoscopic Biopsy
- No pathologic changes.

B Gastric Submucosa, Endoscopic Biopsy
- Focal crypt hyperplasia and mild superficial chronic inflammation.
- Negative for intestinal metaplasia, atrophy and H. pylori bacteria.
- See comment.

C Neo Terminal Ileum, Endoscopic Biopsy
- No pathologic changes.

D Colon, Random, Endoscopic Biopsy
- No pathologic changes.

Gross Description

A) The specimen is labelled "Kevin Gallant" and "duodenum" and consists of three pieces of tissue measuring 2 to 5 mm. The specimen is entirely submitted in cassette A1.

B) The specimen is labelled "Kevin Gallant" and "gastric submucosa lesion" and consists of two pieces of tissue each measuring 3 mm. The specimen is entirely submitted in cassette B1.

C) The specimen is labelled "Kevin Gallant" and "neo terminal ileum" and consists of four pieces of tissue measuring 3 to 4 mm. The specimen is entirely submitted in cassette C1.

D) The specimen is labelled "Kevin Gallant" and "random colon" and consists of multiple pieces of tissue measuring 1 to 4 mm. The specimen is entirely submitted in cassette D1 and D2.

FF /KDP

Surgical Pathology Report

Collected Date:	Received Date:	Accession Number:	Pathologist:
2023/Mar/17 14:04	2023/Mar/17 14:04	QH-23-02686	Shogan,Ahmad,MD

Comment

The changes in biopsy B. could be suggestive of reactive gastropathy or could be reactive changes next to an ulcer site. Clinical and endoscopic correlation is indicated.

***

Electronic Signature

Ahmad Shogan, MD, FRCPC

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: MacKinnon,Randy J,MD
Copy For: **MacKinnon,Randy J,MD**

Lab No: 23-066-01431

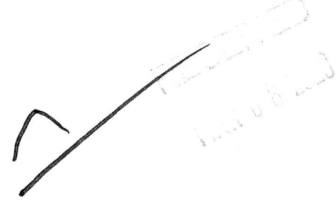
Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD
Khan,Rajal,MD

Biochemistry

Routine Biochemistry

Collected Date / Collected Time / Procedure	2023/Mar/07 09:35	Reference Interval	Units
Sodium Level	141	[135-145]	mmol/L
Potassium Level	4.1	[3.5-5.1]	mmol/L
Chloride	107	[98-107]	mmol/L
Calcium Level Total	2.25	[2.10-2.60]	mmol/L
Glucose Random	6.0	[4.2-11.0]	mmol/L
Creatinine	72	[63-106]	umol/L
eGFR (CKD-EPI)	106 ^1	[>=60]	mL/min/1.73m^2
Total Protein	68	[64-83]	g/L
Albumin Lvl	38	[35-50]	g/L
Bilirubin Total	6.6	[<=21.0]	umol/L
ALT	29	[5-56]	mU/mL
GGT	18	[<=50]	mU/mL
Alkaline Phosphatase	93	[40-120]	mU/mL
LD	166 ^2	[<=250]	unit(s)/L
Lipase Level	137	[23-300]	mU/mL
Creatine Kinase	42 ^3	[30-200]	mU/mL
Phosphate Level	0.8 ^4	[0.8-1.5]	mmol/L
Urate	404 ^5	[180-500]	umol/L
Magnesium	0.81	[0.66-1.07]	mmol/L



Interpretive Data

^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

^2: LD
LDH is only appropriate for monitoring of known hematological malignancies and to investigate possible hemolytic anemia.

^3: Creatine Kinase

^4: Phosphate Level
Phosphate has a strong biphasic circadian rhythm. Phosphorus values are lowest in morning, peak in late afternoon and are maximal in the late evening. Fasting reduces daily phosphate variation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: MacKinnon,Randy J,MD
Copy For: **MacKinnon,Randy J,MD**

Lab No: 23-066-01431

Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD
Khan,Rajal,MD

Biochemistry

Routine Biochemistry

Interpretive Data
^5: Urate
Urate levels are highly dependant on a number of patient factors such as age, diet, BMI, menopause and the use of population based reference intervals is debatable. Clinical gout may be evident within our reported intervals, and levels may be lower during acute attacks. A common treatment target is <360 nmol/L. Rasburicase treatment falsely lowers urate levels.

Nutritional Status

Collected Date	2023/Mar/07		
Collected Time	09:35		
Procedure		Reference Interval	Units
Ferritin Level	103 ^6	[30-380]	mcg/L

Interpretive Data
^6: Ferritin Level
Ferritin levels should be interpreted within the context of the patient as inflammation can raise this analyte. Values less than 30-45 ug/L are associated with iron deficiency, whereas Ferritin >100 ug/L generally excludes iron deficiency.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: MacKinnon,Randy J,MD

Copy For: **MacKinnon,Randy J,MD**

Lab No: 23-066-01431

Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD
Khan,Rajal,MD

Immunology

Immunology

Collected Date	2023/Mar/07		
Collected Time	09:35		
Procedure		Reference Interval	Units
CRP	6.7 ^7	[<=8.0]	mg/L

Interpretive Data
^7: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: MacKinnon,Randy J,MD

Copy For: **MacKinnon,Randy J,MD**

Lab No: 23-066-01431

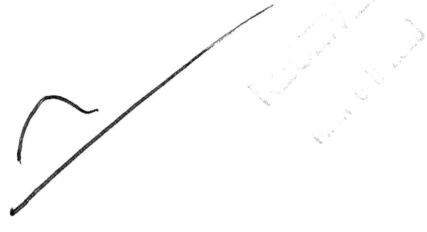
Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD
Khan,Rajal,MD

Hematology

CBC

Collected Date Collected Time Procedure	2023/Mar/07 09:35	Reference Interval	Units
WBC	4.70	[4.50-11.00]	x10^9/L
Hgb	149	[130-170]	g/L
Platelet	334	[140-400]	x10^9/L
RBC	4.82	[4.50-6.20]	x10^12/L
Hct	0.440	[0.420-0.520]	L/L
MCV	91.3	[80.0-100.0]	fl
MCH	30.9	[25.0-35.0]	pg
MCHC	339	[310-370]	g/L
RDW	12.6	[11.0-17.0]	%
Neut #	3.40	[1.50-8.50]	x10^9/L
Lymph #	**0.70** L	[1.50-4.00]	x10^9/L
Mono #	0.40	[0.00-1.00]	x10^9/L
Eos #	0.10	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc



3rd March 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229+1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET, CHARLOTTETOWN, Prince Edward Island C1A 1Z7

Kevin was seen for consultation 2023-03-02

Dear Dr. MacKinnon,

I spoke with your patient, Kevin Gallant, on the telephone today in follow-up for his Crohn's disease.

Kevin tells me he is feeling miserable since our last appointment. He is having 4 loose bowel movements daily and he is describing black tarry looking bowel movements at times. He continues to have left-sided periumbilical abdominal pain and says he has a sensation of "a tennis ball filled with fluid "in his abdomen when he is moving around. He says he has decreased appetite and has had an unintentional weight loss of 14 pounds in the past month. He continues to take pantoprazole 40 mg twice daily and stopped prednisone approximately 5 days ago.

He tells me that there are days that his abdominal pain is so bad that he cannot lay on his stomach. He has no appetite and is in pain constantly. This started Christmas Day and has never fully resolved.

As you know, he had a CT abdomen and pelvis without contrast [he is allergic] which showed no bowel obstruction. There was nothing to suggest bowel ischemia or perforation. There was no loculated collection or abscess formation identified. He went on to have a normal fecal calprotectin [49 on January 3], blood work on January 1 showed a CRP of 2.0, white blood cell count 6.20, hemoglobin 144, platelets 351. He had normal electrolytes and liver function at that time as well.

He had a colonoscopy and gastroscopy with Dr. Khan on September 16 in which he described distal esophagitis, a polypoid lesion in the duodenal bulb and mild changes at his anastomosis in the colon.

We had a conversation about management going forward. I am not sure what is causing his ongoing

3rd March 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

abdominal pain at this time. I suggested we repeat the gastroscopy and colonoscopy as he is describing melena which is new. I will arrange a follow-up appointment with Dr. Khan to discuss the results of the scopes and treatment plan going forward.

We had a discussion about contacting the office if he is having a change in his symptoms or presenting to the emergency department if he is having severe abdominal pain.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

30th January 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229+1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET, CHARLOTTETOWN, Prince Edward Island C1A 1Z7

Kevin was seen for consultation 2023-01-30

Dear Dr. MacKinnon,

I had the pleasure of speaking with your patient, Kevin Gallant, on the telephone today in follow-up for his Crohn's disease and abdominal pain.

I last spoke with Kevin on January 9. At that time, he was feeling significantly better taking Pantoprazole twice daily and being mindful of his diet. He tells me within 4 days of getting to Mexico he had increased symptoms so he started taking Prednisone. He took 50 mg for 1 day followed by 15 mg for 4 days, 10 mg for 3 days and then stopped. His symptoms of increased abdominal pain and swelling returned so approximately 7 to 8 days ago he started taking Prednisone 10 mg daily and his symptoms have completely resolved.

He went from having 5-6 bowel movements a day down to once a day with the Prednisone. He no longer has abdominal pain, bloating, and swelling. He continues to take Pantoprazole 40 mg twice daily, and has not had any Percocet since Christmas Day.

His fecal calprotectin from January 3 was normal at 49.

The patient was diagnosed with: Crohn's Disease (Disorder).

Impression and Plan: Kevin is a 46-year-old male with Crohn's disease who presented to the emergency department in December with significant abdominal pain and burning sensation in his abdomen. He had an unremarkable CT abdomen and pelvis, unremarkable x-ray, and unremarkable blood work including normal CRP, white blood cell count, lactate, and D-dimer. He has a normal fecal

30th January 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

calprotectin.

I felt that Kevin had gastritis so increased his PPI to twice daily and he felt significant improvement within a few days. Despite this, he had a return of abdominal pain just left of his umbilicus so he started taking Prednisone which cleared his symptoms very quickly.

I explained to Kevin that I am not sure what is causing his abdominal pain as his imaging, blood work, and stool testing have all been very reassuring. I have suggested that he continue with Prednisone 10 mg daily for another week then decrease to 5 mg daily for 1 week and then stop. He knows to reach out to the office if he has any increasing symptoms.

I have arranged a telephone follow-up appointment for him in 1 month.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Thomas NP,Laurie A
Copy For: MacKinnon,Randy J,MD

Lab No: 23-003-01441

Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD
Khan,Rajal,MD

Urinalysis

Stool Analysis

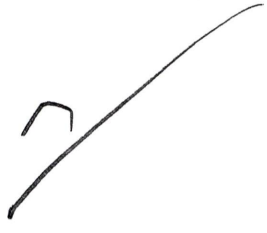
Collected Date	2023/Jan/03		
Collected Time	12:15		
Procedure		**Reference Interval**	**Units**
Fecal Calprotectin	49 R1		mg/kg

Result Comments
R1: Fecal Calprotectin

Negative: <50 mg/kg
Indeterminate: 50-200 mg/kg
Positive: >200 mg/kg

Negative results are not indicative of inflammation of the GI tract.

Sample received had excess mucous. Effect of mucous on results is knot known. Please recollect solid sample if clinically indicated.



9th January 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin was seen for consultation 2023-01-09

Dear Dr. MacKinnon,

I had the pleasure speaking with your patient, Kevin Gallant, on the telephone today in follow-up for his Crohn's disease and abdominal pain.

Kevin tells me he is feeling 75 to 80% better since we last spoke. He says the burning and tearing sensation that he had in his abdomen has completely resolved. He does continue to have some bloating and pain after his supper in the evening. He says that this resolves by the morning after having a bowel movement. He is taking pantoprazole twice daily with good effect and is also avoiding coffee, soda, chocolate, and spicy foods.

Kevin is leaving for Mexico tomorrow and returning on the 27th. We had a conversation about whether or not he should start taking prednisone. As discussed last week, I am not sure he has active inflammation at this time. I have suggested that he take the prescription of prednisone with him to Mexico and if he feels his symptoms are getting worse, he could try it.

He is going to continue taking pantoprazole twice daily for the duration of time he is away and we will plan for a follow-up visit when he is back. I have encouraged him to seek medical care while he is away if he has any new or concerning symptoms.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

6th January 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin was seen for consultation 2023-01-06

Dear Dr. MacKinnon,

Your patient Kevin Gallant presented to the office today without an appointment with concerns of ongoing abdominal pain. He says he visited your office and he was instructed to come here. He has been to the emergency department twice over the course of the past week. He was seen on December 29 and again on January 1. He is having symptoms of a tearing sensation and a burning sensation in his abdomen. He had an unremarkable CT abdomen and pelvis. He had an unremarkable x-ray and his bloodwork including CRP, WBCs, platelets and hemoglobin were all within normal limits. He also had a normal lactate and a normal D-dimer.

He tells me that his symptoms started suddenly around Christmas. Upon questioning, prior to that for several days, he was having significant increase in the amount of spicy food and chocolate he was consuming. He was drinking 24 to 25 cups of coffee a day as well. He was also drinking a lot of Kombucha.

He tells me that his bowels are moving small amounts. He is also passing flatus. He says that he has been drinking less coffee over the past couple of days and he has noticed a mild improvement in his symptoms.

I do wonder whether this represents more of a gastritis than a flare of his IBD. There was nothing on CT to suggest active disease or evidence of obstruction.

He mentioned that he had a prescription for Prednisone from you. He is leaving for Mexico for his wife to have surgery next Tuesday. He is concerned that he is going to have problems while he is in

6th January 2023

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 46 years old
106-55 CHESTNUT STREET CHARLOTTETOWN
Prince Edward Island Canada C1A1Z7

PE
00825976

Phone
C: +1 902 218 1335

another country. I have advised him not to travel at this time and if his wife could reschedule her surgery, I would recommend that.

I have advised him to hold off on the Prednisone now because I am not convinced that he has active inflammation. I said that he should take that prescription with him to Mexico so he has it if he needs, but right now I would like to try increasing his Pantoprazole to twice daily and avoiding known trigger foods including carbonated beverages, anything containing caffeine, chocolates, spicy foods, anything citrus. I have also encouraged him to have a low residue diet and avoiding a lot of raw fruits and vegetables and fibrous meats such as red meat.

I have arranged a telephone follow-up appointment with Kevin for next Monday to touch base and see how he is feeling before he leaves on his trip.

I explained to him that even if his symptoms are related to gastritis, it does not explain all his symptoms. He says when he presented to emerg he had bilateral numbness in his legs that would not be explained by the diagnosis of gastritis. I have encouraged him that if he is having any chest or abdominal symptoms that he would rate as an 8, 9 or 10/10 for pain or if he has any new symptoms that are worsened or concerning for him then he should present to the emergency department. He is agreeable to this.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

LT/ll

The patient was diagnosed with: Crohn'S Disease (Disorder)

Ambulatory Care Services

Queen Elizabeth Hospital
P.O. Box 6600
Charlottetown, PE C1A 8T5

Special Testing Service
Heather C. Williams, MD
Tel: 629-8872

2022/Dec/22
RE: GALLANT, KEVIN H.
MRN: 825976
DOB: 1976/Oct/03
CLINIC DATE: 2022/Dec/22

EMG REPORT

REASON FOR REFERRAL: Query lumbar radiculopathy.

December 22, 2022.

Dear Dr. MacKinnon,

Thank you for referring Kevin Gallant, 46-year-old right-handed man complaining of low back pain radiating down to his right leg. It began around the time of a motor vehicle collision. This occurred on February 17, two years ago. He was rear ended, while at stop and he says his car was pushed forward several vehicle lengths. Immediately when he got out of his truck he had pain in his neck and back that day and ongoing neck pain, headache, low back pain and leg pains. He has had visual disturbances, trouble focusing his eyes at night, loss of vision in the left lower quadrant of his vision and photophobia. He has been seeing Dr. Best about that. I did not have time to fully go into the details of his headache and neck pain today as the reason for this referral was for his low back and leg pains.

He says things have been getting worse over the past two years rather than better. He was feeling better while he was going to physio and massage three times a week, but that was discontinued a short time ago because his insurance said they would no longer pay for it and he is unable to afford it. He does not have any private insurance. It was simply being covered by the vehicle insurance.

He describes any time he sits for example, at restaurant, when in the car, at the bathroom he gets a throbbing sensation down the back of his leg and then pins and needles and a burning sensation and numbness in his foot. This is in the right leg. The pain radiates down the back of his right leg into his gluteal region and toward the right hip and then goes down the back of the leg toward his foot. He also has pain when he lies down like a muscle cramping sensation in the posterior thigh like a Charley horse. This happens about four times a week and really prevents him from getting a good night's sleep. Things gradually seem to be worsening over time. He has had to modify his activities, for example, he has been unable to ride his motorcycle because of the pains and numbness and there was one time when he thought he had his foot on the ground, but due to the numbness he missed and so he fell over while on his motorcycle while at a stop.

He has significant pain in his lower back region radiating down the right leg when driving and so he is unable to drive any longer distances. He gets a severe burning sensation in his foot and it only gets alleviated when he gets up to walk.

The low back pain is worse with activity. For example, any walking or lifting and it is a shooting sensation that goes to the right hip and at rest it is more of a throbbing feeling.

He has no feeling of numbness, tingling, burnings or pain on the left side.

There is no history of any prior injuries.

I found no specific nerve injury today. I suspect some of his issues may be soft tissue injury related. He also complains of the headaches. He asked about whether he would qualify for Botox. Unfortunately, we did not get into that today, but to qualify for Botox he would have to fail at least two prophylactic agents for migraine management. I gave him a prescription today for Amitriptyline 10 mg p.o. at bedtime that he can try taking this for both the headache pain as well as some of the other pains he is experiencing. If he finds it helpful without significant side effects than Dr. MacKinnon could increase it gradually by 10 mg once a month to a target dose of around 40 to 50 mg at bedtime.

I will verify the status of his MRI, which has been requested. According to a review from an independent neurologist through his insurance company they have requested an MRI of his lumbar spine as well as brain and cervical spine as well as an MRA COW and cervical vessel imaging for possible vertebral dissection given his visual disturbances. I will follow up with him after these images are completed so that we can review the results.

I would also recommend referral to the Chronic Pain Clinic if this has not been done already.

I will follow up with him and plan to do a further review of his headache history when I see him next, and see if he has had a response to the amitriptyline. If Amitriptyline fails, I would recommend another trial of something like Propranolol or Topamax since he would have to fail at least two oral agents before we would be able to apply for compassionate coverage of Botox.

Thank you for involving me in his care.

Heather C. Williams, MD
Copies To: Randy J. MacKinnon, MD

DD: 2022/Dec/22 09:18:52
DT: 2022/Dec/22 09:35:00
T: clr
Job: 35647932/11187362

Electronically Authenticated By: Williams, Heather C, MD
Date and Time: 23-Dec-2022 02:00 PM

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Foley,Mark G,MD

Copy For: MacKinnon,Randy J,MD

Lab No: 23-001-00021

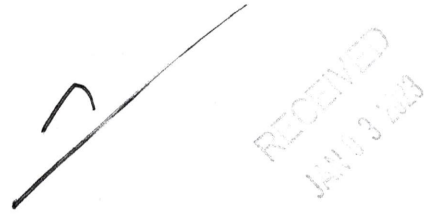
Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Coagulation

Collected Date	2023/Jan/01		
Collected Time	00:52		
Procedure		**Reference Interval**	**Units**
D-Dimer Quantitative	305 ^1	[0-420]	mcg/L

Interpretive Data
^1: D-Dimer Quantitative
In non-pregnant patients at low or moderate pre-test probability of first lower extremity DVT, a value of <500 mcg/L virtually excludes venous thromboembolism (negative predictive value 99.7%). Results are reported in FEUs.



LEGEND: @=Corrected C=Critical L=Low H=High

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Foley,Mark G,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

Lab No: 23-001-00016

Copies To: MacKinnon,Randy J,MD

Biochemistry

Routine Biochemistry

Collected Date / Collected Time / Procedure	2023/Jan/01 00:36	Reference Interval	Units
Sodium Level	139	[135-145]	mmol/L
Potassium Level	3.9	[3.5-5.1]	mmol/L
Chloride	105	[98-107]	mmol/L
Total CO2	23	[21-30]	mmol/L
Anion Gap	11	[4-12]	mmol/L
Glucose Random	5.8	[4.2-11.0]	mmol/L
Creatinine	104	[63-106]	umol/L
eGFR (CKD-EPI)	74 ^1	[>=60]	mL/min/1.73m^2
Bilirubin Total	12.8	[<=21.0]	umol/L
ALT	47	[5-56]	mU/mL
Alkaline Phosphatase	67	[40-120]	mU/mL
Lipase Level	99	[23-300]	mU/mL

Interpretive Data
^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Foley,Mark G,MD
Copy For: MacKinnon,Randy J,MD

Lab No: 23-001-00016

Location: Queen Elizabeth Hospital
Emerg QEH

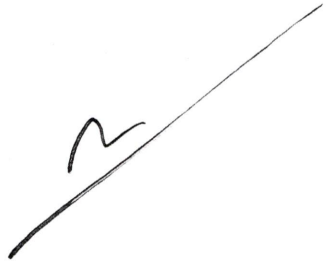
Copies To: MacKinnon,Randy J,MD

Blood Gases

Blood Gases

Collected Date	2023/Jan/01		
Collected Time	00:36		
Procedure		Reference Interval	Units
Body Temp Ven	**36.0** L	[37.0-37.0]	degC
pH Ven	7.40 R1	[7.33-7.43]	
pCO2 Ven	42 R1	[38-50]	mmHg
HCO3 Ven	26 R1	[23-27]	mmol/L
Base Excess Ven	1.2 R1	[-2.0-3.0]	mmol/L
Lactate	1.9 R1	[0.5-2.2]	mmol/L

Result Comments
R1: Base Excess Ven, HCO3 Ven, Lactate, pCO2 Ven, pH Ven
Results confirmed by repeat



Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Foley,Mark G,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

Lab No: 23-001-00016

Copies To: MacKinnon,Randy J,MD

Immunology

Immunology

Collected Date	2023/Jan/01		
Collected Time	00:36		
Procedure		Reference Interval	Units
CRP	2.0 ^2	[<=8.0]	mg/L

Interpretive Data
^2: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Foley,Mark G,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

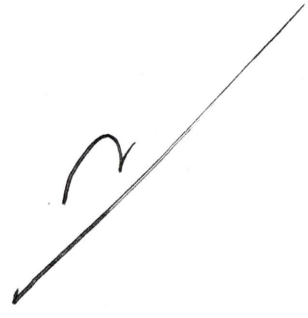
Lab No: 23-001-00016

Copies To: MacKinnon,Randy J,MD

Hematology

CBC

Collected Date	2023/Jan/01		
Collected Time	00:36		
Procedure		Reference Interval	Units
WBC	6.20	[4.50-11.00]	x10^9/L
Hgb	144	[130-170]	g/L
Platelet	351	[140-400]	x10^9/L
RBC	4.52	[4.50-6.20]	x10^12/L
Hct	**0.409** L	[0.420-0.520]	L/L
MCV	90.5	[80.0-100.0]	fl
MCH	31.8	[25.0-35.0]	pg
MCHC	352	[310-370]	g/L
RDW	12.7	[11.0-17.0]	%
Neut #	3.80	[1.50-8.50]	x10^9/L
Lymph #	1.60	[1.50-4.00]	x10^9/L
Mono #	0.60	[0.00-1.00]	x10^9/L
Eos #	0.20	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc



QUEEN ELIZABETH HOSPITAL

PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY
Date of birth: 03-Oct-1976
Accession: 4621775
Exam: (QEH) DABD2V - DIAGNOSTIC ABDOMEN 2 VIEWS -A
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2023-Jan-01

Requesting Provider: FOLEY, MARK G, MD
Attending Provider: MACKINNON, RANDY J MD

Extra Report Sent To:

FINAL

Date of Exam:

Abdominal radiograph
Nonspecific bowel gas pattern. No free air. No definite air-fluid levels. Several dilated bowel loops in the left hemiabdomen.

Date exam taken: 2023-Jan-01
Transcriptionist date: 2023-Jan-01
Finalized date: 2023-Jan-01

Interpretating Radiologist: YOON, PAUL RADIOLOGIST
Transcriptionist : User, Interface
Radiologist(s) sign off: YOON, PAUL

QUEEN ELIZABETH HOSPITAL
PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY
Date of birth: 03-Oct-1976
Accession: 4620526
Exam: (QEH) DABD2V - DIAGNOSTIC ABDOMEN 2 VIEWS -A
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2022-Dec-29

Requesting Provider: CARMICHAEL, HARRISON CHARLES, MD **Extra Report Sent To:**
Attending Provider: MACKINNON, RANDY J MD

FINAL

ABDOMINAL RADIOGRAPH

Clinical information: abdominal pain.chrons.

There are nondilated loops of small and large bowel containing gas and stool.

There are no dilated loops to suggest ileus or obstruction.

There is no evidence of free intra-abdominal gas.

PA CHEST X-RAY
No evidence of aspiration.
The cardiomediastinal contours are within normal limits.
No focal consolidation or lobar collapse. No lung mass.
No pleural effusion or pneumothorax.

Date exam taken: 2022-Dec-29
Transcriptionist date: 2022-Dec-30
Finalized date: 2022-Dec-30

Interpretating Radiologist: KIU, ALEX RADIOLOGIST
Transcriptionist : User, Interface
Radiologist(s) sign off: KIU, ALEX

QUEEN ELIZABETH HOSPITAL
PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY
Date of birth: 03-Oct-1976
Accession: 4620528
Exam: (QEH) DCHEST1V - DIAGNOSTIC CHEST 1 VIEW -C
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2022-Dec-29

Requesting Provider: CARMICHAEL, HARRISON CHARLES, MD **Extra Report Sent To:**
Attending Provider: MACKINNON, RANDY J MD

FINAL

ABDOMINAL RADIOGRAPH

Clinical information: abdominal pain.chrons.

There are nondilated loops of small and large bowel containing gas and stool.

There are no dilated loops to suggest ileus or obstruction.

There is no evidence of free intra-abdominal gas.

PA CHEST X-RAY
No evidence of aspiration.
The cardiomediastinal contours are within normal limits.
No focal consolidation or lobar collapse. No lung mass.
No pleural effusion or pneumothorax.

Date exam taken: 2022-Dec-29
Transcriptionist date: 2022-Dec-30
Finalized date: 2022-Dec-30

Interpretating Radiologist: KIU, ALEX RADIOLOGIST
Transcriptionist : User, Interface
Radiologist(s) sign off: KIU, ALEX

MACKINNON, RANDY J, MD
Queen Street Medical Centre

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Carmichael,Harrison C,MD
Copy For: MacKinnon,Randy J,MD

Lab No: 22-363-00612
Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Biochemistry

Routine Biochemistry

Collected Date	2022/Dec/29		
Collected Time	10:15		
Procedure		Reference Interval	Units
Sodium Level	138	[135-145]	mmol/L
Potassium Level	4.7	[3.5-5.1]	mmol/L
Chloride	104	[98-107]	mmol/L
Total CO2	24	[21-30]	mmol/L
Anion Gap	10	[4-12]	mmol/L
Glucose Random	7.5	[4.2-11.0]	mmol/L
Creatinine	86	[63-106]	umol/L
eGFR (CKD-EPI)	93 ^1	[>=60]	mL/min/1.73m^2

Interpretive Data
^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 22-363-00612

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Carmichael,Harrison C,MD

Copy For: MacKinnon,Randy J,MD

Location: Queen Elizabeth Hospital
Emerg QEH

Blood Gases

Blood Gases

Collected Date	2022/Dec/29		
Collected Time	10:15		
Procedure		Reference Interval	Units
Lactate	**3.8** H	[0.5-2.2]	mmol/L

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Carmichael,Harrison C,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

Lab No: 22-363-00612

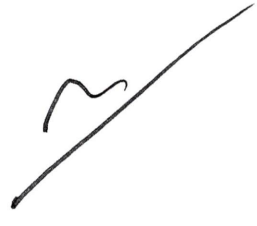
Copies To: MacKinnon,Randy J,MD

Immunology

Immunology

Collected Date	2022/Dec/29		
Collected Time	10:15		
Procedure		Reference Interval	Units
CRP	3.7 ^2	[<=8.0]	mg/L

Interpretive Data
^2: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.



Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Carmichael,Harrison C,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

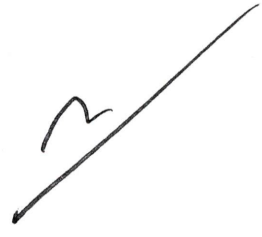
Lab No: 22-363-00612

Copies To: MacKinnon,Randy J,MD

Hematology

CBC

Collected Date	2022/Dec/29		
Collected Time	10:15		
Procedure		Reference Interval	Units
WBC	5.50	[4.50-11.00]	x10^9/L
Hgb	147	[130-170]	g/L
Platelet	352	[140-400]	x10^9/L
RBC	4.73	[4.50-6.20]	x10^12/L
Hct	0.431	[0.420-0.520]	L/L
MCV	91.1	[80.0-100.0]	fl
MCH	31.2	[25.0-35.0]	pg
MCHC	342	[310-370]	g/L
RDW	12.8	[11.0-17.0]	%
Neut #	3.80	[1.50-8.50]	x10^9/L
Lymph #	**0.90** L	[1.50-4.00]	x10^9/L
Mono #	0.40	[0.00-1.00]	x10^9/L
Eos #	0.30	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc



Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 22-363-01083

Copies To: MacKinnon,Randy J,MD

Ordering Provider: St.Onge,Jonathan M,MD

Copy For: MacKinnon,Randy J,MD

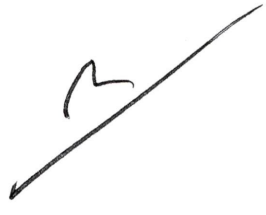
Location: Queen Elizabeth Hospital
Emerg QEH

Biochemistry

Routine Biochemistry

Collected Date / Collected Time / Procedure	2022/Dec/29 13:15	Reference Interval	Units
Total Protein	76 R1	[64-83]	g/L
Albumin Lvl	40	[35-50]	g/L
Bilirubin Total	12.1 R2	[<=21.0]	umol/L
ALT	55	[5-56]	mU/mL
AST	See Comment R3	[<=50]	mU/mL
GGT	9	[<=50]	mU/mL
Alkaline Phosphatase	68	[40-120]	mU/mL
Lipase Level	91	[23-300]	mU/mL

Result Comments
R1: Total Protein
Hemolysis = 3+. Possible positive result interference. Interpret with caution.
R2: Bilirubin Total
Hemolysis = 3+. Possible negative result interference. Interpret with caution.
R3: AST
Result not reported. Significant positive interference from hemolysis. Recollect if clinically indicated.



Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: St.Onge,Jonathan M,MD
Copy For: MacKinnon,Randy J,MD

Lab No: 22-363-01083

Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Blood Gases

Blood Gases

Collected Date	2022/Dec/29		
Collected Time	13:15		
Procedure		Reference Interval	Units
Body Temp Ven	37.0	[37.0-37.0]	degC
pH Ven	7.38 R4	[7.33-7.43]	
pCO2 Ven	45 R4	[38-50]	mmHg
HCO3 Ven	26 R4	[23-27]	mmol/L
Base Excess Ven	0.7 R4	[-2.0-3.0]	mmol/L
Lactate	2.2 R4	[0.5-2.2]	mmol/L

Result Comments
R4: Base Excess Ven, HCO3 Ven, Lactate, pCO2 Ven, pH Ven
Results confirmed by repeat

00825976 GALLANT, KEVIN HENRY

DOB: 03-Oct-1976 46 Years Male

03-Dec-2022 01:28:34

PEI (1)
QEH (10)
Main (00)

HR 87 . Sinus rhythm

PR 158
QRSD 81
QT 349
QTc 421

-- AXIS --
P 46
QRS 27
T 15

Room: TRIAGE
Oper: MMURPHY
Fam Dr.: MACKINNON

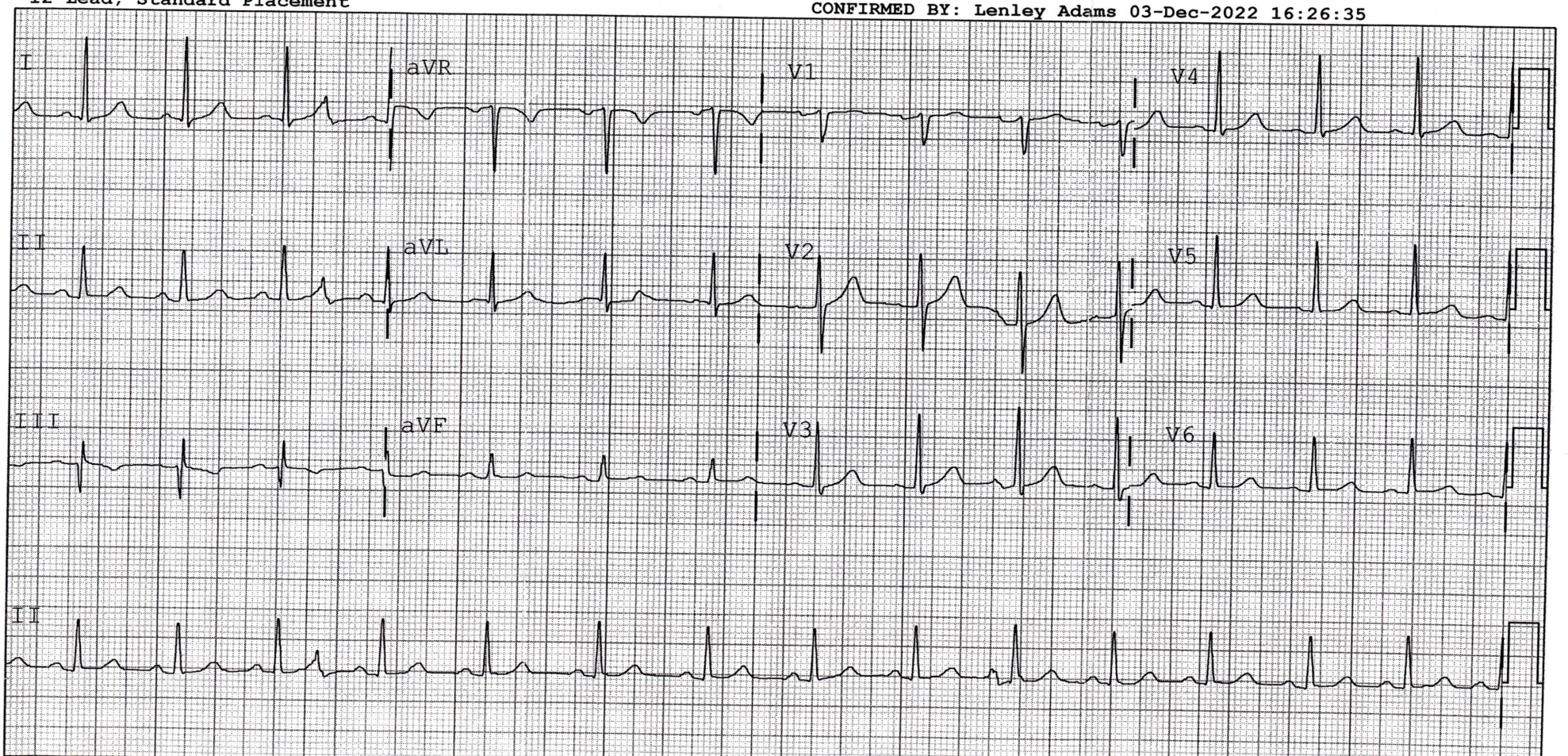
- NORMAL ECG -

PREVIOUS:15-Aug-2022 10:07:58 - Borderline Confirmed

Requested By: WONNACOTT

12 Lead; Standard Placement

CONFIRMED BY: Lenley Adams 03-Dec-2022 16:26:35



Device: TC09 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60~ 0.15-100 Hz PH110C b L P?

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Wonnacott,Joseph S,MD
Copy For: MacKinnon,Randy J,MD
Location: Queen Elizabeth Hospital
Emerg QEH

Lab No: 22-337-00049

Copies To: MacKinnon,Randy J,MD

Biochemistry

Routine Biochemistry

Collected Date	2022/Dec/03		
Collected Time	01:54		
Procedure		Reference Interval	Units
Sodium Level	140	[135-145]	mmol/L
Potassium Level	4.2 R1	[3.5-5.1]	mmol/L
Chloride	104	[98-107]	mmol/L
Total CO2	23	[21-30]	mmol/L
Anion Gap	**13** H	[4-12]	mmol/L
Glucose Random	6.6	[4.2-11.0]	mmol/L
Creatinine	85	[63-106]	umol/L
eGFR (CKD-EPI)	95 ^1	[>=60]	mL/min/1.73m^2
Magnesium	0.74	[0.66-1.07]	mmol/L

Result Comments
R1: Potassium Level
Hemolysis = 1+. Possible positive result interference.

Interpretive Data
^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

Cardiac Function & Lipids

Collected Date	2022/Dec/03		
Collected Time	01:54		
Procedure		Reference Interval	Units
Troponin I -hs	<10.0 ^2	[<=34.2]	ng/L

Interpretive Data
^2: Troponin I - hs
Troponin cut-off levels are gender-specific. Increased levels are defined as **>15.6 ng/L in women**, and **>34.2 ng/L in men. Troponin should only be requested in patients with suspected acute coronary syndrome.**

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Lab No: 22-337-00049

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Wonnacott,Joseph S,MD

Copy For: MacKinnon,Randy J,MD

Location: Queen Elizabeth Hospital
Emerg QEH

Hematology

CBC

Collected Date	2022/Dec/03		
Collected Time	01:54		
Procedure		Reference Interval	Units
WBC	5.50	[4.50-11.00]	x10^9/L
Hgb	141	[130-170]	g/L
Platelet	329	[140-400]	x10^9/L
RBC	**4.44** L	[4.50-6.20]	x10^12/L
Hct	**0.403** L	[0.420-0.520]	L/L
MCV	90.7	[80.0-100.0]	fl
MCH	31.8	[25.0-35.0]	pg
MCHC	350	[310-370]	g/L
RDW	12.6	[11.0-17.0]	%
Neut #	3.20	[1.50-8.50]	x10^9/L
Lymph #	1.60	[1.50-4.00]	x10^9/L
Mono #	0.50	[0.00-1.00]	x10^9/L
Eos #	0.10	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 46 years
Sex: Male

Ordering Provider: Wonnacott,Joseph S,MD
Copy For: **MacKinnon,Randy J,MD**

Lab No: 22-337-00049

Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Coagulation

Collected Date	2022/Dec/03		
Collected Time	01:54		
Procedure		Reference Interval	Units
PT	12.8	[11.2-14.8]	sec(s)
INR	1.0	[0.9-1.1]	

LEGEND: @=Corrected C=Critical L=Low H=High

2nd December 2022

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant	**PE**	**Phone**
Male / 3rd October 1976 / 46 years old	00825976	C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin was seen for consultation 2022-11-22

Dear Dr. MacKinnon,

I had the pleasure of speaking with your patient Kevin Gallant on the telephone today.

We last saw each other approximately a month ago. We had discussed doing a trial of Cholestyramine to see if that would help slow down his bowel movements along with repeating a fecal calprotectin to rule out active disease. Unfortunately, he has not submitted the sample for a fecal calprotectin because he says that he has been feeling unwell over the course of the past month. He has had issues with upper respiratory infections and an eye infection. He does plan to submit the sample over the course of the next couple weeks once he is feeling better.

He does tell me that he has started a pack of Cholestyramine a day. He has some days where his bowels do not move now and other days where they move several times. I have suggested that he actually just start with a half packet a day to see if that evens things out for him and prevents any issues with constipation. He plans to do a trial of that and then we will follow up in the near future.

I have asked him to reach out to the office once he has submitted his fecal calprotectin test and we will schedule him in for a follow up appointment approximately two weeks after that to go over those results and develop a treatment plan going forward.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

LT/ll

integra

INDEPENDENT MEDICAL EXAMINATION
NEUROLOGY

Examinee	GALLANT, Kevin Henry
Date of Loss	February 17, 2021
Prepared For	Jamie MacGillivray MacGillivray Injury and Insurance Law 134 Provost Street New Glasgow, Nova Scotia B2H 2P7
Date of Assessment	September 21, 2022
Date of Report	September 26, 2022
Prepared By	Rehan Dost, BSc., MA, MD, FRCPC Neurologist

call for appt
Need to consider ① MRI/MRA brain
② MRI L-spine
EMGIS
③ Neurology

booked

integra

INTRODUCTION

Kevin Gallant (DOB: February 17, 2021) was seen for a neurological evaluation on September 21, 2022. This examination was completed such that this writer could provide an independent opinion to the requesting party, Jamie MacGillivray of MacGillivray Law, regarding Mr. Gallant's diagnosis, disability status, treatment and vocational capabilities. The details of the opinion sought are outlined in the letter of instruction dated August 11, 2022, which is attached as Appendix I.

Prior to commencing, the nature and purpose of the assessment was explained to Mr. Gallant, and written consent was obtained. Mr. Gallant was made aware that no doctor-patient relationship would ensue as a result of this examination. He understood that a report would be forwarded to the requesting party, Jamie MacGillivray of MacGillivray Law, upon completion.

QUALIFICATIONS

I received my Medical Doctorate from the University of Toronto in 1994 and am a graduate from the University of Western Ontario in Neurology. I am a member of the College of Physicians and Surgeons of Ontario and British Columbia, Ontario Medical Association, and a Fellow of the Royal College of Physicians. I currently have a private practice as a neurologist and electromyographer and have experience as a CAT and IME assessor. My curriculum vitae is attached as Appendix II.

STATEMENT OF REPRESENTATIONS

In accordance with Civil Procedure Rule 55.04 – Report Certification Relating to Expert Reports, as it pertains to Mr. Kevin Gallant, I, Dr. Rehan Dost, state the following:

a) I am providing an objective opinion for the assistance of the court, even though I have been retained by the Plaintiff in this matter;

b) I am prepared to testify at the trial or hearing, comply with directions of the court, and apply independent judgment when assisting the court in this matter;

c) My report includes everything I regard as relevant to my expressed opinions and it draws attention to anything that could reasonably lead to a different conclusion;

d) I will answer written questions put by parties as soon as possible after the questions are delivered to me;

e) I will notify each party in writing of a change in the opinion, or of a material fact that was not considered when the report was prepared and could reasonably affect the opinion, as soon as possible after arriving at the changed opinion or becoming aware of material fact;

f) Unless otherwise stated, the opinions expressed in my reports are held by me to a reasonable degree of certainty and it is more probable than not that they are correct and accurate;

g) Attached to my report is a true copy of my Curriculum Vitae which sets out my relevant qualifications, including a listing of all my publications on the subject of the opinion.

FACTS AND ASSUMPTIONS

This report has been prepared using certain facts and assumptions. These have been obtained from the examinee interview and physical examination carried out by the writer as well as a review of the documents which are identified in Appendix I and references from the literature where indicated.

DOCUMENTS REVIEW

The following documents have been reproduced verbatim.

- **Tab 9: CT Scan, Lumbar Spine, dated March 11, 2022**

  This shows osteophytes, left facet L5/S1, with significant narrowing of the left nerve root foramen. Diffuse disc bulge L4/5 associated with small central left paracentral posterolateral disc protrusion, flattening of the left side of thecal sac, causing mild stenosis.

- **Tab 10: Ambulance Call Report dated February 17, 2021**

  Patient was driving truck. Hit from behind. States truck moved seven to eight car lengths up the road. Patient initially got out of the vehicle. Spoke with the other driver. Now complaining of neck and back pain that increases with movement.

- **Tab 7: Family Vision Centre Note dated March 11, 2021**

  This indicates suffered concussion after being rear-ended. Ocular/visual assessment February 25th. Hit back of head. Does complain of photophobia of the left eye as well as the infra-temporal where things do not focus. He does show full confrontation fields. Acuity is 20/20 right; 20/25 left.

- **Tab 2: Report by Dr. MacKinnon dated June 9, 2021**

  This indicates [direct result of] motor vehicle collision. Suffered whiplash-associated disorder, grade 2, affecting cervical/lumbar spine. In addition, sustained left trapezius injury. Sustained concussion. Gone on to develop some post-concussive symptoms. Possible flare of underlying left ulnar neuropathy.

- **Tab 1: Internal Medicine Consultation Note dated July 28, 2017**

  This indicates has a history of anxiety, depression, PTSD.

- **Tab 1: Report by Dr. Clark dated January 31, 2017**

  Presents with fibrostenotic Crohn's.

- **Tab 1: Report by Dr. Dhillon dated July 24, 2017**

  This contains history of PTSD, [alcohol history, alcohol-induced intoxication] resulting in the disorder secondary to drug use.

CLINICAL INTERVIEW

The claimant states he was involved in a motor vehicle collision on February 17, 2021.

He states prior to this he had Crohn's disease and a left ulnar nerve transplant, which did not really cause any ongoing significant issues. He states he did have some minor low back discomfort but never any leg pain.

The index motor vehicle collision occurred February 17, 2021. He states he was the belted driver of a vehicle. He was suddenly rear-ended, and he hit his head. He states he did not black out. He recalls the impact. He states, however, he did understand that he was going to be hit. He straightened the wheels of his truck and recalls the impact. However, just moments after the impact, he states he did not know where he was. He then got his bearings straight. He was able to get out of the vehicle. He states as he stepped out, he felt neck and back pain. EMS arrived. He was taken to the local ER. He was evaluated and discharged. This was at Queen Elizabeth Hospital in PEI.

He states the pain did not begin until he got out of the vehicle, and he states he was not overly emotional due to stress, just irritated he had been hit.

The following day, he saw his family physician, Dr. Randy MacKinnon. He has undergone physiotherapy, massage therapy and treatment at CBI Health.

CURRENT COMPLAINTS

The claimant relates the following symptoms, which persist:

1. He states 90 percent of his problem is his lower back on the right. This was not a significant problem before. It came on immediately after the accident. Within weeks, it began radiating down the right leg with numbness and tingling. He states most of the tingling is over the heel (S1). It is made better bending forward. It is worse with any kind of activity. This is the most disabling symptom. He will use up to four Percocet per day to treat this, although he wishes not to do so. He states he never had leg pain before this accident.

2. He reports cervical, left shoulder pain, which comes and goes.

3. He reports right unilateral headache daily. He noticed some visual changes in his lower quadrant, and there is some light and noise sensitivity with the headache. He denied a prior history of significant headache.

4. He reports altered sleep because of his back pain.

5. He reports depressed mood and anxiety because of the limitations and the fact that he is in pain all the time.

6. He notices a decreased focus, memory, concentration, problems with multi-tasking; definitely notes a correlation to the level of cognitive impairment and the amount of pain he has, his mood as well as his quality of sleep.

VOCATIONAL HISTORY

He states at the time of the accident he was employed full-time for Midland Transport as a truck driver. This also involved being a forklift driver. He states he has not been able to return to work, and he attributes this entirely to his back pain with radiation to the right leg.

SOCIAL HISTORY

He does continue to operate a motor vehicle but only during the day. He does not do any nighttime driving because he feels his vision is off in the right eye.

He lives in an apartment with his spouse and son, who lives there part-time. Prior to the accident he did most of the housekeeping, snow blowing, grass cutting, laundry, removal, dishes, sweeping, etc. He states post-

accident he can only do light sweeping. He is independent with his basic activities of daily living. He does some of the light dishes. He does not do the heavier aspects of the housekeeping because of his back and leg pain. He used to enjoy motorcycling, biking, boating – none of which he has been able to resume because of the back and leg pain. He is now selling his motorbike. He also states he is unable to play with his child, specifically outdoor sports, because of his back and leg pain.

He does not smoke. He does not drink.

MEDICATIONS

He is currently on Percocet as needed for pain.

CLINICAL EXAMINATION

This evaluation was conducted virtually, and I could not conduct a neurological examination.

SUMMARY AND CONCLUSIONS

The claimant was involved in a rear-end motor vehicle collision February 17, 2021. He reports the immediate onset of neck pain and low back pain. He has ongoing right-sided unilateral headache, neck, right shoulder pain, low back pain with radiation to the right leg with numbness and tingling, non-restorative sleep, psychological issues and cognitive inefficiencies correlated with the level of pain, quality of sleep and psychological symptoms.

Opinion

Based upon the evidence and with a reasonable degree of medical certainty, the following conclusions are drawn:

1. **As to the nature of the Plaintiff's cognition:**

   In order to diagnose mTBI/concussion the criteria (CDC, WHO, DSM-5) stipulate that all of the following must be present:

   a. Concussive force transmission.

   b. One of loss of consciousness, amnesia, disorientation or confusional state at the time of the trauma, attributable to brain trauma.

c. The above cannot be due to non-brain injury factors; for example, acute pain, psychological duress, attrition of memories with time, physiological amnesia, etc.

d. Post-concussive symptoms such as headache, light and noise sensitivity, dizziness, etc., can be supportive but in isolation cannot be used to make the diagnosis as the symptoms non-specific and will occur in the context of trauma in the absence of brain injury; for example, somatic manifestation of psychological conditions as well as due to headache.

In this particular instance, the Plaintiff does not relate a loss of consciousness or gap in memory. That being said, he states immediately in the aftermath of the accident he did not know where he was. I find that this is related to brain trauma, not other factors:

a. Firstly, he did not experience any pain or psychological duress in the moments after the impact; therefore, these are not explanatory variables.

b. He knew the accident was going to happen and was anticipating it, yet after the accident, he did not know where he was, which is unusual and indicates a disoriented/confusional state.

c. Supporting this, he developed post-concussive symptoms.

Therefore, on the balance of probabilities, he sustained an mTBI.

His ongoing cognitive issue are not due to brain damage:

a. The literature states individuals who sustain an mTBI and have persistent cognitive symptoms, [that these are unlikely on the] basis of brain damage.

b. I have no evidence of brain damage in this case.

c. Pain, sleep and psychiatric factors are known to have large effect sizes on cognitive function.

d. The Plaintiff relates the pain, sleep and psychiatric factors directly correlated with the level of cognitive impairment.

Therefore, in my view, this gentleman's ongoing cognitive issue are due to pain, sleep and psychiatric factors.

I cannot comment on this gentleman's psychiatric state, especially given his complexity with a prior history of PTSD, anxiety and substance abuse. I defer this to the psychiatrist, and I would appreciate a copy to review.

That being said, the Plaintiff relates that cognitive issues are not his disabling symptom, rather, it is low back and his right leg symptoms, which I will discuss below.

2. As to the nature of the Plaintiff's headaches:

The Plaintiff's headaches would satisfy the IHS criteria for chronic headache attributable to whiplash, perpetuated by non-reactive sleep and psychological factors. They are undertreated. I recommend nortriptyline (25 to 50 mg at night). If ineffective after six weeks, Botox, two trials, three months apart.

These types of post-traumatic headaches can cause visual disturbances, which may explain his visual complaints as well. That being said, he is complaining of fairly specific and quadrantic defect on the right eye, which does not localize to the ocular system or the optic nerve as typically seen with cerebral injuries. Therefore, at the very least I suggest an MRI scan of the brain, which should include an MRA to look for vertebral artery dissection, which can occur after rear-end collisions, resulting in occipital infarcts and quadrantic defects.

I would be pleased to comment on this further once I am provided this imaging.

With respect to headache treatment, I would recommend a trial of occipital nerve blocks on the right side, at least two, at the greater and lesser occipital nerve.

3. As to the nature of the Plaintiff's low back pain with radiation to the right leg:

This gentleman's low back pain and right leg is related to the accident; this is based on the following principle of medical causation:

a. Absence of symptoms before – whilst I would recognize he had some intermittent low back pain, it was not of this severity, nor did he have leg pain or sensory symptoms of the leg.

b. Presence of symptoms post event with a strong temporal correlation – in this particular instance, both by self-report and the EMS records, he developed low back pain immediately post-collision with the onset of leg symptoms within weeks, which is typical for a disc herniation with root compression.

c. Absence of a more plausible explanation – I find no evidence of an alternate explanation for his problems such as trauma otherwise.

The description of the symptoms are consistent with a disc herniation, L5/S1, with root compression at the S1 level. However, I did review his CT scan, and this actually shows more prominent problems on the left, not the right. There are only two possible explanations:

a. This represents myofascial injury to the lumbar spine with radicular symptoms in the leg due to central sensitization amplified by psychological factors (i.e., chronic myofascial pain syndrome).

b. The root compression was missed on the CT, which can occur as the CT tends to be inferior for imaging soft tissue. Therefore, I would recommend MRI of the lumbar spine as well as a nerve conduction/EMG study of the right lower limb. I would be pleased to comment on this further once I have provided this for review.

Irrespective of the label placed on this gentleman's low back and leg pain with sensory symptoms, the impairment and disability would be the same. This gentleman's impairment is the experience of low back with pain radiation to the right leg with numbness and tingling. How this impairment impacts on activities of normal living is termed disability. There is a poor correlation between impairment and disability. This must be determined by accuracy of self-report and demonstrated functional performance.

From self-reporting, the Plaintiff, as a direct result of the back and leg pain has been unable to return to work as a truck driver, unable to complete the heavier aspects of his housekeeping, unable to take part in his recreational activities or interact with his children as much (for example, playing outdoor sports with them).

With respect to treatment, this largely depends on the pain generator, and I cannot comment or prognosticate until I am provided with the missing requisite information, specifically MRI of the lumbar spine, nerve conduction/EMG study right lower limb.

I found no other neurological issues.

Answers to Specific Questions

1. What injuries do you believe were caused or materially contributed to by the February 17, 2021 car accident?

The injuries from the neurological perspective are as follows:

a. Mild traumatic brain injury/concussion, ongoing cognitive issues due to non-brain damage factors.

b. Non-verifiable radicular symptoms in the right leg with low back pain. The differential diagnosis includes chronic myofascial pain with central sensitization or L5/S1 disc with root compression. He requires MRI of the lumbar spine, nerve conduction/EMG study right lower limb.

c. Chronic headache attributed to whiplash, exclude occipital infarct due to vertebral artery dissection. Recommend MRI/MRA.

2. **How, if at all, has the accident and resulting injuries impacted Kevin psychologically?**

I cannot comment on psychological issues as this is beyond the scope of a neurologist.

3. **Do you believe the injuries are of long-term and indefinite duration?**

With respect to his headaches, I am unable to answer this question in the absence of appropriate treatment. As I have suggested, he requires nortriptyline (25 to 50 mg over six weeks). If ineffective, I suggest two trials of occipital nerve blocks on the right. If ineffective, I would support the use of Botox, two trials, three months apart.

With respect to his cognitive issues, this largely depends upon successful treatment of his pain and psychiatric symptoms, and I defer this to the relevant specialist.

With respect to his low back and right leg pain, I cannot comment as he is under investigated, and the pain generator is unclear.

4. **Do you believe there is short- or long-term benefit to treatment for Kevin, and if so, what do you recommend? Can you address physio, RMT, psychological counselling, medication and any other modalities that you feel help Kevin?**

I have recommended this above, specifically with respect to his headaches.

With respect to his low back and right leg pain, I am unable to comment until I am provided with the imaging and nerve conduction/EMG studies of the right lower limb.

5. **At present, is Mr. Gallant physically and mentally fit to perform the substantial duties of any occupation for which he is reasonably fitted by education, training or experience?**

Not at the present time from the neurological point of view due predominantly to his complaints of right leg and back pain. I have discussed this above.

6. **Do you feel Mr. Gallant would have to endure an unreasonable amount of pain to work at any reasonably suitable occupation?**

At this time, my answer to this question is yes, with the caveat that my opinion is incomplete in the absence of an MRI lumbar spine, nerve conduction/EMG study of the right lower limb.

7. **Do you feel that a "real world" employer or "reasonable" employer is likely to hire Mr. Gallant given their restrictions, pain related or otherwise?**

   No because of the amount of back and leg pain, which from self-report has a significant impact on his instrumental ADLs, vocational and recreational pursuits.

8. **Do you believe that Mr. Gallant's self-reporting to you is genuine and credible?**

   Yes. I have not been provided any evidence to the contrary.

This concludes my opinion. If you require further assistance, please do not hesitate to contact me through Integra Medical Consulting.

Respectfully submitted,

Rehan Dost, BSc., MA, MD, FRCPC
Neurologist
RD/CAM

APPENDIX I – LETTER OF INSTRUCTION AND DOCUMENTS LIST

Enclosed.

APPENDIX II – CURRICULUM VITAE

Enclosed.

Queen Elizabeth Hospital
60 Riverside Drive PO Box 6600
Charlottetown, PE C1A 8T5

Patient Name: GALLANT, KEVIN HENRY
MRN: 000825976

DOB: 1976/Oct/03 **Age:** 46 years **Sex:** Male
Address: 106-55 CHESTNUT STREET
CHARLOTTETOWN, PE C1A1Z7

Phone: 9022181335

Encounter Number: 08353238
Location: Endoscopy QEH

Admit Date: 2022/Sep/16
Discharge Date: 2022/Sep/16

Document Copy For: MacKinnon,Randy J,MD

Physician Surgical Documentation

Document Status: Auth (Verified)
Document Type: Ambulatory Procedure Record
Event Date: 2022/Sep/16 08:59
Performed By: Khan,Rajal,MD (2022/Sep/21 08:38)

Ambulatory Procedure Record
PROCEDURE DATE: 2022/Sep/16
PRIMARY CARE PROVIDER: Randy J. MacKinnon MD
PROCEDURE PERFORMED: Gastroscopy with biopsies. Colonoscopy to the anastomosis and into the neoterminal ileum with biopsies.

PREPROCEDURE DIAGNOSIS: Crohn's disease with worsening symptoms including upper GI symptoms.

POSTPROCEDURE DIAGNOSIS: Distal esophagitis. Small hiatus hernia. Quite normal appearing neoterminal ileum and colon.

CLINICAL NOTE: Kevin is a 45-year-old gentleman that was seen recently by Laurie Thomas, IBD nurse practitioner. He has been diagnosed with Crohn's disease since 2000. He has had multiple resections. He is not currently maintained on any medications. He has been experiencing increasing symptoms including upper GI symptoms. We decided to go ahead with gastroscopy and colonoscopy to further investigate and decide about further management plan.

Kevin tells me that things are still not going very well for him. He says that he has not eaten any solid food in several days because of obstructive type symptoms. Otherwise, he has been doing about the same as when he saw Laurie. He did drop off a fecal calprotectin, but I have not seen the result yet. It is not yet on Cerner.

I discussed the gastroscopy and colonoscopy procedures including the risks of bleeding and perforation today with Kevin. He understood the procedure and the risks and decided to proceed with gastroscopy and colonoscopy. We have obtained informed consent.

PROCEDURE: The patient was transferred to the procedure area and placed in the left lateral decubitus position. He was placed on continuous blood pressure, heart rate and oxygen saturation monitors. He was administered intravenous sedation with a total of 10 mg of Midazolam and 200 mcg of Fentanyl which were given in a gradual fashion. We began with the gastroscopy. Posterior pharynx was sprayed with Xylocaine spray. A bite block was placed.

The gastroscope was introduced from the mouth and into the esophagus. The esophagus appeared normal in the proximal and mid portions. In the distal esophagus, there were signs of esophagitis. There were 3 or 4 linear ulcers, maybe about a half to three-quarters of a centimeter in length. I would call the changes moderate. There was a small hiatus hernia. The Z-line appears quite regular.

I advanced the scope into the stomach. There was a lot of fluid in the stomach obscuring some of the views, but I was able to mostly suction this as there was mostly liquid. The body and the antrum appeared normal. There were no signs of gastritis or peptic ulcer disease. I took biopsies from the antrum and the body to rule out H. pylori. In the antrum, I retroflexed the scope. I can see the small hiatus hernia. There were no other abnormalities.

Physician Surgical Documentation

I straightened the scope and advanced it into the duodenum. The duodenal bulb appeared normal except for a polypoid lesion just distal to the pylorus. I do not think this represents anything worrisome. There may be some gastric heterotopia. I took some biopsies of this and included them in the duodenal biopsies. Otherwise, the duodenal bulb and second portion of the duodenum appeared normal. There were no signs of duodenitis or celiac disease. I did take multiple biopsies from the duodenum including from the polypoid lesion.

I then withdrew the scope completely from the patient. The patient tolerated the procedure well.

We then repositioned the patient for colonoscopy. Rectal examination was performed and this was normal. There were no signs of perianal disease.

The colonoscope was introduced from the anus and into the rectum. It was advanced through the rectum, sigmoid colon, descending colon, transverse colon and into the ascending colon remnant. Here, I came to the anastomosis with the small bowel. At the anastomosis, there was some mild change with some erythema and edema. There were a couple of aphthous ulcers in the area of the anastomosis. However, I was able to find the opening to the small bowel. This was a widely patent. I had absolutely no problem intubating this. The neoterminal ileum also appears normal. I was able to advance the scope into the neoterminal ileum for a distance of about 8 cm. All of this mucosa appears normal. I could not really advance the scope beyond this point due to looping and patient discomfort. I did take multiple biopsies from the neoterminal ileum.

I then withdrew the scope to the colonic side of the anastomosis. I took a few biopsies from the actual anastomosis and put these in a separate jar.

From the anastomosis, I slowly withdrew the scope and carefully examined the mucosa. The Boston Bowel Preparation score for today's examination was 5.

There were no signs of inflammation anywhere in the colon. I did not see any polyps or diverticula. The colon appears quite normal.

I withdrew the scope completely from the patient. The patient tolerated the procedure very well.

IMPRESSION AND PLAN: There are certainly signs of distal esophagitis here. I think that this likely represents reflux esophagitis. He is not on a PPI. I am going to start him on Pantoprazole 40 mg daily. I am sending in the prescription to his pharmacy. He should continue on this for at least 3 months. We will discuss about continuing this further. There is likely some benefit in continuing this in the long term.

As far as the colonoscopy, we can discuss this further. If the biopsies show H. pylori, this should be treated with standard bismuth containing quadruple therapy for 14 days and I will leave this up to his family physician.

As far as the colonoscopy, the colon and neoterminal ileum actually appear quite well today. I really do not see signs of recurrent Crohn's disease at the anastomosis. The mild change at the anastomosis is likely in keeping with an anastomotic site, but we have taken biopsies and we will see what these show.

We will see Kevin back in the clinic to have a further discussion. He really does not have much in the way of active disease. We will see what the fecal calprotectin shows. There may be some benefit in discussing prophylactic treatment even though he does not have much disease at this time given some high risk features of his disease. We can discuss this further when we have the biopsies and see him back in the clinic. We will make further decisions at that point.

Rajal Khan, MD
Copies To: Randy J. MacKinnon, MD

Physician Surgical Documentation

Laurie A. Thomas, NP

DD: 2022/Sep/16 08:59:13
DT: 2022/Sep/21 08:37:00
T: tad
Job: 25943153/7542773

Electronically Authenticated By: Khan, Rajal, MD
Date and Time: 10-Nov-2022 04:28 PM

14th October 2022

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant	**PE**	**Phone**
Male / 3rd October 1976 / 46 years old	00825976	C: +1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin was seen for consultation 2022-10-11

Dear MacKinnon,

I had the pleasure of seeing your patient Kevin Gallant today in the office in follow up for his Crohn's disease.

Kevin continues to feel the same since his last visit. He is having four to five liquid bowel movements daily with no blood, mucus or melena. He says that these are concentrated in the morning. He has no stool accidents or nocturnal bowel movements. He does have urgency with his bowel movements and describes crampy abdominal pain that is relieved with bowel movements. He has no nausea, vomiting or perianal symptoms. He denies eye pains, joint pains, skin rashes and mouth ulcers. He has no fevers, chills or night sweats. His weight is stable around 182 lbs and his diet is normal.

He tells me that after the colonoscopy he ended up presenting to the emergency department with intense abdominal pain and inability to pass gas. At that time, his imaging and bloodwork were unremarkable. Dr. Craswell was consulted and it was recommended that he be hospitalized for a couple of days and start IV antibiotics. Kevin was not keen on that and was given Amoxiclav on an outpatient basis and he got along fine.

Medications: There have been no changes since his last visit.

The patient was diagnosed with: Crohn'S Disease (Disorder)

Impression/Plan: Kevin is a pleasant 46-year-old male who was diagnosed with Crohn's disease around 2000. He has had multiple surgeries for this and has not been on medical therapy for more than seven years.

14th October 2022

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant	**PE**	**Phone**
Male / 3rd October 1976 / 46 years old	00825976	C: +1 902 218 1335

Recent colonoscopy does not show much in the way of active disease. He did have esophagitis and started Pantoprazole 40 mg daily and has noticed a significant improvement in reflux symptoms since his last visit. He continues to have four to five liquid bowel movements daily despite not having much active disease on colonoscopy. We had a conversation today that he might have issue with bile acid reabsorption given the surgery in the area of his terminal ileum. We discussed doing a trial of Cholestyramine. He said he had been on this in the past but was taking so much he was a bit constipated, so he stopped. We had a conversation about using Cholestyramine, starting with a half packet a day and titrating up as needed to control his bowel movements. He is agreeable to trying this.

I also had a conversation today about his fecal calprotectin. I do not see the results in the system, although he is adamant that he submitted a sample. I think that we should repeat the sample and see the results as it may help determine treatment plan going forward. There may be some benefit to putting him on medication for his Crohn's disease prophylactically as he is at an increased risk for active disease given his history. We will await the results of the fecal calprotectin and make decisions after that.

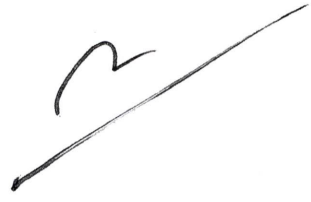
For now, I recommend:

1. Repeat the fecal calprotectin. I have given him the requisition and the container for this.
2. Cholestyramine half packet per day. I told him to titrate up to three packets per day as needed to control his bowel movements.
3. We will have a phone follow up in one month to discuss his fecal calprotectin results and treatment plan going forward.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

LT/ll



ANATOMIC PATHOLOGY REPORT

Provincial Laboratory Services - Health PEI

Queen Elizabeth Hospital
60 Riverside Drive
Charlottetown, PE C1A 8T5
Phone: (902) 894-2300 Fax: (902) 894-2385

Prince County Hospital
65 Roy Boates Avenue
Summerside, PE C1N 6M8
Phone: (902) 438-4280 Fax: (902) 438-4281

Patient: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03
Age: 45 years
Lab No: QH-22-07992
Sex: Male

Ordering Physician: Khan,Rajal,MD
Location: Queen Elizabeth Hospital

Primary Provider: MacKinnon,Randy J,MD
Copy For: MacKinnon,Randy J,MD
Additional Copies:

Surgical Pathology Report

Collected Date:	Received Date:	Accession Number:	Pathologist:
2022/Sep/16 00:00	2022/Sep/19 12:30	QH-22-07992	Sadeghi Aval,Pouya,MD, FRCPC

Surgical Pathology Final Report – 2022/Sep/26 09:41

Clinical Summary

45 yo male w/ Crohn's Dz + prior resections; nil medical Tx at present; increased symptoms including UGI Sx; EGD - distal esophagitis, polypoid lesion in duodenal bulb; C-scope - mild changes at anastomosis, N neo-TI, N colon.

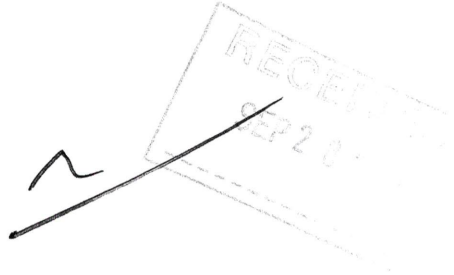
Diagnosis

A Duodenum, Endoscopic Biopsy
- Mild chronic duodenitis
- Negative for granulomas and dysplasia

B Gastric Mucosa, Endoscopic Biopsy
- Antral and body type mucosa with no diagnostic pathologic abnormalities
- Negative for granulomas and dysplasia

C Neoterminal Ileum, Endoscopic Biopsy
- Small intestinal mucosa with focal mild active inflammation
- No features of chronicity identified
- Negative for granulomas and dysplasia

D Anastomosis, Endoscopic Biopsy
- Small intestinal mucosa with pyloric gland metaplasia
- Negative for active inflammation
- Negative for granulomas and dysplasia



E Colon, Random, Endoscopic Biopsy
- Colonic mucosa with no diagnostic pathologic abnormalities
- Negative for granulomas and dysplasia

Surgical Pathology Report

Collected Date:	Received Date:	Accession Number:	Pathologist:
2022/Sep/16 00:00	2022/Sep/19 12:30	QH-22-07992	Sadeghi Aval,Pouya,MD, FRCPC

Gross Description

A. The specimen is labelled "Kevin Gallant" and "duodenum" and consists of multiple pieces of tissue measuring 2 to 3 mm. The specimen is entirely submitted in cassette A1.

B. The specimen is labelled "Kevin Gallant" and "stomach" and consists of four pieces of tissue measuring 3 mm. The specimen is entirely submitted in cassette B1.

C. The specimen is labelled "Kevin Gallant" and "neoterminal ileum" and consists of multiple pieces of tissue measuring 2 to 3 mm. The specimen is entirely submitted in cassette C1.

D. The specimen is labelled "Kevin Gallant" and "anastomosis" and consists of one piece of tissue measuring 2 mm. The specimen is entirely submitted in cassette D1.

E. The specimen is labelled "Kevin Gallant" and "random colon" and consists of multiple pieces of tissue measuring 2 to 3 mm. The specimen is entirely submitted in cassette E1.

GR /MM

***

Electronic Signature

Pouya Sadeghi Aval, MD, FRCPC

Provincial Laboratory Services - Health PEI

Queen Elizabeth Hospital
60 Riverside Drive
Charlottetown, PEI C1A 8T5
Phone: (902) 894-2300 Fax: (902) 894-2120

Prince County Hospital
65 Roy Boates Avenue
Summerside, PEI C1N 6M8
Phone: (902) 438-4280 Fax: (902) 438-4281

Patient: GALLANT, KEVIN HENRY
MRN: 000825976
DOB: 1976/Oct/03 **AGE:** 45 years
Sex: Male

Physician: Green,Nicole M,MD
Copy For: **MacKinnon,Randy J,MD**

Lab No: 22-260-00746

Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

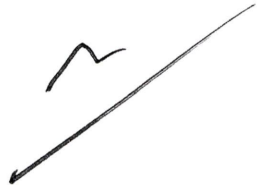
Blood Cultures

Procedure:	Blood Culture-Aerobic/Anaerobic O1	Received Date/Time:	2022/Sep/18 08:09
Source:	Blood-Peripheral	Collected Date/Time:	2022/Sep/17 14:53
Body Site:	ACF R	Accession:	22-260-00746
Free Text Source:		Ordering Physician:	Green,Nicole M,MD

Final Report
Verified Date/Time: 2022/Sep/20 09:42

No growth after 2 days incubation

Order Comments
O1: Blood Culture-Aerobic/Anaerobic
Bottle received without required blood volume marking. Interpret results with caution as both underfilled and overfilled blood culture vials are associated with false negative results.



QUEEN ELIZABETH HOSPITAL

PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY HENRY
Date of birth: 03-Oct-1976
Accession: 4527356
Exam: (QEH) DCHEST2V - DIAGNOSTIC CHEST 2 VIEWS -C
Patient Location/Status: EMERG, ER

MRN: 0000825976
Gender: M
Completed date: 2022-Aug-15

Requesting Provider: TWIDDY, MATTHEW, MD
Attending Provider: MACKINNON, RANDY J MD

Extra Report Sent To:

FINAL

PA AND LATERAL CHEST X-RAY

Clinical history:Exclude pneumonia

Findings:

The cardiomediastinal contours are within normal limits.
No focal consolidation or lobar collapse. No lung mass.
No pleural effusion or pneumothorax.
No fracture. No destructive bone lesion.

AUG 17 2022

Date exam taken: 2022-Aug-15
Transcriptionist date: 2022-Aug-16
Finalized date: 2022-Aug-16

Interpretating Radiologist: KIU, ALEX RADIOLOGIST
Transcriptionist : User, Interface
Radiologist(s) sign off: KIU, ALEX

QUEEN ELIZABETH HOSPITAL

PO Box 6600, Riverside Dr., Charlottetown, PE C1A 8T5 (902) 894-2233

Name: GALLANT, KEVIN HENRY HENRY
Date of birth: 03-Oct-1976
Accession: 4523030
Exam: (QEH) DCHEST2V - DIAGNOSTIC CHEST 2 VIEWS -C
Patient Location/Status: OUTPATIENT, WALK

MRN: 0000825976
Gender: M
Completed date: 2022-Aug-08

Requesting Provider: HANSEN, DARREN EDWIN, MD
Attending Provider: MACKINNON, RANDY J MD

Extra Report Sent To:

FINAL

Chest x-ray 2 views:

Comparison is made to the previous examination dated February 12, 2022.

The heart and mediastinal contours are normal. The lungs are clear. No evidence of an infiltrate, pleural effusion or pneumothorax. The pulmonary vasculature is within normal limits.

Opinion: No acute pulmonary pathology.

Date exam taken: 2022-Aug-08
Transcriptionist date: 2022-Aug-10
Finalized date: 2022-Aug-10

Interpretating Radiologist: WHITE, MARY RAD
Transcriptionist : User, Interface
Radiologist(s) sign off: WHITE, MARY

00825976 GALLANT, KEVIN HENRY

DOB: 03-Oct-1976 45 Years Male

15-Aug-2022 10:07:58

PEI (1)
QEH (10)
EMERG (06)

HR	82
PR	149
QRSD	82
QT	349
QTc	408

-- AXIS --

P	51
QRS	34
T	24

. Sinus rhythm
* Consider RVH or posterior infarct (new abnormal anterior R wave progression)

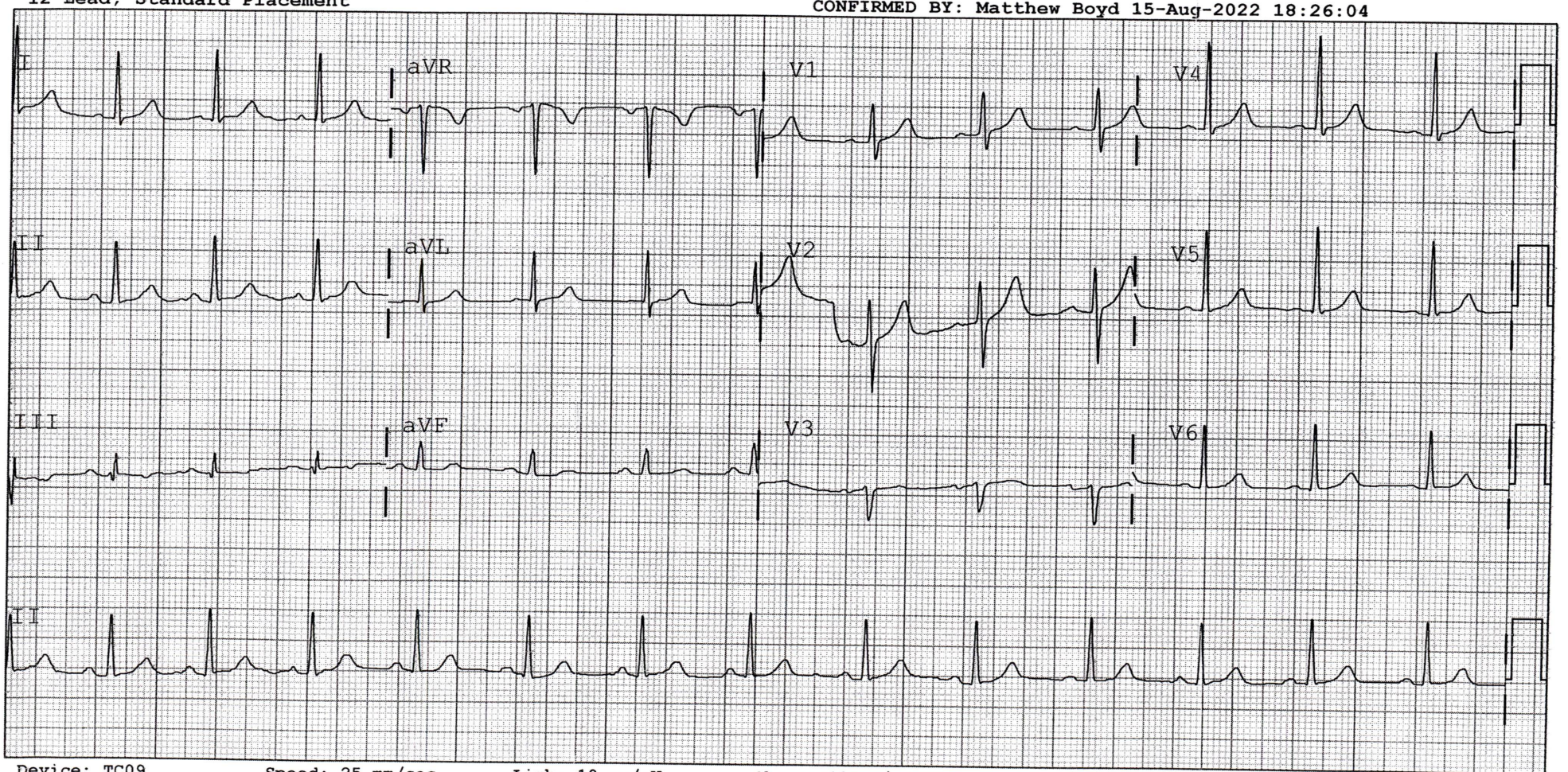
Room: TRIAGE
Oper: LEM
Fam Dr.: MACKINNON

- BORDERLINE ECG -

Edited
PREVIOUS:30-Mar-2022 20:27:05 - Borderline Confirmed

12 Lead; Standard Placement

CONFIRMED BY: Matthew Boyd 15-Aug-2022 18:26:04



Device: TC09 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60~ 0.15-100 Hz PH110C b L?P?

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Twiddy,Matthew R,MD
Copy For: MacKinnon,Randy J,MD

Lab No: 22-227-00801
Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Biochemistry

Routine Biochemistry

Collected Date	2022/Aug/15		
Collected Time	10:56		
Procedure		Reference Interval	Units
Sodium Level	140	[135-145]	mmol/L
Potassium Level	4.5	[3.5-5.1]	mmol/L
Chloride	106	[98-107]	mmol/L
Total CO2	26	[21-30]	mmol/L
Anion Gap	8	[4-12]	mmol/L
Glucose Random	5.4	[4.2-11.0]	mmol/L
Creatinine	81	[63-106]	umol/L
eGFR (CKD-EPI)	101 ^1	[>=60]	mL/min/1.73m^2

Interpretive Data
^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

Cardiac Function & Lipids

Collected Date	2022/Aug/15		
Collected Time	10:56		
Procedure		Reference Interval	Units
Troponin I -hs	<10.0 ^2	[<=34.2]	ng/L

Interpretive Data
^2: Troponin I - hs
Troponin cut-off levels are gender-specific. Increased levels are defined as **>15.6 ng/L in women**, and **>34.2 ng/L in men. Troponin should only be requested in patients with suspected acute coronary syndrome.**

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Twiddy,Matthew R,MD
Copy For: **MacKinnon,Randy J,MD**
Location: Queen Elizabeth Hospital
Emerg QEH

Lab No: 22-227-00801

Copies To: MacKinnon,Randy J,MD

Immunology

Immunology

Collected Date	2022/Aug/15		
Collected Time	10:56		
Procedure		Reference Interval	Units
CRP	1.4 ^3	[<=8.0]	mg/L

Interpretive Data
^3: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Twiddy,Matthew R,MD
Copy For: MacKinnon,Randy J,MD

Lab No: 22-227-00801

Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Hematology

CBC

Collected Date	2022/Aug/15		
Collected Time	10:56		
Procedure		Reference Interval	Units
WBC	**4.40** L	[4.50-11.00]	x10^9/L
Hgb	146	[130-170]	g/L
Platelet	393	[140-400]	x10^9/L
RBC	4.65	[4.50-6.20]	x10^12/L
Hct	0.421	[0.420-0.520]	L/L
MCV	90.6	[80.0-100.0]	fl
MCH	31.5	[25.0-35.0]	pg
MCHC	347	[310-370]	g/L
RDW	12.9	[11.0-17.0]	%
Neut #	2.90	[1.50-8.50]	x10^9/L
Lymph #	**1.10** L	[1.50-4.00]	x10^9/L
Mono #	0.30	[0.00-1.00]	x10^9/L
Eos #	0.10	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Twiddy,Matthew R,MD

Copy For: MacKinnon,Randy J,MD

Lab No: 22-227-00801

Location: Queen Elizabeth Hospital
Emerg QEH

Copies To: MacKinnon,Randy J,MD

Coagulation

Collected Date / Collected Time / Procedure	2022/Aug/15 10:56	Reference Interval	Units
D-Dimer Quantitative	<270 O1 ^4	[0-420]	mcg/L
PT	12.6	[11.2-14.8]	sec(s)
INR	1.0	[0.9-1.1]	

Order Comments
O1: D-Dimer Quantitative
Add-On request received from blake in emerg at 2022-Aug-15 11:52:01.

Interpretive Data
^4: D-Dimer Quantitative
In non-pregnant patients at low or moderate pre-test probability of first lower extremity DVT, a value of <500 mcg/L virtually excludes venous thromboembolism (negative predictive value 99.7%). Results are reported in FEUs.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Lab No: 22-221-00934

Copies To: MacKinnon,Randy J,MD

Ordering Provider: Hansen,Darren E,MD

Copy For: MacKinnon,Randy J,MD

Location: Physicians Office
LAB QEH

Immunology

ANA & Vasculitis

Procedure	Collected Date / Collected Time: 2022/Aug/09 08:10	Reference Interval	Units
MPO	<3.5	[<=3.4]	IU/mL
PR3	<2.0	[<=1.9]	IU/mL
GBM	<7.0 ^1	[<=6.9]	AU/mL
Vasculitis Interpretation	See Interp. ^2		

Interpretive Data

^1: GBM

	Negative	Equivocal	Positive
GBM	<7.0	7.0 to 10.0	>10.0

^2: Vasculitis Interpretation

	Negative	Equivocal	Positive
MPO	<3.5	3.5 to 5.0	>5.0
PR3	<2.0	2.0 to 3.0	>3.0

LEGEND: @=Corrected C=Critical L=Low H=High

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Hansen,Darren E,MD

Copy For: MacKinnon,Randy J,MD

Lab No: 22-221-00934

Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD

Immunology

Immunology

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		Reference Interval	Units
CRP	**23.4** H ^3	[<=8.0]	mg/L

Interpretive Data
^3: CRP
CRP elevations are non-specific and must be considered within the context of the patient. Levels >8.0 mg/L are consistent with acute inflammation.

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Hansen,Darren E,MD

Copy For: MacKinnon,Randy J,MD

Lab No: 22-221-00934

Location: Physicians Office
LAB QEH

Copies To: MacKinnon,Randy J,MD

Biochemistry

Nutritional Status

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		**Reference Interval**	**Units**
Transferrin Saturation	~~40~~	[20-50]	%
Vitamin B12 Level	178	[138-652]	pmol/L

Endocrinology & Tumor Markers

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		**Reference Interval**	**Units**
TSH Diagnostic	1.06	[0.35-4.50]	mU/L

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Hansen,Darren E,MD
Copy For: MacKinnon,Randy J,MD
Location: Physicians Office
LAB QEH

Lab No: 22-221-00934

Copies To: MacKinnon,Randy J,MD

Hematology

CBC

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		Reference Interval	Units
WBC	7.60	[4.50-11.00]	x10^9/L
Hgb	144	[130-170]	g/L
Platelet	389	[140-400]	x10^9/L
RBC	4.55	[4.50-6.20]	x10^12/L
Hct	**0.417** L	[0.420-0.520]	L/L
MCV	91.7	[80.0-100.0]	fl
MCH	31.6	[25.0-35.0]	pg
MCHC	345	[310-370]	g/L
RDW	13.0	[11.0-17.0]	%
Neut #	6.00	[1.50-8.50]	x10^9/L
Lymph #	**0.90** L	[1.50-4.00]	x10^9/L
Mono #	0.60	[0.00-1.00]	x10^9/L
Eos #	0.10	[0.00-0.80]	x10^9/L
Baso #	0.00	[0.00-0.20]	x10^9/L
nuc RBC	0	[<=1]	/100 wbc

Provincial Laboratory Services- Health PEI

Patient Name: GALLANT, KEVIN HENRY HENRY
MRN: 000825976
DOB: 1976/Oct/03 **Age:** 45 years
Sex: Male

Ordering Provider: Hansen,Darren E,MD
Copy For: MacKinnon,Randy J,MD
Location: Physicians Office
LAB QEH

Lab No: 22-221-00934
Copies To: MacKinnon,Randy J,MD

Biochemistry

Routine Biochemistry

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		Reference Interval	Units
Sodium Level	142	[135-145]	mmol/L
Potassium Level	4.1	[3.5-5.1]	mmol/L
Chloride	105	[98-107]	mmol/L
Calcium Level Total	2.22	[2.10-2.60]	mmol/L
Glucose Fasting	5.9	[4.2-6.1]	mmol/L
Creatinine	74	[63-106]	umol/L
eGFR (CKD-EPI)	106 ^1	[>=60]	mL/min/1.73m^2
Total Protein	66	[64-83]	g/L
Albumin Lvl	38	[35-50]	g/L
Bilirubin Total	16.5	[<=21.0]	umol/L
ALT	33	[5-56]	mU/mL
GGT	18	[<=50]	mU/mL
Alkaline Phosphatase	76	[40-120]	mU/mL
Phosphate Level	**0.7** L ^2	[0.8-1.5]	mmol/L
Magnesium	0.76	[0.66-1.07]	mmol/L

Interpretive Data

^1: eGFR (CKD-EPI)
eGFR calculations are only reliable when serum creatinine is stable for > 4 days (steady state conditions); and eGFR should not be used to assess acute changes in renal status. For patients of African descent, eGFR (CKD-EPI) may be multiplied by 1.159. Caution should be used when interpreting eGFR in hospitalized patients, in patients with extremes of body weight or amputations, and in pregnancy. eGFR is an important component of numerous kidney failure risk scores that are freely available.

^2: Phosphate Level
Phosphate has a strong biphasic circadian rhythm. Phosphorus values are lowest in morning, peak in late afternoon and are maximal in the late evening. Fasting reduces daily phosphate variation.

Nutritional Status

Collected Date	2022/Aug/09		
Collected Time	08:10		
Procedure		Reference Interval	Units
Iron	23.0	[9.0-31.3]	umol/L
TIBC	57	[41-77]	umol/L

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant	**PE**	**Phone**
Male / 3rd October 1976 / 45 years old	00825976	+1 902 218 1335

Randy MacKinnon
418 Queen St.
Charlottetown, PE C1A 4E7
Canada
+1 902 566 1229 +1 902 628 6337

Re: Kevin Henry Gallant DOB: 1976-10-03 Sex: Male PHIN: 00825976
Mobile: +1 902 218 1335 Bus: Home: Email:
106-55 CHESTNUT STREET , CHARLOTTETOWN Prince Edward Island C1A1Z7

Kevin Henry was seen for consultation 2022-06-27

Dear Dr. MacKinnon,

Thank you for the kind referral on Kevin Gallant. You had sent him to us for ongoing management of his Crohn's disease and he was seen today in the office.

As you know, Kevin was diagnosed with Crohn's disease around 2000. He has had multiple surgeries for this and has not been on any medical therapy for more than 7 years. He has been intolerant to oral medications, Methotrexate, and Imuran in the past. His last colonoscopy in January of 2020 showed active disease of the neoterminal ileum.

Apparently at that time Dr. Chiba told him to lose weight and that would be enough to manage his disease. Unfortunately, he is having considerable symptoms. He says that if he eats anything he has to run to the washroom shortly thereafter. He is having about 6 to 7 liquid bowel movements daily. He is noticing blood and mucus with those and occasionally he is noticing some very dark stools that he describes as being black. He is not having any stool accidents or nocturnal bowel movements. He does have a lot of urgency and crampy abdominal pain that is relieved with bowel movements. He has significant nausea mainly with obstructive symptoms but does have some nausea outside these obstructive symptoms as well and over the course of the last 6 months is having significant issues with reflux symptoms. He denies any perianal symptoms. He does not have any eye pains, joint pains, skin rashes or mouth ulcers but he is questioning whether he has some ulcerations in his nose.

He describes that approximately once a month he will have upwards of 24 hours where he has no bowel movements. He is not passing gas, he has a lot of nausea with this. During these times he does not eat any solid foods and just drinks copious amounts of water. This seems to be enough to settle things down and then his symptoms will pass. He states that he is eating a fairly low residue diet but he does occasionally to eat raw fruits and vegetable and he says that these do not agree with him. He has a lot of symptoms especially with rhubarb. He has no fevers or chills but he does

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 45 years old

PE
00825976

Phone
+1 902 218 1335

have night sweats and his weight is stable around 190 pounds.

Past Medical History: He had an ulnar nerve transplant. He was in an MVC last year and had quite a hit to the head. He has had issues with memory since.

Past Surgical History: He has had approximately 5 bowel surgeries and he has had left shoulder repair done for removed trauma.

Medications: He is on Percocet 1 to 2 pills daily and Zantac as needed for reflux symptoms.

Allergies: He has significant allergy to contrast dye, both iodine based and gadolinium. He is intolerant of Methotrexate and Imuran. Both cause severe nausea.

Family History: His twin has Crohn's disease and he has a paternal aunt with colitis. His mother, father and brother have polyps. His mother and father, 3 maternal uncles, 3 maternal aunts and 1 maternal first cousin all had colorectal cancer. Apparently there is a genetic cancer in his family that has killed 7 people in 7 years. It either impacts the back or the bowels. He was supposed to have genetic testing done if his mother tested positive for this gene. She was tested approximately 10 years and was told she did not have it and within 2 years developed that particular cancer and died. I have strongly suggested that he reach out to yourself, Dr. MacKinnon, to discuss this and to arrange genetic testing, if it is warranted.

Social History: He vapes. He used to smoke 3 packages of cigars a day but quit 3 years ago. He denies any recreational drug use including cannabis and he does not consume alcohol. His vaccines are up-to-date.

Physical Exam: Kevin appears well and in no acute distress. He is not pale or jaundiced. There is no scleral icterus or lymphadenopathy. His chest is clear and his heart sounds are normal. His abdomen is soft and non-tender. Bowel sounds are present. There is no hepatosplenomegaly and surgical scars are noted on his abdomen.

Investigations: Kevin's most recent bloodwork is from March 30, 2022. At that time his sodium, potassium and chloride were within normal limits as was his random glucose level. His creatinine and eGFR were normal. His total protein was 68, albumin was 39, and total bilirubin was 7.7. His ALT was 24, AST was 18, GGT was 13, alkaline phosphatase was 82 and lipase was 180. His magnesium was 0.80. His CRP was 1.5. White blood cell count was 6.10, hemoglobin was 146 and platelets were high at 422. His D-dimer was less than 270. His INR was 1.0.

His last colonoscopy was January 20, 2020. Dr. Chiba made note that there was minor aphthous ulcers in the terminal ileum. Biopsies showed mild chronic active inflammation in the neoterminal ileum and architectural distortion, negative for dysplasia in the rectum.

6th July 2022

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 45 years old

PE
00825976

Phone
+1 902 218 1335

He had a MRI enterography on July 26, 2017 for obstructive symptoms. At that time there was a short segment of distal small bowel for which a combination of active disease and fibrostenotic disease was suspected. The neoterminal ileum was relatively stable in appearance. Note was made during that MRI that the patient experienced a severe adverse reaction to the intravenous gadolinium which included urticaria and severe bronco spasm which initially necessitated administration of intravenous Benadryl and epinephrine. The patient then began to complain of severe chest pain and shortness of breath which necessitated activation of the active response team. The patient eventually settled and was ultimately transferred to the emergency department for further investigation. Note was also made that the patient reacted to the iodine IV contrast following CT examinations in the past. The radiologist said it is therefore recommended that intravenous contrast be strictly avoided in all future CT and MRI investigations in this patient unless it is absolutely necessary and if so that he would require premedication prior to the examination.

He had a CT abdomen and pelvis with oral contrast on January 22, 2020. At that time he had presented with symptoms of obstruction 5 days after a colonoscopy. There was no evidence of obstruction but there was a dilated small bowel loops likely related to an ileus at that time. There is no free gas to suggest a perforation.

The patient was diagnosed with: Crohn'S Disease (Disorder)

Impression and Plan: Kevin is a 45-year-old male who was diagnosed with Crohn's disease around 2000. He has had multiple surgeries for this and has not been on any medical therapy for more than 7 years. He had moderate active disease at the neoterminal ileum in January of 2020 when he had his last colonoscopy, but Dr. Chiba told him that if he just lost weight it would be enough to manage his symptoms. Unfortunately, he is struggling. He says if he eats anything it goes right through him. He is having 6 to 7 liquid bowel movements a day with blood and mucus and he has noticed melena stool as well. He is also having symptoms of obstruction approximately once a month that last upwards of 24 hours. During this time he is not passing any stool or flatus and he is having significant nausea. During these times he is not taking any food but does drink lots of fluid and the symptoms seem to resolve on their own without intervention. He has also been describing nausea and a lot of reflux type symptoms that resolve on their own without intervention. He has also been describing nausea and a lot of reflux type symptoms that are new over the course of the past 6 months and some query ulcerations inside his nose and the back of his throat.

We had a discussion today about the fact that he has not been on any medical therapy for his Crohn's disease in many years despite there being evidence of active disease. We discussed that he might need to go on something after we scope him. He has been intolerant of Methotrexate and Imuran in the past. Therefore, I think it is reasonable to discuss biologic drugs if he has active disease.

For now, I recommend:

6th July 2022

Laurie Thomas
License Number: 105132

Dr. Khan - Polyclinic
199 Grafton St.
Charlottetown PE, Canada C1A 1L2
Phone 902-629-8810
Fax 833-563-2288

Kevin Henry Gallant
Male / 3rd October 1976 / 45 years old

PE
00825976

Phone
+1 902 218 1335

1. We will arrange a colonoscopy to assess the level of active disease.
2. I will arrange for a gastroscopy at that time as he is having new reflux symptoms, nausea and ulcerations.
3. I will arrange a fecal calprotectin to correlate with scope findings.
4. I have given him a requisition for bloodwork in case we have to start biologic therapy including hepatitis B, hepatitis C and tuberculosis testing.
5. We will follow up in approximately 3 weeks after his endoscopy to discuss his biopsy results and develop a treatment plan going forward.

Sincerely,

Laurie Thomas, Gastroenterology IBD Nurse Practitioner

LT/ll

Power Notes ED

Document Status: Auth (Verified)
Document Type: ED Note-Physician
Event Date: 2022/Sep/17 14:05
Performed By: Green,Nicole M,MD (2022/Sep/17 15:49)

Query post polypectomy syndrome

Patient: **GALLANT, KEVIN HENRY** **MRN: 000825976** **FIN: 08359204**
Age: **45 years** Sex: **Male** DOB: **1976-Oct-03**
Associated Diagnoses: **Abdominal or Pelvic Disorder 789.9**
Author: **Green, Nicole M, MD**

Basic Information
Time seen: Assign Time Seen
Time Seen:
Green, Nicole M, MD / 09/17/2022 10:30

Patient information:: Triage: History of Present Illness : History of Present Illness/Injury
2022-Sep-17 09:51 History of Present Illness/Injury Pt has hx of Crohn's- has had 6 bowel surgeries due to same. Had scope done yesterday - both directions. States when he got home he developed diffuse abd pain, indigestion, and a fever. He reports his abd feels distended, and that he is not passing gas. Additional Hx Present Illness/Injury States he is burping a lot. ++ nauseous, but no vomiting as of yet. Bowels have not moved since the scope. Pt has not voided since before scope yest am. States feels dehydrated. Bowel sounds little to none x 4 quadrants. Pt uncomfortable at triage. .

History of Present Illness

Vital Signs
Vital Signs

2022-Sep-17 09:51	Temperature Oral	36.6 degC
	Peripheral Pulse Rate	97 bpm
	Respiratory Rate	20 br/min
	Systolic Blood Pressure	137 mmHg
	Diastolic Blood Pressure	**97 mmHg HI**
	BP Measurement Device	Automated
	BP measurement location	Right arm .

Basic Oxygen Information

2022-Sep-17 09:51	Oxygen Therapy Device	Room air
	SpO2 Saturation	97 % .

RECEIVED SEP 22 2022

45-year-old man presents to the ED with abdominal pain post endoscopy.
Patient had bidirectional endoscopy yesterday because he has been having 3 months of increased abdominal discomfort and some loose stools with blood.
He also had some possible hemoptysis or hematemesis earlier in the year after a COVID infection and so his GI wanted to do both upper and lower scopes.
He said this endoscopy was much more painful than any he has had in the past, and he he is usually awake throughout the entire procedure but after he was having so much discomfort he said he heard the specialist said to give him some more sedation and then he does not member anything until he woke up in recovery.
He said when he got home yesterday afternoon he does continue to have discomfort he was belching any was not passing any gas.
Later in the evening he started to feel some upper abdominal discomfort and then he got chilled and cold and when he checked his temperature it was 38.4 and later 38.9.
He went to bed because his wife does not like to drive after dark and he was feeling too unwell to drive, and this morning he got up and ultimately brought himself here.
He still has not passed gas, he says he is feeling nauseated but he has not vomited.
He is having significant pain and it was worse when he was going over bumps on the way into the hospital.

Power Notes ED

Past Medical History:
1. Crohn's disease (diagnosed 2005 with multiple bowel surgeries since including small bowel resection and right hemicolectomy with terminal ileal resection, has had postsurgical complications including abscess and adhesive disease)
2. Anxiety
3. Depression
4. PTSD
5. Lower GI bleed (2019)
6. Anal fissures
7. Cholecystectomy
8. Shoulder surgery
9. Ulnar nerve transposition
10. Resection of fatty deposits from breast bilaterally
11. Atrial fibrillation
12. Chest pain (with a negative stress test)

Medications: Pantoloc, vitamins, Percocet as needed
Allergies: Gravel, latex, Zofran, contrast dye, NSAIDs

Social History: Patient is an ex cigar smoker, used to smoke heavily but now only vapes occasionally, ports occasional alcohol, denies any THC or illicit drugs. He lives with his female partner, has part-time custody of his son. He owns 2 restaurants.

Physical Examination:
Patient appears well, no acute distress
Heart sounds normal, no audible murmur, no peripheral edema
No increased work of breathing, good air entry to lung bases bilaterally, chest clear to auscultation
Abdomen soft but diffusely tender with rebound tenderness, worse in the right lower quadrant.
No rash

Medical Decision Making

Results review: Lab results : Lab View

2022-Sep-17 10:26

Sodium Level	139 mmol/L
Potassium Level	4.1 mmol/L
Chloride	105 mmol/L
Total CO2	24 mmol/L
Anion Gap	10 mmol/L
Glucose Random	5.9 mmol/L
Creatinine	81 umol/L
eGFR (CKD-EPI)	101 mL/min/1.73m^2
Total Protein	66 g/L
Albumin Lvl	40 g/L
Bilirubin Total	19.5 umol/L
ALT	35 mU/mL
AST	19 mU/mL
GGT	14 mU/mL
Alkaline Phosphatase	71 mU/mL
WBC	6.50 x10^9/L
Hgb	147 g/L
Platelet	298 x10^9/L
RBC	4.68 x10^12/L
Hct	0.430 L/L
MCV	91.8 fl
MCH	31.4 pg
MCHC	342 g/L
RDW	12.8 %
Neut #	5.00 x10^9/L
Lymph #	**1.00 x10^9/L LOW**
Mono #	0.50 x10^9/L
Eos #	0.00 x10^9/L

Power Notes ED

	Baso #	0.00 x10^9/L
	nuc RBC	0 /100 wbc
2022-Sep-17 10:11	POC Covid	Negative .

Radiology results: Computed tomography
CT Abdomen / Pelvis w/o Contrast

09/17/22 12:03:00
Date of Exam:

Assess for perforation, history of endoscopy, significant pain with rebound tenderness.
TECHNIQUE: CT scan of the abdomen and pelvis without intravenous contrast. Coronal and sagittal reformats were provided.
COMPARISON: Abdomen radiograph dated 9/17/2022
FINDINGS:
Lack of intravenous contrast limits assessment of the parenchyma and vasculature.
Lower Chest: Visualized lungs are clear. No pleural or pericardial effusion.
Liver: Hepatic steatosis.
Biliary System: Postcholecystectomy. No biliary ductal dilatation.
Pancreas: No ductal dilatation. No peripancreatic fluid or fat stranding.
Spleen: Not enlarged.
Adrenal Glands: No nodule.
Kidneys: No hydronephrosis or stones.
Bowel: No bowel dilatation or obstruction. Post right hemicolectomy.
Collapsed loops of bowel are not adequately assessed.
Mesentery, Omentum and Peritoneum: No pneumoperitoneum or ascites.
Pelvic Organs: Unremarkable.
Lymph Nodes: No enlarged lymphadenopathy.
Vasculature: No abdominal aortic aneurysm.
Bones and Soft Tissues: No destructive osseous lesion.
IMPRESSION:
No pneumoperitoneum or bowel obstruction.

Interpreting Radiologist: DURWAS, KANAK
Exam Date: 2022-SEP-17 12:03
Results Verified Date: 2022-SEP-17 12:23
Accession: 4550692
Ordering Provider: GREEN, NICOLE
Attending Physician: UNKNOWN PHYSICIAN, PHYSICIAN
Family Physician: MACKINNON, RANDY J

cc. Physician:

Signed By: Durwas, Kanak, MD
, There is no obvious free air on the patient's x-ray..

1400/
Patient reassessed, he seems to be feeling better after some logistics. He is nauseated and will try some Maxeran.
He is starting to feel some gurgling in the abdomen but still has not passed gas.

Reviewed with Dr. Craswell, he indicated that the patient may have had a post polypectomy syndrome if he had a polypectomy with electrocautery yesterday which can cause abdominal pain and for, and even transient bacteremia.
He suggested monitoring with IV antibiotics for couple of days in hospital under the hospitalist service, with follow-up with his GI and monitoring for any symptoms to suggest frank perforation.

When I went to discuss this again with the patient, he was adamant that he needs to go home.
He says he has no backup plan for his restaurants, his dogs and is supposed to have custody of his son tomorrow and really does not want to be in hospital.
We discussed the fact that he did increase risk of complications such as development of sepsis and/or an intra-abdominal infection if he did have any microscopic perforation that was not yet visible on imaging, and he understands that it is possible but would prefer to go home on oral antibiotics and come back if he has worsening symptoms or recurrent fever.

Power Notes ED

I reviewed the above with Dr. Craswell, he thought that Amox-Clav would be a reasonable choice and agreed with the plan and advice given to the patient.

Impression and Plan

In summary, 45-year-old man who had a bidirectional endoscopy yesterday with a history of Crohn's disease, presented with fever last night and increasing abdominal pain with worrisome findings on exam but CT is negative for perforation. He is not febrile today, blood work is normal. He did have polypectomy yesterday and is possible that he may have developed post polypectomy syndrome. The suggestion was for him to be admitted to hospital for some IV fluids and antibiotics pending results of blood cultures and for close observation to ensure he did not develop symptoms more suspicious for intra-abdominal infection or frank perforation, but the patient was adamant that he needed to go home as he has many things to deal with related to both his family and his business. He was aware that there is an increased risk of complication with outpatient management in his situation, and is willing to accept those risks has been discharged on a course of 3 days of Amox-Clav to return if he develops recurrent fever or any increasing abdominal pain. If his blood cultures is all that is positive, he may require a more extended course of antibiotics, but we can follow-up with him at that time and he knows to come back sooner if there is any change.

ED Diagnosis

Abdominal or Pelvic Disorder 789.9 : ICD9 789.9, Discharge, Emergency medicine, Medical

Plan

Disposition: Discharged: Time 2022-Sep-17 15:45:00, to home.
Prescriptions: Launch prescriptions
Pharmacy:

amoxicillin-clavulanate 875 mg-125 mg oral tablet (Prescribe): 875 mg, Oral, BID, 3 day(s).

Electronically Authenticated By: Green, Nicole M, MD
Date and Time: 17-Sep-2022 03:49 PM

MRN: 000825976 Location: Emerg QEH CC: MacKinnon,Randy J,MD
Patient Name: GALLANT, KEVIN HENRY

Power Notes ED

Document Status: Modified
Document Type: ED Note-Physician
Event Date: 2022/Dec/29 12:31
Performed By: Green,Nicole M,MD (2022/Dec/29 19:59); Carmichael,Harrison C,MD (2022/Dec/29 12:33)

Addendum by Green, Nicole M, MD on 2022-Dec-29 19:59

Case received in handover from Dr. Carmichael at 1600.
Chart reviewed, patient reassessed at 1815.

He is feeling better after Buscopan, has not passed gas yet but is not having as much pain and has not had any nausea or vomiting.
He tells me that recently he started on cholestyramine for diarrhea and also has been taking some Percocet after episode of pain started and so wonders if he is also a bit constipated.
He is tolerating clear fluids and would like to trial going home.

Abdomen is less distended, mildly tender only, no worrisome findings on exam.

In summary, 46-year-old man with known Crohn's disease and multiple bowel resections who presented with symptoms consistent with a bowel obstruction that began shortly after Christmas dinner. He has not been passing any gas but has not been vomiting either. CT today did not show any evidence of obstruction and he has improved with some Buscopan. His blood work is reassuring. Is tolerating clear fluids. Is reasonable for him to trial ongoing conservative management at home with a clear fluid diet, Buscopan as needed, Tylenol only for pain, avoidance of cholestyramine and reassessment in 48 hours if he still not passing gas, sooner if he develops any worsening pain, vomiting or fever.

Electronically Authenticated By: Green, Nicole M, MD
Date and Time: 29-Dec-2022 07:59 PM

Abdo pain

Patient: **GALLANT, KEVIN HENRY** **MRN: 000825976** **FIN: 08517490**
Age: **46 years** Sex: **Male** DOB: **1976-Oct-03**
Associated Diagnoses: **Abdominal or Pelvic Disorder 789.9**
Author: **Carmichael, Harrison C, MD**

Basic Information
Time seen: Assign Time Seen
Time Seen:
Carmichael, Harrison C, MD / 12/29/2022 12:19

Patient information:: Triage: History of Present Illness : History of Present Illness/Injury
2022-Dec-29 10:06 History of Present Illness/Injury LBM Dec 25. LLQ pt feels firm and though he has SBO. Pain now radiates into the groin and back as of this AM. Pt has had several previous blockages, can sometimes resolve with clear fluid diet but unable to this time. Has not had any OTC fleets or softene Additional Hx Present Illness/Injury rs - states is not allowed to use. Pain relieved with laying supine, inc pain with ambulation. Abd distended. Nauseated. Required previous bowel resections. (Modified) , Pre-Arrival Information

No qualifying data available..

History of Present Illness

Vital Signs
Vital Signs

2022-Dec-29 10:06	Temperature Oral	37 degC
	Peripheral Pulse Rate	**102 bpm HI**
	Respiratory Rate	18 br/min
	Systolic Blood Pressure	**154 mmHg HI**
	Diastolic Blood Pressure	**98 mmHg HI**

Power Notes ED

Basic Oxygen Information

2022-Dec-29 10:06 Oxygen Therapy Device Room air
SpO2 Saturation 99 % .

46-year-old male who presents the emergency department with abdominal pain

Ongoing for 4 days. Feels pain most in the left lower quadrant. He has a history of Crohn's with multiple bowel resections. He states this feels similar to previous bowel obstructions that he has had.

He tried treating himself at home for quite some time but he had decreased output and increasing pain today.

No fever no chills he has ongoing nausea no significant vomiting there is no blood in his stool.

On exam looks well no acute distress
His vital signs are noted to have some tension and mild tachycardia.
He is tender with guarding in the left lower quadrant no masses. His abdomen is slightly distended
Otherwise appears warm well perfused.

His blood work reveals an elevated lactate unfortunately there is not a venous gas with this we will plan to add that on when to get a CT scan of his abdomen I have a concern about a partial/complete bowel obstruction and possible bowel ischemia. Unfortunately has an anaphylactic allergy to IV contrast and thus will do a noncontrast scan to start.

Patient still having ongoing pain his blood work looks okay CT shows no obvious blockage. Were planning to treat his pain bit more aggressively and try some Buscopan. I will handover care.

Impression and Plan

ED Diagnosis

Abdominal or Pelvic Disorder 789.9 : ICD9 789.9, Discharge, Emergency medicine, Medical

Plan

Disposition: Patient care transitioned to: time: 2022-Dec-29 15:50:00.

Electronically Authenticated By: Carmichael, Harrison C, MD
Date and Time: 29-Dec-2022 03:50 PM

Power Notes ED

Document Status: Auth (Verified)
Document Type: ED Note-Physician
Event Date: 2023/Jan/01 03:47
Performed By: Foley,Mark G,MD (2023/Jan/01 03:53)

Abdominal pain

Patient: **GALLANT, KEVIN HENRY** **MRN: 000825976** **FIN: 08520443**
Age: **46 years** Sex: **Male** DOB: **1976-Oct-03**
Associated Diagnoses: **Abdominal pain 789.00**
Author: **Foley, Mark G, MD**

Basic Information

Time seen: Date & time 2023-Jan-01 03:47:00.

Additional information: Triage: History of Present Illness : History of Present Illness/Injury
2023-Jan-01 00:31 History of Present Illness/Injury was seen in ED 2 days previously for abdo pain, today feeling ripping sensation to LUQ and L sided chest, states was feeling unwell all day but pain just began, numbness to bilat lower extremities, good colour, abdo firm to LUQ, no incont, c/o SOB .

History of Present Illness

46-year-old patient with a history of Crohn's disease with previous bowel resections presenting today with persistent abdominal pain ongoing for several days but worse today. He was seen here 2 days ago and did have a CT scan albeit without contrast which did not show any new abnormality. He states since then his pain is worse increased in nature and more of a tearing or burning sensation that is constant. He states it is worse to the left upper abdomen. He reports 2 bowel movements today. No fevers no vomiting.

PAST MEDICAL HISTORY:

1. Crohn's disease diagnosed in 2005, multiple bowel surgeries including 3 small bowel resections and a right hemicolectomy with a terminal ileum resection. Recent colonoscopy with Dr. Chiba, pathology shows moderate chronic active inflammation.
2. Postop bowel surgery complications abscess, adhesive disease.
3. Anxiety, depression, PTSD.
4. **Anaphylaxis IV contrast**
5. Admission with lower GI bleed in April 2019 under Dr. Craswell.
6. Cholecystectomy in 2011.
7. Anal fissures.
8. Normal EMG studies May 2018.

Initially upon triage apparently patient looked to be very uncomfortable. By the time I assessed him the emergency department he appeared in no acute distress and nontoxic with normal stable vital signs. Afebrile.

Bedside ultrasound shows some tenderness with deep palpation but no evidence of AAA or obvious dissection flap. Portions of the abdominal aorta were not visualized due to overlying bowel gas

He has no localizable peritonitis no other bruising or other visual abnormality of the abdomen. Lungs clear to auscultation

Plain film of the abdomen shows perhaps 1 or 2 small air-fluid levels but nothing obvious. In comparison to his x-ray from several days ago it is unchanged

2 hours: Pain still present after pain medication. CBC lites creatinine CRP VBG and lactate normal.

At the moment I think the patient may have a partial or early bowel obstruction. Unfortunately he is allergic to IV dye. He may need another CT scan in the morning.

At this point the patient was informed he may need to wait in the waiting room as we have run out of critical care space and there are no other beds to use in the department. He did become very upset over this. He feels we are kicking him out of the department. I tried to explain to him that this is not a perfect situation and we do not have ideal space for everyone. At this point we did have a sicker patient who needed his space and trauma.

This patient was offered space in our room the 5 anterior waiting room which he declined. He was able to leave under his own power easily.

I am frustrated by this as I do feel he may have other pathology in his abdomen but he did not want to stay for a CT scan in the morning. At the moment he is not acutely unwell and there is no evidence of bowel perforation or ischemia with a normal lactate normal CRP and even a normal D-dimer.

Power Notes ED

I have advised the patient to return if he worsens. He was advised he can stay in a stretcher in room 5 overnight but that it may be turned into another waiting room in the morning. He was upset with this.

Unfortunately this is another example of the difficulties we are facing here in the emergency department due to overcrowding. I tried to explain this to the patient but he was not willing to listen

Health Status

Allergies:

Allergic Reactions (Selected)

Medium

Zofran- No reactions were documented.

High

Contrast Dye- Redness, cardiac arrest and edema.

Severity Not Documented

Advil Liquigel- Shortness of breath and blotchy.
Gravol- Redness, edema, generalized and hives.
Latex- Eye swelling
23-apr-2020 12:26:45<$>, shortness of breath and edema of oral soft tissues..

Medications: Include Med List (Selected)

Prescriptions

Prescribed

Buscopan: 10 mg, Oral, TID, For abdominal pain, 10 day(s)
amoxicillin-clavulanate 875 mg-125 mg oral tablet: 875 mg, Oral, BID, 3 day(s)

Documented Medications

Documented

Oxycocet 325 mg-5 mg: 1 tab(s), Oral, BID, PRN: Pain, 0 Refill(s)
Vitamin B12: 1,000 mcg, IM, q28d
pantoprazole (as magnesium/Tecta): 40 mg, Oral, Daily.

Physical Examination

Vital Signs

Vital Signs

2023-Jan-01 00:31	**Peripheral Pulse Rate**	**101 bpm**	**HI**
	Respiratory Rate	**22 br/min**	**HI**
	Right Arm Systolic Blood Pressure	**89 mmHg**	**LOW**
	Right Arm Diastolic Blood Pressure	**49 mmHg**	**LOW**
	Left Arm Systolic Blood Pressure	**187 mmHg**	**HI**
	Left Arm Diastolic Blood Pressure	**131 mmHg**	**HI**

Basic Oxygen Information

2023-Jan-01 00:31	Oxygen Therapy Device	Room air
	SpO2 Saturation	99 %

Impression and Plan

Diagnosis

Abdominal pain 789.00 : ICD9 789.00, Discharge, Emergency medicine, Medical

Plan

Disposition: Discharged: time 2023-Jan-01 03:53:00.

Electronically Authenticated By: Foley, Mark G, MD
Date and Time: 01-Jan-2023 03:53 AM

Power Notes ED

Severity Not Documented
Advil Liquigel- Shortness of breath and blotchy.
Gravol- Redness, edema, generalized and hives.
Latex- Eye swelling
23-apr-2020 12:26:45<$>, shortness of breath and edema of oral soft tissues..

Medications: Include Med List (Selected)

Inpatient Medications

Ordered

Gastrografin: 15 mL, Oral, Once
Gastrografin: 15 mL, Oral, Once

Prescriptions

Prescribed

Buscopan: 10 mg, Oral, TID, For abdominal pain, 10 day(s)
amoxicillin-clavulanate 875 mg-125 mg oral tablet: 875 mg, Oral, BID, 3 day(s)

Documented Medications

Documented

Oxycocet 325 mg-5 mg: 1 tab(s), Oral, BID, PRN: Pain, 0 Refill(s)
Vitamin B12: 1,000 mcg, IM, q28d
pantoprazole (as magnesium/Tecta): 40 mg, Oral, Daily.

Past Medical/ Family/ Social History

Problem list: Include problem list

All Problems

chrons / Confirmed
Chrons disease / Confirmed
Hiatus hernia / SNOMED CT 139434018 / Confirmed
tooth pain with facial swelling / Confirmed
Upper abd lump? / Confirmed
awaiting consult from Dr. Craswell.

Physical Examination

Vital Signs

Vital Signs

2023-Apr-20 14:50	Temperature Oral	36.8 degC
	Peripheral Pulse Rate	100 bpm
	Respiratory Rate	**24 br/min HI**
	Systolic Blood Pressure	128 mmHg
	Diastolic Blood Pressure	**92 mmHg HI** .

Basic Oxygen Information
2023-Apr-20 14:50 Oxygen Therapy Device Room air .

Impression and Plan

Diagnosis

Abdominal pain 789.00 : ICD9 789.00, Discharge, Emergency medicine, Medical

Plan

Disposition: Discharged: time 2023-Apr-20 21:19:00.

Electronically Authenticated By: Kaul, Tom, MD
Date and Time: 20-Apr-2023 09:19 PM

Power Notes ED

Document Status: Auth (Verified)
Document Type: ED Note-Physician
Event Date: 2023/Apr/20 16:57
Performed By: Kaul,Tom,MD (2023/Apr/20 17:00)

Abdominal pain

Patient: **GALLANT, KEVIN HENRY** **MRN: 000825976** **FIN: 08692823**
Age: **46 years** Sex: **Male** DOB: **1976-Oct-03**
Associated Diagnoses: **Abdominal pain 789.00**
Author: **Kaul, Tom, MD**

Basic Information

Time seen: Date & time 2023-Apr-20 16:59:00.

Additional information: Triage: History of Present Illness : History of Present Illness/Injury
2023-Apr-20 14:50 History of Present Illness/Injury Has chrons disease. Roughly 8 surgeries. Today severe pain lower abdomen around scars. 10/10 ! looks uncomfortable. Trouble passing stool. Tender to touch all over, .

History of Present Illness

46-year-old gentleman presents with abdominal pain. It was suggested by his family physician that he come here for a CT scan of his belly. There is concerns about a potential umbilical hernia causing him significant symptoms. He has had some abdominal discomfort since Christmas time. They are concerned that this was a bowel obstruction with this turned out not to be true. They are concerned this is related to his Crohn's but he had bidirectional endoscopy performed by his gastroenterologist in the last 2 weeks which was normal. The pain is been focused in his umbilicus. He does think he could previously palpate a small lump there. He had extensive abdominal surgery relating to his Crohn's disease as well as an abdominal wall revision to try to fix all postoperative elements. He unfortunately has a severe contrast dyé allergy. He is also allergic to quite a few of our potential medications for both pain and nausea.

While this pain is been present for the last 4 months or so, it became significantly worse today. He was seen by his family physician who palpated his belly and organize an outpatient CT but suggested they come to the emergency department be preferable. The patient resisted but unfortunately as the pain worsened following his appointment, he acquiesced to come to the emergency department today. He has not been vomiting. His bowels have been slow of late.

On examination, he looks well. He is uncomfortable. His abdomen is soft generally with no peritonitis. He is very reluctant to have me touch anywhere in the vicinity of his umbilicus. There is no surrounding erythema redness etc. There is no visible bulge.

X-rays and blood work are normal.

We will get a noncontrast CT to try to assess.

Can does not demonstrate any visible hernia. However there is extensive adhesions throughout his abdomen and loops of small bowel that appear to be adherent in the as of the radiologist to the anterior abdominal wall. I know that anterior abdominal wall to have had significant surgical management with plastic surgery and general surgery in an effort to rebuild it after some complex surgical procedures.

He remains exquisitely tender in that region. I am going to contact the on-call surgeon who is familiar with this gentleman's abdomen to see if he has any thoughts with respect management.

I spoke with the on-call surgeon and he informed me that his findings on CT are very much typical of anybody who has had a laparotomy. He suggested some pain management for the patient but in light of his reassuring CT and blood work nothing surgical available.

And prescribed this gentleman some Percocet and stress he follow-up with his family physician. I do wonder if there is a musculoskeletal route to this pain. As I talk more with him after all these testing has been done, it sounds though he said multiple flares very similar to what he is experiencing over the last day and the part of his frustration is that this continues to happen to him. Given that his lab work and CT scan are entirely normal, her left with musculoskeletal abdominal wall pain is likely source which certainly he will be at risk for given the extensive surgeries experience on his abdomen.

Health Status

Allergies:

Allergic Reactions (Selected)
Medium
Zofran- No reactions were documented.
High
Contrast Dye- Redness, cardiac arrest and edema.