

6/13/2023 10:42 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 001 OF 003

F A X S H E E T

Date: 06/13/2023 10:29:10 AM
To: DR. AVERILL
Subject: Progress Notes
Fax Number: 7272104600
To Company:
From Name: Aviles, Abby
From Company: Louis Aviles M.D., PL
From Facility: Louis Aviles M.D., PL
Support Contact: 727-447-9000
Number of Page(s): 3

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6/13/2023 10:42 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 002 OF 003
Patient Name: AVERILL, ROSE, DOB: 10/26/1961, Account No: 48219

**AVERILL, ROSE C**

61 Y old Female, DOB: 10/26/1961

Account Number: 48219

2140 LONG BOW LN, CLEARWATER, FL 33764-6405

Home: 727-424-3402

Guarantor: AVERILL, ROSE C Insurance: UNITED HEALTHCARE Payer ID: 87726

PCP: ANUP DESAI, MD

Appointment Facility: Louis Aviles M.D., PL

03/01/2023

Progress Notes: Louis Aviles, M.D.

Current Medications**Taking**

- metFORMIN 500 mg tablet 1 tab(s) orally 2 times a day
 - gabapentin 300 mg capsule 1 cap(s) orally 3 times a day
 - atorvastatin 10 mg tablet 1 tab(s) orally once a day
 - ibuprofen 800 mg tablet 1 tab(s) orally 3 times a day
 - tramadol 50 mg tablet 1 tab(s) orally every 6 hours
 - Zyrtec 10 mg tablet 1 tab(s) orally once a day
 - Claritin 10 mg tablet 1 tab(s) orally once a day
 - cyanocobalamin 1000 mcg/mL solution as directed intramuscularly once a month
- Medication List reviewed and reconciled with the patient

Past Medical History

LONGSTANDING GERD.
H/O COLON POLYPS-TUBULAR ADENOMA
07/2022.
H/O HEMORRHOIDS.
SLEEP APNEA.
MORBID OBESITY (BMI > 40).
DIABETES TYPE II.
LIPEDEMA.
Genital herpes.
DYSLIPIDEMIA.
REFRACTORY GERD.

Allergies

NKDA.

Review of Systems**REVIEW:**

Review Patient completed extensive ROS questionnaires. Unless otherwise noted, all other symptoms in the review were negative.

GENERAL:

Fatigue Yes.

HEAD & EYES:

Eye Glasses Yes.

Dermatology:

Itching? Yes.

PULMONARY:

SLEEP APNEA Yes.

GASTROENTEROLOGY:

Abdominal pain Yes, Occasional. Heartburn / GERD Yes.

GU / FEMALE

Number of pregnancies Two.

MUSCULOSKELETAL:

Back pain Yes.

Reason for Appointment

1. ACID REFLUX

History of Present Illness**Gastroenterology (Upper):**

61 year old female presents with c/o HEARTBURN frequent, aggravated with food, no response to current treatment.

**MARCH 1, 2023: Pleasant woman comes in with worsening heartburn. States she has had it for many years but seems to have gotten worse. She has no C/O swallowing difficulties.

Vital Signs

Ht 67.

Examination**General examination:**

general appearance Pleasant, fully dressed, morbidly obese, White woman, NAD. skin warm, moist. HEENT unremarkable, sclera anicteric, EOMI. neck supple. lungs clear to auscultation & percussion. heart RRR, normal S1S2, no murmurs. abdomen soft, NT/ND, BS present, no tenderness, no hepatosplenomegaly, no hemias present. extremities no clubbing, no edema. Neurology Alert, oriented and appropriate, uses a cane.

Assessments

1. Gastroesophageal reflux disease - K21.9 (Primary), Differential including esophagitis, esophageal ulcers, hiatal hernia, Barrett's esophagus or esophageal malignancy.
2. Morbid (severe) obesity due to excess calories - E66.01
3. Body mass index [BMI] 40.0-44.9, adult - Z68.41
4. Allergic rhinitis, unspecified seasonality, unspecified trigger - J30.9
5. Colonic diverticular disease - K57.30
6. Type 2 diabetes mellitus with other specified complication - E11.69
7. Lipedema - R60.9
8. Mixed hyperlipidemia - E78.2
9. Dyslipidemia (high LDL; low HDL) - E78.5
10. Osteoarthritis of knee, unspecified - M17.9
11. Polyneuropathy - G62.9
12. Pre-operative examination - Z01.818
13. Encounter for limited medical examination - Z00.00

Treatment**1. Gastroesophageal reflux disease**

Notes: She has had heartburn for greater than 10 years and I have suggested an EGD to better assess what is going on in the lower esophageal area. Discussed procedure, indications and possible complications with the patient. Patient understands and agrees. Consent for procedure obtained.

2. Morbid (severe) obesity due to excess calories

Notes: Unfortunately this contributes to her reflux.

3. Others

Notes: Discussed briefly Antireflux maneuvers.

Procedures**EGD:**

Indication(s) HEARTBURN & GERD. Anesthesia TIVA. EGD-CONSENT

6/13/2023 10:42 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 003 OF 003
Patient Name: AVERILL, ROSE, DOB: 10/26/1961, Account No: 48219

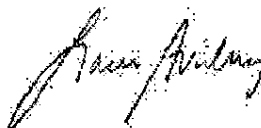
Discussed with patient the risks, benefits and possible complications including but not limited to that of ASPIRATION, BLEEDING, MEDICATION REACTION, PERFORATION AND REMOTE CHANCE OF DEATH. Also discussed the alternative of radiologic testing.

Visit Codes

99213 Office Visit-EST 3.

Follow Up

Patient to call and schedule her tests



Electronically signed by Louis Aviles, MD on 03/05/2023 at 07:31 PM EST

Sign off status: Completed

Louis Aviles MD, PL
1007 Jeffords Street Suite 102
Clearwater, FL 337564082
Tel: 727-447-9000
Fax: 727-447-9255

Progress Note: Louis Aviles, M.D. 03/01/2023

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

St.Francis Sleep Allergy & Lung Institute
802 N Belcher Road
Clearwater FL 337652103
Phone: 727-447-3000 Fax: 727-210-4600

Visit Note

Provider:

Performing: Regina Pruitt, PA

Supervising: Francis Averill, MD

Encounter Date: Feb 22, 2022

Patient: Averill, Rose (AVERO000)

Sex: F

DOB: Oct 26, 1961 Age: 60 Year 3 Month 3 Week

Race: White

Address: 802 belcher rd, Clearwater FL 337652103

Primary Dr.: Anup Desai, MD

Insurance:

UNITED HEALTHCARE (PP) Insurance ID: 912012181

Description: GENERAL

Chief Complaint:

***** Knee pain**

HPI:

***** Pt is a 61 year old female with PMH**

Lipidema

Prediabetes

Morbid obesity

Hyperlipidemia

Osteoarthritis of knee joints

allergic rhinitis

presents with c/o knee pain

describedd as a constant pain around her knees

Worse woith weight bearing and walking

Has lipidema with decreased ROM of knees

Hx OSA

Currently on CPAP

Gets benefit from CPAP

Feels more rested on CPAP

Current Medication:

1 Advil 200 Mg Liqui-gel Capsule SIG: As needed

2 Allegra Allergy 60 Mg Tablet SIG: As needed

3 Claritin 10 Mg Liqui-gel Cap SIG: As needed

4 Montelukast Sod 10 Mg Tablet SIG: once daily

ROS:

Cardiovascular: Patient denies: high blood pressure, heart attack, heart murmur, irregular heart beat, heart valve disorder, orthopnea, pacemaker, palpitations, varicose veins, edema, congenital heart disease, cold/blue hands, claudication, chest pressure, chest pain, and arrhythmia.

Constitutional: Patient Denies: loss of appetite, chills, fever, night sweats, fatigue/exhaustion, generalized weakness, headaches, malaise, recent weight gain, recent weight loss.

Skin: Patient Denies: rashes, itching, hives, acne, and ecchymosis.

ENT: Patient Denies: nasal congestion, runny nose, post nasal drainage, nosebleed, deviated septum, sinus problem, dental problems, dry mouth, mouth ulcers, hoarseness of voice, earache, ear drainage, hearing loss, ringing in ears, and vertigo.

GI: Patient Denies: abdominal pain, constipation, diarrhea, nausea, vomiting, difficulty swallowing, belching/flatulence, heartburn/reflux, blood in stool.

GU: Patient Denies: decreased urinary stream, dysuria, frequency, urgency, painful urination, urinary retention, hematuria, incontinence, nocturia, kidney stones, bladder cancer and prostate cancer.

Hematologic: Patient Denies: anemia, bleeding disorder, blood clots in legs, and blood clots in lung.

Musculoskeletal: (+) arthritis: ; (+) bone pain ; (+) joint pain: ; (+) limitation of motion: ; (+) muscle cramps: ; (+) muscle pain: ; (+) stiffness: .

Neurologic: Patient Denies: stroke, seizures, tremors, headaches, head injury, memory loss, dizziness, loss of coordination, numbness/tingling, speech impairment, and syncope.

Psychiatric: Patient Denies: agitation, anxiety, depression, irritability, mood changes, confusion, suicidal thoughts, history of suicide attempts, and sleep disturbances.

RESPIRATORY: Patient Denies: asthma, bronchitis, chest congestion, chest constriction, choking feeling, cough, chest pain, chest pain worst with deep breaths, chronic cough dyspnea, hemoptysis, orthopnea, persistent cough, pneumonia, recurrent URI's, shortness of breaths, sighing, sleep apnea, snoring, sore throat, tuberculosis, wheezing, chest tightness, and insomnia.

Lipedema: Pain, Fatigue, Fluid retention, Sensitive to touch, Easy bruising, Loss of mobility, Joint Pain.

Vital Signs:

Weight: 292 lbs

Temperature: 99.1 F (Tympanic)

BP: 128/77(Right Arm)(Sitting)

Pulse: 65

Oxygen: 97(Room air)

Examination:

General: obese.

Skin: moist, subcutaneous inspection normal and no rashes or lesions.

Head: normocephalic, atraumatic, no history or any evidence of head trauma and no alopecia.

Eyes: no abnormalities, pupils are equal, round and reactive to light and accommodation, extraocular muscles are intact and no conjunctival injection.

Ears: tympanic membranes are intact with good hearing acuity and canals clear.

Nose: normal nasal mucosa with no significant swelling or discharge, septum is midline, turbinates are not enlarged and sinuses are nontender.

Neck: supple, non-tender, trachea is midline, the thyroid is not enlarged with no masses, no JVD and no bruits.

Cardiac: regular rate and rhythm, no murmurs, rubs or gallops, no heaves and peripheral pulses are normal bilaterally.

Lungs: symmetric chest with normal excursion and expansion, no increased use of accessory muscles, normal diaphragmatic excursion, normal percussion of the chest with normal percussion note, no tactile fremitus elicited on palpation and auscultation reveals no rales, rhonchi, wheezes or rubs.

Abdomen: soft and nontender, no organomegaly, no masses, normal bowel sounds and no rebound.

Extremities: decreased ROM, lipdemia depositis.

Lymphatics: grossly normal and no palpable lymph nodes.

Neurologic: grossly intact, cranial nerves are intact, alert and oriented x3 and normal mood and affect.

Lipedema: Bilateral swelling / edema, Fat pads, Ankle cuff.

*** Disproportionate upper and lower body with upper body being much smaller

Tender nodules and fat in the upper gluteal area

small amount of fat in the upper arms without tender nodules

small amount of fat in the forearm without cuffing

hands negative stemmer sign

hips with tender nodules bilaterally

thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules
non pitting edema

Epworth Sleepiness:

Date:

Sitting & Reading: 3.

Watching Television: 3.

Sitting inactive in public place- for example a theater or a meeting: 2.

As a passenger in a car for an hour without a break: 2.

Lying down to rest in the afternoon: 3.

Sitting and talking to someone: 0.

Sitting quietly after lunch (When you've had no alcohol): 2.

In a car while stop in traffic: 0.

Total: 15

Interpretation:

0-10 = Normal range for healthy adults

11-14 = Mild sleepiness

15-17 = Moderate sleepiness

18 + = Severe sleepiness.

Diagnosis:

M25.561 Pain in right knee

G47.33 Obstructive sleep apnea (adult) (pediatric)

R60.1 Lipidema

R20.8 Other disturbances of skin sensation

I89.0 Lymphedema, not elsewhere classified

M79.609 Pain in unspecified limb

R26.9 Unspecified abnormalities of gait and mobility

Prescription:

1 Lidocaine 5% Patch SIG: Apply ONE PATCH Q 12 HRS As needed QTY: 30.00

Plan:

*** Order PSG

If OSAS order CPAP titration study

Recommend B12 injections for energy

Current medications documented and reviewed.

Advised not to drive if sleepy or drowsy.

Advised of risks of EDS and OSAS.

Advised regarding sleep hygiene.

Current medications documented and reviewed.

Influenza immunization previously received.

Pneumococcal vaccination has not been given nor previously received.

Keto low carb diet

walk 30 mins daily

Water exercise

RTC in 3 weeks

CC:

Dr Jamie Schwartz : 02/05/2024

Dr Schwartz : 02/05/2024

This visit note has been electronically signed off by following providers.

This visit note has been electronically signed off by Francis Averill, MD.

This visit note has been electronically signed off by Regina Pruitt, PA.

Sharecare - HDS

Fax Cover Sheet

Subject Sharecare EDelivery
To 17272104600
From
Date 2021-08-05 15:01:39 EDT

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

- Tear of medial meniscus of knee - Onset: 06/09/2017, Left
- Tear of medial meniscus of knee - Onset: 12/13/2018

Family History

Reviewed Family History

Mother

- Arthritis
- Malignant neoplastic disease
- Diabetes mellitus
- Obesity

Father

- Cerebrovascular accident
- Diabetes mellitus
- Heart disease
- Hypertensive disorder

Social History

Reviewed Social History

AFO Social History

Education: Post Graduate

General stress level: High

Marital status: Married

Live alone or with others?: with others

Single or multi-level home/work?: single level home

Smoking Status: Never smoker

Non-smoker

Alcohol intake: Occasional

Caffeine intake: Occasional

Exercise level: Occasional

Seat belts used routinely: Y

Advance directive: N

Chewing tobacco: none

Number of children: 2

Hand Dominance: Right

Are you currently employed?: Y

Work related injury?: N

Auto related injury?: N

If injured, is litigation ongoing?: N

Surgical History

Reviewed Surgical History

* Hysterectomy - 2003

* Cesarean Section - 1991

* Cesarean Section - 1988

Past Medical History

Reviewed Past Medical History

Back Pain: Y

Fractures: Y

High Cholesterol: Y

Obesity: Y

Sleep Apnea: Y

Urinary Tract Infection: Y

Varicose Veins: Y

Screening

None recorded.

HPI

Knee

Reported by
patient.

Location: right

Quality: aching; stabbing; constant; worsening

Duration: november 2nd

Context: exiting a plane, felt pain

Alleviating Factors: ice; rest; elevation

Aggravating Factors: upstairs; downstairs

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Associated Symptoms: **weakness; numbness; tingling; swelling; radiation down leg**

Previous Surgery: none

Prior Imaging: x ray (2 weeks)

Previous Injections: none

Previous PT: none

Working: regular duty

Notes: patient states right knee and leg pain and tightness/ using walker and cane

ROS

Constitutional:Constitutional: no fever, fatigue, or significant weight change and happy/content, good appetite, and normal activity level.

Eyes:Eyes: no eye pain, redness, itchiness, swelling, or discharge; no blurry vision; and normal movement.

ENMT:ENMT: no ear pain or discharge and no drooling, congestion, hoarseness, hearing loss, sinus pressure, facial swelling, sore throat, or mouth lesions.

Cardiovascular:Cardiovascular: no chest pain and normal heart rate.

Chest/Breasts:Breasts: no lumps, tenderness, or discharge.

Respiratory:Respiratory: no cough, wheezing, chest tightness, or pain with respiration and normal respiration.

Gastrointestinal:GI: no nausea, vomiting, diarrhea, constipation, difficulty swallowing, abdominal pain, blood in stools, or mucous in stool.

Genitourinary:GU: no discharge, blood in urine, pain with urination, increase in frequency of urination, voiding urgency, or vaginal discharge.

Musculoskeletal:Musculoskeletal: no myalgia, trauma, soft tissue swelling, joint swelling, or previous injuries and moves all extremities well.

Skin:Skin: no skin dryness, lesions, growths, or lumps and no pain, itchiness, flaking, redness, rash, hives, swelling, bruising, diaper rash, or insect bites.

Neurological symptoms:Neuro: no numbness, weakness, tingling, burning, headache, dizziness, shooting pain, or loss of consciousness.

Psychiatric:Psych: no depression, anxiety, insomnia, stress, or loss of interest.

Endocrine:Endocrine: normal drinking and no temperature intolerance.

Allergic/Immunologic:Allergy/Immunologic: no sneezing or runny nose.

Physical Exam

Patient is a 57-year-old female.

General:Appearance well-nourished and NAD. Gait limp . Orientation oriented to person, place, problem, and time. Mood appropriate mood and affect. Skin no suspicious lesions. Peripheral Vascular no clubbing, cyanosis, or edema. Lymphatics lymphedema absent.

Sensory Exam:Lower extremity sensation normal.

Reflexes:Deep Tendon Reflexes Normal.

Hips:Inspection Right Hip Normal. Inspection Left Hip Normal. Palpation Right Hip tenderness none. Palpation Left Hip tenderness none. ROM Right Hip normal . ROM Left Hip normal .

Knees:Inspection Right Knee: no deformity, mass, warmth, or erythema;effusion yes mild and swelling yes mild; and prepatellar bursitis no. Inspection Left Knee: no deformity, mass, warmth, or erythema; effusion yes mild and swelling yes mild; and prepatellar bursitis no. Soft Tissue Palpation Right Knee: no tenderness of the quadriceps tendon, the patellar tendon, the medial collateral ligament, the lateral collateral ligament, the pes anserinus, the popliteal fossa, or the gastrocnemius; Retro

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

patella crepitus and tenderness. Soft Tissue Palpation Left Knee: no tenderness of the quadriceps tendon, the patellar tendon, the medial collateral ligament, the lateral collateral ligament, the pes anserinus, the popliteal fossa, or the gastrocnemius; **Normal.** Bony Palpation Right Knee: no tenderness of the medial tibial plateau, the lateral tibial plateau, the superior pole patella, the inferior pole patella, or the tibial tubercle and **tenderness of the medial joint line.** Bony Palpation Left Knee: no tenderness of the medial tibial plateau, the lateral tibial plateau, the superior pole patella, the inferior pole patella, or the tibial tubercle and **tenderness of the medial joint line.** ROM Right Knee: normal, flexion normal, extension normal, and **crepitus yes.** ROM Left Knee: normal, flexion normal, extension normal, and **crepitus yes.** Stability Right Knee: no laxity or subluxation and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, Lachman test negative, and reverse Lachman test negative; **Normal.** Stability Left Knee: no laxity or subluxation and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, Lachman test negative, and reverse Lachman test negative; **Normal.** Special Tests Right Knee: patella compression test negative and apprehension sign negative and Apley's compression test negative and **McMurray's test positive.** Special Tests Left Knee: patella compression test negative and apprehension sign negative and Apley's compression test negative and **McMurray's test positive.** Strength Right Knee: no hamstring weakness or quadriceps weakness and flexion 5/5 and extension 5/5. Strength Left Knee: no hamstring weakness or quadriceps weakness and flexion 5/5 and extension 5/5.

Assessment / Plan

Osteoarthritis of knee

M17.12: Unilateral primary osteoarthritis, left knee

Tear of medial meniscus of knee- Left

S83.231A: Complex tear of medial meniscus, current injury, right knee, initial encounter

PHYSICAL THERAPY REFERRAL - Schedule Within: provider's discretion

Evaluate & Treat: yes Visits per Week: 2-3

Number of Weeks: 4-6 Modalities: pm

Side: LEFT Range of Motion:
yes

Strengthening: yes

Discussion Notes

The patient is a 57 year old female here today for a follow up regarding her right knee. DOI 11/2/18. The patient states her knee has gotten worse over the last few months. She states she has been having a lot of muscle tightness around her knee. She has been taking both Motrin and Tylenol to manage her pain. I ordered physical therapy. I ordered a handicap parking sticker. I will follow up with the patient in 1 month.

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Michael J Smith, MD, 04/03/2019.

Encounter performed and documented by Michael J Smith, MD

Encounter reviewed & signed by Michael J Smith, MD on 04/03/2019 at 4:02pm

Imaging Results

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

US VENOUS LOWER EXTREMITY BILATERAL (#11354659, Final, 07/19/2019 3:49pm)

Patient: AVERILL, ROSE C DOB: 10/26/1961
Gender: F

MRN: 2104682138
Account: 1109351742

Completed Date: 07/19/2019

US VENOUS LOWER EXTREMITY BILATERAL

CLINICAL INDICATION: Bilateral leg pain and edema

COMPARISON: Lower extremity ultrasound venous Doppler November 21, 2018

TECHNIQUE: Gray scale imaging with graded compression and spectral and color Doppler evaluation was performed.

FINDINGS:

RIGHT:

There is normal Doppler waveform and color Doppler flow at the right common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

LEFT:

There is normal Doppler waveform and color Doppler flow at the left common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler, MD Radiologist

Transcribed By: IA 07/19/2019

Electronically Signed By: Kevin Michael Kuppler, MD Radiologist 07/19/2019 03:53:00 pm

XR, FOOT 07/19/2019 - RIGHT (#11350353)

Interpretation:	Review of xr foot taken on 07/19/2019 at AFO CLINIC shows:
Foot:	
Findings:	Radiographic Findings: no fracture and no dislocation.

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

XR, TIBIA + FIBULA 07/19/2019 - RIGHT (#11350347)

Interpretation:	Review of xr tibia + fibula taken on 07/19/2019 at AFO CLINIC shows:
	Lower Leg:
	Radiographic Findings: no fracture and no dislocation.

XR, ANKLE 07/19/2019 - LEFT (#11350329)

Interpretation:	Review of xr ankle taken on 07/19/2019 at AFO CLINIC shows:
	Ankle:
	Radiographic Findings: no fracture and no dislocation.

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AVERILL, ROSE (Id #711165, dob: 10/26/1961)

US, DOPPLER, VENOUS (#11354926, 07/19/2019 12:00am)

Baycare Health Sys 7/19/2019 4:37:48 PM PAGE 1/002 Fax Server



FAX COVER SHEET

From:

Centricity RIS-IC Application

To:

Smith, Michael

BCMPH

Fax: 000-000-0000

Phone: 727-462-7540

Date: 7/19/2019 4:37:40 PM

Fax: 7275227412

Phone:

Pages (Including Cover): 2

Note:

Bartow Regional Medical Center (883) 519-1415
 Mease Countryside Hospital (727) 725-6105
 Mease Dunedin Hospital (727) 734-6535
 Morton Plant Bardmoor Emer Ctr (727) 395-2635
 Morton Plant Hospital (727) 462-7540
 Morton Plant North Bay Hospital (727) 842-8468
 Outpatient Carlisle Imaging Center (727) 452-7514
 Outpatient Imaging Bardmoor (727) 394-5900
 Outpatient Imaging Big Bend (813) 302-8925
 Outpatient Imaging Carillon (727) 561-2340
 Outpatient Imaging Hampton Lakes (813) 749-7810
 Outpatient Imaging Hyde Park (813) 259-1900
 Outpatient Imaging Martin Luther King (813) 870-4826
 Outpatient Imaging Mease Countryside (727) 725-6463
 Outpatient Imaging St Anthony's (727) 502-4200
 Outpatient Imaging Trinity (727) 372-4162
 Outpatient Imaging Van Dyke (813) 265-6300
 Saint Anthony's Hospital (727) 825-1040
 Saint Anthony's PET CT Center (727) 820-7600
 South Florida Baptist Hospital (813) 757-1200
 St. Joseph's Hospital (813) 870-4600

St. Joseph's Hospital North (813) 843-7141
 St. Joseph's Hospital South (813) 870-4600
 St. Joseph's Women's Hospital (813) 872-8619
 Susan Cheek Needler Breast Center (727) 298-6670
 Urgent Care- COUNTRYSIDE (727) 314-4774
 Urgent Care- NE ST PETE (727) 914-8566
 Urgent Care- SOUTH TAMPA (813) 609-3666
 Urgent Care- VALRICO (813) 502-5666
 Urgent Care- CARROLLWOOD (813) 609-3635
 Urgent Care- CLEARWATER (727) 314-4848
 Urgent Care- MLK TAMPA (813) 559-1888
 Urgent Care- NEW PORT RICHEY (727) 851-9650
 Urgent Care- WALSINGHAM (727) 583-9848
 Urgent Care- WATERS (813) 609-6835
 Urgent Care- ST. PETE BEACH (727) 220-1133
 Urgent Care- TYRONE (727) 317-3388
 Winter Haven Hospital (863) 293-1211
 Winter Haven Women's Hospital (863) 294-7030
 Outpatient Imaging New Tampa (813) 585-7669
 Urgent Care- New Tampa (813) 605-5061

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Baycare Health Sys 7/19/2019 4:37:48 PM PAGE: 2/002 Fax Server

BayCare Morton Plant Hospital

390 Pinellas Street Clearwater, FL 33755 (727) 462-7540

FINAL REPORT

Patient: AVERILL, ROSE C

DOB: 10/26/1961 Sex: F

Requesting: Smith, Michael J

Attending: Smith, Michael J

Interpreted By: Kevin Michael Kuppler

CPE: 101256420

MRN: 2104682138

Account: 1109351742

Patient Status: Outpatient

Patient Location: UL TMH

Smith, Michael J
4600 4th Street North
Saint Petersburg, FL 33703

ACC: 30883915

US VENOUS LOWER EXTREMITY BILATERAL

Completed: 7/19/19 3:49 pm

US VENOUS LOWER EXTREMITY BILATERAL

CLINICAL INDICATION: Bilateral leg pain and edema

COMPARISON: Lower extremity ultrasound venous Doppler November 21, 2018

TECHNIQUE: Gray scale imaging with graded compression and spectral and color Doppler evaluation was performed.

FINDINGS:

RIGHT:

There is normal Doppler waveform and color Doppler flow at the right common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

LEFT:

There is normal Doppler waveform and color Doppler flow at the left common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler

Electronically Signed By: Kevin Michael Kuppler

7/19/19 3:53 pm

Transcribed By: IA

7/19/19 3:53 pm

Name: AVERILL, ROSE C

Location: UL TMH

Patient Status: O

Exam: US VENOUS LOWER EXTREMITY BILATERAL

MRN: 2104682138

Printed: 8/21/2019 4:37 PM

Page 1 of 1

8/21/2019

ALL FLORIDA ORTHOPAEDIC ASSOCIATES • 4600 4TH STREET NORTH, SAINT PETERSBURG FL 33703-3802

AVERILL, ROSE (Id #711165, dob: 10/26/1961)

US, DOPPLER, VENOUS (#11354794, 07/19/2019 12:00am)

Baycare Health Sys 7/19/2019 4:07:38 PM PAGE 1/002 Fax Server



FAX COVER SHEET

From:

Centricity RIS-IC Application

To:

Smith, Michael

BCMPH

Fax: 000-000-0000

Phone: 727-462-7540

Date: 7/19/2019 4:01:28 PM

Fax: 7273695013

Phone:

Pages (Including Cover): 2

Note:

Bartow Regional Medical Center (883) 519-1415
 Mease Countryside Hospital (727) 725-6105
 Mease Dunedin Hospital (727) 734-6535
 Morton Plant Bardmoor Emer Ctr (727) 395-2635
 Morton Plant Hospital (727) 462-7540
 Morton Plant North Bay Hospital (727) 842-8468
 Outpatient Carlisle Imaging Center (727) 462-7514
 Outpatient Imaging Bardmoor (727) 394-5900
 Outpatient Imaging Big Bend (813) 302-8925
 Outpatient Imaging Carillon (727) 561-2340
 Outpatient Imaging Hampton Lakes (813) 749-7810
 Outpatient Imaging Hyde Park (813) 259-1900
 Outpatient Imaging Martin Luther King (813) 870-4826
 Outpatient Imaging Mease Countryside (727) 725-6463
 Outpatient Imaging St Anthony's (727) 502-4200
 Outpatient Imaging Trinity (727) 372-4162
 Outpatient Imaging Van Dyke (813) 265-6300
 Saint Anthony's Hospital (727) 825-1040
 Saint Anthony's PET CT Center (727) 820-7600
 South Florida Baptist Hospital (813) 757-1200
 St. Joseph's Hospital (813) 870-4600

St. Joseph's Hospital North (813) 843-7141
 St. Joseph's Hospital South (813) 870-4600
 St. Joseph's Women's Hospital (813) 872-8619
 Susan Cheek Needler Breast Center (727) 298-6670
 Urgent Care- COUNTRYSIDE (727) 314-4774
 Urgent Care- NE ST PETE (727) 914-8566
 Urgent Care- SOUTH TAMPA (813) 609-3666
 Urgent Care- VALRICO (813) 502-5666
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 Urgent Care- MLK TAMPA (813) 559-1888
 Urgent Care- NEW PORT RICHEY (727) 851-9650
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 Urgent Care- ST. PETE BEACH (727) 220-1133
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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Baycare Health Sys 7/19/2019 4:07:38 PM PAGE 2/002 Fax Server

BayCare Motion Plant Hospital

300 Pinellas Street Clearwater, FL 33755 (727) 482-7540

FINAL REPORT

Patient: AVERILL, ROSE C

DOB: 10/26/1961

Sex: F

Requesting: Smith, Michael J

Attending: Smith, Michael J

Interpreted By: Kevin Michael Kuppler

CPI: 101256420

MRN: 2104682138

Account: 1103351742

Patient Status: Outpatient

Patient Location: ULTMH

Smith, Michael J

4600 4th Street North

Saint Petersburg, FL 33703

ACC: 30883915 US VENOUS LOWER EXTREMITY BILATERAL

Completed 7/19/19 3:49 pm

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IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler

Transcribed By: LA

7/19/19 3:53 pm

Electronically Signed By: Kevin Michael Kuppler

7/19/19 3:53 pm

Name: AVERILL, ROSE C

Location: ULTMH

Patient Status: O

Exam: US VENOUS LOWER EXTREMITY BILATERAL

MRN: 2104682138

Printed: 07/19/2019 4:08PM

Page 1 of 1

07/19/2019

ALL FLORIDA ORTHOPAEDIC ASSOCIATES • 4600 4TH STREET NORTH, SAINT PETERSBURG FL 33703-3802

AVERILL, ROSE (id #3585604, dob: 10/26/1961)

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 08/02/2021

Patient

Name	AVERILL, ROSE (59yo, F) ID# 3585604	Appt. Date/Time	08/02/2021 09:15AM
DOB	10/26/1961	Service Dept.	AFO CLINIC
Provider	MICHAEL SMITH, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 912012181 Policy/Group # : 6F4546 Prescription: OPTUMRX COMMERCIAL - Member is eligible, details		

Chief Complaint

Followup: Tear of medial meniscus of knee

Patient's Care Team

Primary Care Provider: ANUP DESAI: 908 S FORT HARRISON AVE, CLEARWATER, FL 33756-3904, Ph (727) 442-5138, Fax (727) 461-5011 NPI: 1346348778

Patient's Pharmacies

WALGREENS DRUG STORE #06293 (ERX): 1505 S BELCHER RD, CLEARWATER, FL 33764, Ph (727) 536-7552, Fax (727) 536-7262

Vitals

08/02/2021 09:39 am

Wt: 280 lbs (127.01 kg)

Ht: 5 ft 6 in (167.64 cm)

BMI: 45.2

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

acyclovir 200 mg capsule TAKE 1 CAPSULE BY MOUTH FIVE TIMES PER DAY	07/22/21 filled
ALPRAZolam 0.25 mg tablet TAKE 1 TO 3 TABLETS BY MOUTH PRIOR TO PROCEDURE	03/03/21 filled
azithromycin 250 mg tablet	11/27/20 filled
cephALEXin 500 mg capsule TK 1 C PO QID FOR 5 DAYS	09/18/20 filled
furosemide 20 mg tablet	08/24/20 filled
methyIPREDNISolone 4 mg tablets in a dose pack FOLLOW PACKAGE DIRECTIONS	04/23/21 filled
Omega 3 start 06/09/2017	06/09/17 started
potassium chloride ER 20 mEq tablet,extended release(part/cryst)	08/27/20 filled
proGESTerone start 07/19/2019	07/19/19 started

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AVERILL, ROSE (Id #3585604, dob: 10/26/1961)

triamcinolone acetonide 0.1 % topical cream

09/17/20 filled

Vitamin D3 125 mcg (5,000 unit) tablet

08/04/15 filled

Take 1 tablet every day by oral route.

Vaccines

None recorded.

Problems

Reviewed Problems

- Acute pain - Onset: 07/27/2017
- Osteoarthritis of hip - Onset: 08/02/2021
- Osteoarthritis of knee - Onset: 06/09/2017
- Knee pain
- Degeneration of lumbosacral intervertebral disc - Onset: 08/02/2021
- Fracture of tibial plateau
- Tear of medial meniscus of knee - Onset: 12/13/2018
- Tear of medial meniscus of knee - Onset: 06/09/2017, Left
- Sprain of ankle - Onset: 07/19/2019
- Trochanteric bursitis of left hip - Onset: 08/02/2021

Family History

Reviewed Family History

Social History

Reviewed Social History

Gender Identity and LGBTQ Identity

Surgical History

Reviewed Surgical History

- Cesarean section
- Hysterectomy

GYN History

(not configured)

Past Medical History

Reviewed Past Medical History

HPI

Hip(s)

Reported by patient.

Location: left

Quality: sharp

Severity: moderate

Duration: 6 weeks

Timing: cannot identify

Context: cannot identify

Aggravating Factors: walking; bending/squatting; ROM

Knee Pain/Injury

Reported by patient.

Location: right; medial

Duration: 6 weeks

Severity: moderate

Quality: aching; sharp

Context: cannot identify

Timing: chronic

Aggravating Factors: bending/squatting; upstairs; downstairs

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AVERILL, ROSE (id #3585604, dob: 10/26/1961)

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no dry eyes, no irritation, and no vision change. She reports no difficulty hearing and no ear pain. She reports no teeth problems. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, and no coughing up blood. She reports no abdominal pain, no vomiting, normal appetite, no diarrhea, and not vomiting blood. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, and no swelling in the extremities. She reports no abnormal mole, no jaundice, and no rashes. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, and no headaches. She reports no swollen glands, no bruising, and no history of blood clots. She reports no runny nose, no sinus pressure, no itching, no hives, no frequent sneezing, and no metal or contact allergies.

Physical Exam

Patient is a 59-year-old female.

Constitutional: General Appearance: NAD and morbidly obese.

Gait and Station: Appearance: antalgic gait.

Cardiovascular System: Arterial Pulses Right: **Normal Pulses**. Arterial Pulses Left: **Normal Pulses**. Edema Right: none and no edema. Edema Left: none and no edema. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: **No Adenopathy**. Inspection/Palpation Left: **No Adenopathy**.

Knees: Inspection Right: no deformity, mass, induration, warmth, erythema, or swelling. Inspection Left: no deformity, mass, induration, warmth, erythema, or swelling. Bony Palpation Right: no tenderness of the inferior pole patella, the superior pole patella, the tibial tubercle, or the head of fibula and **tenderness of the lateral joint line and the medial joint line**. Bony Palpation Left: no tenderness of the superior pole patella, the inferior pole patella, the tibial tubercle, or the head of fibula and **tenderness of the medial joint line and the lateral joint line**. Soft Tissue Palpation Right: no tenderness of the quadriceps tendon, the prepatellar bursa, the patellar tendon, the medial collateral ligament, the pes anserinus, the lateral collateral ligament, the gastrocnemius, or the infrapatellar tendon. Soft Tissue Palpation Left: no tenderness of the quadriceps tendon, the prepatellar bursa, the patellar tendon, the medial collateral ligament, the pes anserinus, the lateral collateral ligament, the gastrocnemius, or the infrapatellar tendon. Active Range of Motion Right: **limited and crepitus**. Active Range of Motion Left: **limited and crepitus**. Passive Range of Motion Right: **limited**. Passive Range of Motion Left: **limited**. Stability Right: no laxity or ligamentous instability and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, and Lachman test negative. Stability Left: no laxity or ligamentous instability and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, and Lachman test negative. Special Tests Right: **McMurray's test positive and Apley's compression test positive**. Special Tests Left: **McMurray's test positive and Apley's compression test positive**. Strength Right: extension 5/5; **Normal Strength**. Strength Left: extension 5/5; **Normal Strength**.

Skin: Right Lower Extremity: normal. Left Lower Extremity: normal. Lumbosacral Spine: normal skin.

Neurologic: Coordination: heel-to-shin normal. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2); **Normal Reflexes**. Knee Reflex Left: normal (2); **Normal Reflexes**. Sensation on the Right: T12 normal, L2 normal, L4 normal, S2 normal, L5 normal, S1 normal, and normal distal extremities; **Normal Sensation**. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, S2 normal, L5 normal, S1 normal, and normal distal extremities; **Normal Sensation**. Special Tests on the Right: seated straight leg raising test negative.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Lumbar Spine: Inspection: normal alignment and alignment and no induration, ecchymosis, or swelling. Bony Palpation: no tenderness of the spinous process, the paraspinals, the sacrum, the coccyx, or the transverse process and **tenderness of the spinous process at L 3**. Special Tests: seated straight leg raising test negative. Soft Tissue Palpation on the Right: no tenderness of the iliolumbar region and **tenderness of the paraspinal region at L (Paraspinal tenderness throughout)**. Soft Tissue Palpation on the Left: no tenderness of the iliolumbar region and **tenderness of the paraspinal region at L (Paraspinal tenderness throughout)**. Active Range of Motion: flexion normal, extension normal, and lateral flexion normal. Passive Range of Motion: flexion normal, extension normal, and lateral flexion normal.

Hip/Pelvis Appearance: Inspection: normal axial alignment.

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AVERILL, ROSE (Id #3585604, dob: 10/26/1961)

Hips: Bony Palpation Right: no tenderness of the iliac crest, the ASIS, the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation Left: no tenderness of the iliac crest, the ASIS, the sciatic notch, or the SI joint and tenderness of the greater trochanter. Active Range of Motion Right: normal, flexion normal, extension normal, internal rotation normal, and external rotation normal. Active Range of Motion Left: normal, flexion normal, extension normal, internal rotation normal, and external rotation normal; Painful range of motion. Passive Range of Motion Right: normal. Passive Range of Motion Left: pain elicited by motion. Strength Right: normal 5/5. Strength Left: normal 5/5.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Procedure Documentation

AFO Corticosteroid Injection Trochanteric:

After discussion of the risks and benefits, the patient elected to proceed with a cortisone injection into the left trochanteric hip. Confirmed that the patient does not have history of prior adverse reactions, active infections, or relevant allergies. There was no erythema, or warmth, and the skin was clear.

The skin was prepped. A 22 gauge needle was inserted into the joint. The site was injected with a mixture of 80 mg DepoMedrol and 2 cc Lidocaine. Gloves were worn.

The patient tolerated the procedure well and was instructed to avoid strenuous activity for the next 24-48 hours and to use ice, NSAIDs, or Acetaminophen for pain as needed. The patient will call immediately with any concerns, signs of infection or allergic reaction.

Assessment / Plan

Pain of left hip joint

M25.552: Pain in left hip

- XR, HIP + PELVIS, UNILATERAL, 2 OR 3 VIEW
Side: LEFT

Low back pain

M54.5: Low back pain

- XR, LUMBAR SPINE - Note to Imaging Facility: 3 views
Views (X-RAY, LUMBAR SPINE): AP Lateral Spot

Pain in right knee

M25.561: Pain in right knee

- XR, KNEE - Note to Imaging Facility: AP, Lateral and Sunrise
Side: RIGHT Views (X-RAY, KNEE): AP, Lateral and Sunrise

Trochanteric bursitis of left hip

M70.62: Trochanteric bursitis, left hip

Degeneration of lumbosacral intervertebral disc

M51.37: Other intervertebral disc degeneration, lumbosacral region

Osteoarthritis of hip

M16.12: Unilateral primary osteoarthritis, left hip

- HIP ARTHRITIS: CARE INSTRUCTIONS
- OSTEOARTHRITIS: CARE INSTRUCTIONS

Osteoarthritis of knee

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AVERILL, ROSE (Id #3585604, dob: 10/26/1961)

Osteoarthritis of knee

M17.0: Bilateral primary osteoarthritis of knee

KNEE ARTHRITIS: CARE INSTRUCTIONS

XR, LUMBAR SPINE

- Views (X-RAY, LUMBAR SPINE): AP Lateral Spot

Review of xr, lumbar spine taken on 08/02/2021 at AFO CLINIC shows:

Imaging Studies:

Degenerative disk disease: **diffusely moderate.**

Facet arthropathy: **no facet disease.**

Compression fracture: **no fracture.**

Sagittal alignment: **no sagittal deformity.**

Spondylolisthesis: **no spondylolisthesis.**

Scoliosis: **no scoliosis.**

Instability on flexion/extension views: **no instability on flexion/extension views.**

Prior Surgery: **no evidence of prior surgery.**

Congenital abnormalities: **no congenital abnormalities.**

XR, HIP + PELVIS, UNILATERAL, 2 OR 3 VIEW

- Side: **LEFT**

Review of xr, hip + pelvis, unilateral, 2 or 3 view taken on 08/02/2021 at AFO CLINIC shows:

Imaging Studies:

Degenerative changes: **no degenerative changes.**

Fracture: **no fracture.**

XR, KNEE

- Side: **RIGHT**, Views (X-RAY, KNEE): AP, Lateral and Sunrise

Review of xr, knee taken on 08/02/2021 at AFO CLINIC shows:

Imaging:

Side: **Bilateral.**

General Radiographic Findings: **osteophytes lateral tibial plateau, osteophytes lateral femoral condyle, osteophytes medial tibial plateau, and osteophytes medial femoral condyle** but no fracture and no dislocation; grade IV DJD bilateral.

AP/ PA Findings: **Good Stress Correction and Intermediate Stress Correction.**

Discussion Notes

59-year-old here for lumbar spine, bilateral knees, left hip

The patient is morbidly obese. Her BMI is 45. The patient says her biggest problem is lipidemia. She has been to 2 specialists, one in Georgia and one in Texas who treated her lipidemia which was not successful. Eventually she will need a knee replacement but she is not a surgical candidate due to her obesity. I injected her left hip 80 mg depo medrol Placed her on naprosyn 500 mg bid. Reevaluate her in a month.

Return to Office

- Michael Smith, MD for FOLLOW UP 10 at AFO CLINIC on 08/30/2021 at 09:15 AM

Encounter Sign-Off

Encounter signed-off by Michael Smith, MD, 08/05/2021.

Encounter performed and documented by Michael Smith, MD

Encounter reviewed & signed by Michael Smith, MD on 08/05/2021 at 11:02am



Healing The Generations, Inc.

"A Strictly Hands-On Therapy Services Provider for Children and Adults"

FAX COVER SHEET

Date: _____

To: Elizabeth Kuman ARNP-BC

From: Wouter Vanderhorst, P.T., Certified Lymphedema Therapist

Fax: 210-4600 Phone: 447-3000

RE: Rose Averill

Comments: Dear Elizabeth

Please review the following evaluation, plan of care or FYI materials, if you agree, please sign and fax back to: 727-536-6006.

- ☒ Physical Therapy/Lymphedema Evaluation and Treatment Plan
☐ Physical Therapy/Lymphedema Medicare 30 Day Re-Certification
☐ Physical Therapy/Lymphedema FYI, no reply needed

If you have any questions regarding the attached information, please call us at 727-535-6746. Thank you.

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14141 46 Street N, Suite 1202, Clearwater, FL 33762 • (727) 535-6746 Fax (727) 536-6006

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Massage Therapy

Email: healingthegenerations@verizon.net • www.healingthegenerations.com



Healing The Generations, Inc.

Elizabeth Kurman
 This has been electronically signed by Elizabeth Kurman ARNP-BC

Strictly Hands-On Therapy Services Provider for Children and Adults

PHYSICAL THERAPY PLAN OF CARE LYMPHEDEMA MANAGEMENT

9/11/2020 17:04:48

Patient Name: <i>Rose Averill</i>	Phone #: 538-0263
Diagnosis/Current Complaints/Symptoms:	<i>Lipedema lymph 189.0</i>
Re/Certification From: 9/01/2020	Through: 9/30/2020

PROCEDURE/MODALITIES

- | | |
|---|--|
| <input type="checkbox"/> Evaluation | <input checked="" type="checkbox"/> Home Exercise Program |
| <input checked="" type="checkbox"/> Lymphatic Drainage | <input checked="" type="checkbox"/> Therapeutic Activities |
| <input checked="" type="checkbox"/> ADL/Patient Education | <input checked="" type="checkbox"/> Therapeutic Exercises |
| <input checked="" type="checkbox"/> Complete Decongestive Therapy | <input type="checkbox"/> Palliative Care |

Frequency: *Biweekly status post liposuction surgery*

LONG TERM OUTCOME (GOALS)

- ☒ Mobilization of protein rich fluids, reduce swelling
- ☒ Mobilization of fibrotic tissue, soften and improve skin conditioning
- ☐ Wound Care per MD specifications, with complete healing
- ☒ Skin Care with moisturizing cream, to soften and improve skin conditioning
- ☒ Compression therapy with bandages, to maintain and reduce swelling
- ☒ Measure and fit for compression garment, for long term phase 2 management
- ☐ Teaching of self Manual Lymph Drainage for long term phase 2 management
- ☒ Independent home exercise program, regarding remedial exercises.
- ☒ Maintain the patient's improvement and prevent or slow further deterioration resulting in hospitalization and increase health care cost
- ☒ Education towards the disease process and treatment options.
- ☒ Proper nail care as needed, including clipping and polishing.

Rehab potential: <input type="checkbox"/> Excellent <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair	
Telephone order: Physician/Therapist:	Date: Time:
Therapist Signature: <input checked="" type="checkbox"/> <i>Wouter Vanderhorst,</i> P.T., C.L.T. - A.L.M. 9/09/2020	<input type="checkbox"/> <i>Nadine Verdebout,</i> P.T., C.L.T.

I hereby certify the need for the treatments to benefit the patient and reduce health care cost.

Physician Signature: <input checked="" type="checkbox"/>	Date: <input checked="" type="checkbox"/>
Physician Name (Print): <input checked="" type="checkbox"/>	

14141 46th Street North, Suite 1202, Clearwater, Florida 33762

Phone: (727) 535-6746 • Fax (727) 536-6006

Email: info@healingthegenerations.com • www.healingthegenerations.com

08/28/2020 11:28 Dr Fisher Office

(FAX)2106160581

P.001/006

SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. 1009 904 78229

OFFICE (210) 616-0798

FAX (210) 616-0581

FACSIMILE TRANSMITTAL SHEET

TO: Att: Katarsha	FROM: Jo Ann Z
St Francis Medical Ctr.	DATE: 08/28/2020
COMPANY:	
FAX NUMBER: 727-447-3000	TOTAL NO. OF PAGES INCLUDING COVER: (6)
PHONE NUMBER: 727-210-4600	SENDER'S REFERENCE NUMBER:
RE: Rose Averill	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

operative Report
Rabs

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DAVID FISHER, M.D.

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SURGERY

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PLASTIC & RECONSTRUCTIVE
SURGERY

08/28/2020 11:28 Dr Fisher Office

(FAX)2106160581

P.002/006



San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

Patient: Rose Averill
DOB: 10/26/1961

8/20/2020

Operative Procedure:
Suction lipectomy lipedema thighs.

8/28/2020

Is the patient's first postoperative note. She is doing well. She did bleed a lot at the time of liposuction but fortunately never became symptomatic enough to require a transfusion. She has had a lot of pain although today she feels considerably better. Significant swelling is noted with ecchymoses along the posterior lower thigh. The garment is fitting quite tightly. She did start the Lasix and then doubled up on her dose at my request. Although she feels that urine output is not very high it is very clear. She plans on returning back to Florida on Sunday. At this stage she feels she is up for that. She will add compression hose to her lower legs for the trip. Further instructions were discussed with her and her husband who was on the phone with us during this follow-up visit. She will keep me updated on how she is coming along as well as their reduction in swelling. We need to make a decision on what our next surgical plan will be buttock and 90 do that when I see some photos of how her thighs look in approximately 6-10 weeks time.

A handwritten signature in black ink, appearing to read 'Peter Fisher', is located below the main text block.

Peter Fisher, M.D.
PF

DAVID J. FISHER, M.D.
Board Certified
Plastic Surgery

PETER FISHER, M.D.
Board Certified
Plastic Surgery



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08/28/2020 11:29 Dr Fisher Office

(FAX)2106160581

P.003/006

METHODIST SPECIALTY AND TRANSPLANT HOSPITAL
8026 FLOYD CURL DRIVE
SAN ANTONIO, TX 78229

PATIENT'S NAME: AVERILL, ROSE
DOB: 10/26/61 AGE: 58 SEX: F
ATTENDING PHYS: Dr. Peter Fisher, MD
REPORT TYPE: OPERATIVE REPORT

UNIT NO: N00989520
ACCOUNT NO: N362973236
PT TYPE: DIS IN
ROOM NO: N.510

DATE OF ADMISSION: 08/20/20
DATE OF DISCHARGE: 08/22/20

DATE OF SURGERY: 08/20/2020

TIME OF SURGERY:
(See anesthesia record.)

PREOPERATIVE DIAGNOSIS:
Lipedema of the thighs.

POSTOPERATIVE DIAGNOSIS:
Lipedema of the thighs.

SURGICAL PROCEDURE(S) PERFORMED:
Suction lipectomy, lipedema thighs.

NAME OF SURGEON:
Peter Fisher, MD

ASSISTANT(S):
Matthew Bindewald, MD

ANESTHESIOLOGIST:
Richard Emery, MD

TYPE OF ANESTHESIA ADMINISTERED:
General anesthetic.

SPECIMEN(S) REMOVED:
None.

ESTIMATED BLOOD LOSS:
600mL

HISTORY:
The patient is a 58-year-old lady who has developed significant lipedema of the thighs with massive what looked like possibly lipomas of the medial aspects of the knees, worse on the right than the left. The patient has previously had liposuction of the thighs elsewhere, but comes for more aggressive suctioning of the significant lipedema which causes pain and discomfort.

DESCRIPTION OF PROCEDURE:
The patient was brought to operating suite where following induction of general anesthesia, Foley catheter was placed and the patient was placed on the

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236



Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

08/28/2020 11:29 Dr Fisher Office

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P.004/006

operating table in the prone position where she was appropriately positioned, padded, and prepped and draped in standard fashion. Markings were made for multiple stab incisions along the posterior thigh and hip areas. These were infiltrated with 0.25% Marcaine with epinephrine and incised sharply with an 11-blade. Tumescent solution of 1L Ringer's lactate, 1 unit epinephrine was infiltrated using approximately a liter and half. Suctioning was then performed. Of note, the medial knee aspect; specifically on the left side more than the right, bled considerably more. I feel like the most likely reason was that this area was probably an angioliipoma and had considerable amount of vascularity, which the epinephrine was not able to effect. I removed approximately 1750 from the right posterior thigh and 1800 from the left posterior thigh. Incisions were closed with interrupted 5-0 fast absorbing sutures and the patient was then placed on the operating table in the supine position, appropriately positioned, padded, prepped and draped in standard fashion. Again, multiple stab incisions were made over the preoperative marks that I had made; some of them from our old stab incisions where she had liposuction, having infiltrated with 0.25% Marcaine with epinephrine. Once again, same tumescent solution was used, infiltrating approximately 2L into each thigh. Suctioning was then again performed at this time using #4 Mercedes cannula and #3 Mercedes cannula at a more superficial level. Much more aggressiveness was placed around the knees. Again, unfortunately a considerable amount of bleeding was noted in the left medial knee more so than that of the right. This is the reason, estimated blood loss of 600mL. Total of 3600 was removed from the right thigh and 3100 from the left thigh. Both knees and as high up to the hip as possible was wrapped with 6-inch Ace wraps, having closed the incisions with interrupted 5-0 fast absorbing sutures. The patient was given 2.5L of crystalloid, made approximately 200mL of urine. She was now awakened, extubated, transferred to recovery room in stable condition. Her Ace wrappings were removed in recovery room where she remained stable. Hemoglobin obtained in the recovery room, was 13.1.

Peter Fisher, MD

IN: IOP/N.MR/FISPE
DD: 08/20/2020 2246
DT: 08/20/2020 2315
Job #: 5620839
Cc:

Authenticated by Peter Fisher, MD On 08/24/2020 08:35:36 AM

cpcs rpt#: 0820-0097



PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236

Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

08/28/2020 11:29 Dr Fisher Office

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P.005/006

Electronically Signed by Peter Fisher, MD on 08/24/20 at 0836

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236

Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

08/28/2020 11:29 Dr Fisher Office

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P.006/006



Report Status: Final

AVERILL, ROSE

Patient Information	Specimen Information	Client Information
AVERILL, ROSE DOB: 10/26/1961 AGE: 58 Gender: F Fasting: U Phone: 727.424.3402 Patient ID: 10261961RCA Health ID: 8573001399519469	Specimen: TM026439K Requisition: 0002495 Collected: 07/31/2020 / 13:33 EDT Received: 07/31/2020 / 22:16 EDT Reported: 07/31/2020 / 23:12 EDT (* A Copy From)	Client #: Not Given 9999999 PETER FISHER MD 7950 FLOYD CURL DR STE 1009 SAN ANTONIO, TX 78229

COMMENTS: FASTING:UNKNOWN

Test Name	In Range	Out Of Range	Reference Range	Lab
BASIC METABOLIC PANEL				TP
GLUCOSE	92		65-99 mg/dL	

Fasting reference interval

UREA NITROGEN (BUN)	13	7-25 mg/dL
CREATININE	0.61	0.50-1.05 mg/dL

For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.

eGFR NON-AFR. AMERICAN	100	> OR = 60 mL/min/1.73m2
eGFR AFRICAN AMERICAN	116	> OR = 60 mL/min/1.73m2
BUN/CREATININE RATIO	NOT APPLICABLE	6-22 (calc)
SODIUM	140	135-146 mmol/L
POTASSIUM	3.9	3.5-5.3 mmol/L
CHLORIDE	100	98-110 mmol/L
CARBON DIOXIDE	27	20-32 mmol/L
CALCIUM	9.3	8.6-10.4 mg/dL
CBC (INCLUDES DIFF/PLT)		
WHITE BLOOD CELL COUNT	4.8	3.8-10.8 Thousand/uL
RED BLOOD CELL COUNT	5.00	3.80-5.10 Million/uL
HEMOGLOBIN	14.4	11.7-15.5 g/dL
HEMATOCRIT	43.3	35.0-45.0 %
MCV	86.6	80.0-100.0 fL
MCH	28.8	27.0-33.0 pg
MCHC	33.3	32.0-36.0 g/dL
RDW	13.6	11.0-15.0 %
PLATELET COUNT	201	140-400 Thousand/uL
MPV	10.0	7.5-12.5 fL
ABSOLUTE NEUTROPHILS	2765	1500-7800 cells/uL
ABSOLUTE LYMPHOCYTES	1608	850-3900 cells/uL
ABSOLUTE MONOCYTES	379	200-950 cells/uL
ABSOLUTE EOSINOPHILS	29	15-500 cells/uL
ABSOLUTE BASOPHILS	19	0-200 cells/uL
NEUTROPHILS	57.6	%
LYMPHOCYTES	33.5	%
MONOCYTES	7.9	%
EOSINOPHILS	0.6	%
BASOPHILS	0.4	%

TP

PERFORMING SITE:

TP QUEST DIAGNOSTICS-TAMPA, 4225 E. FOWLER AVE, TAMPA, FL 33617-2026 Laboratory Director: GLEN L HORTIN, MD, PhD, CLIA: 10D0291120

Your request to have a duplicate copy faxed has been acknowledged.
 Queued to: 12106160581

* ST FRANCIS SLEEP ALLERGY has requested a copy of this report be sent to you. Ordering Physician: AVERILL, FRANCIS J

ACHIEVE

PHYSICAL THERAPY
AT LAKEWOOD RANCH

Lipedema Functional Assessment

Patient Name: Rose Averill

Date of Birth: 10/26/1961

History

Client has long history of Lipedema with extensive fat storage in her extremities which is painful to the touch. She has had difficulty with functional mobility due to pain, weakness and fatigue. The patient has had substantial weight loss in the past which did not change the girth of her extremities. She is currently working as the CEO of her own company with extensive time in a sedentary position. She is limited to sitting <20 minute in an office without changing position and elevating her legs due to pain in her extremities and fatigue. History also include Lyme disease '16, B meniscal tear, R achilles tear, vascular ablation of lower legs, Lipedema procedure lower legs. She does report unsteady gait with fear of falling. She currently uses a cane or walker at home or work as needed.

Chief Complaint:

Pain in her upper and lower extremities, especially upper arms, upper thighs and hips. Tender to touch in extremities. Weakness and fatigue. Limited to sitting <20 minutes or walking <1 block.

Pain Profile 1 being lowest / 10 being highest

Worst pain over last 30 days

1 2 3 4 5 6 7 8 9 10

Current Pain

1 2 3 4 5 6 7 8 9 10

Post FCE pain

1 2 3 4 5 6 7 8 9 10

ACHIEVELWR.COM

ACHIEVELWR@YAHOO.COM

OFFICE: (941) 727-2667 • FAX: (941) 727-2669

10910 SR 70 EAST • SUITE 104 • LAKEWOOD RANCH, FL 34202

Vital Signs

Blood Pressure Pretest 150/80 Midtest 148/80 Post Test 142/84
Heart Rate Pretest 74 Midtest 83 Post Test 77

Effort and Cooperation:

X gave maximum, consistent effort.
_____ did not give maximum, consistent effort in all tests

Activity Tolerances - 1 being most able - 10 being unable

1. Vigorous run/lift tasks 1 2 3 4 5 6 7 8 9 10
2. Walk more than 1 mile 1 2 3 4 5 6 7 8 9 10
3. Climb a flight of stairs 1 2 3 4 5 6 7 8 9 10
4. Lift or carry groceries 1 2 3 4 5 6 7 8 9 10
5. Bend, kneel, stoop 1 2 3 4 5 6 7 8 9 10
6. Vacuum or yard chores 1 2 3 4 5 6 7 8 9 10
8. Hand wash dishes/pots 1 2 3 4 5 6 7 8 9 10
9. Get up from floor 1 2 3 4 5 6 7 8 9 10
10. Sitting for activities 1 2 3 4 5 6 7 8 9 10
11. Travel long distances 1 2 3 4 5 6 7 8 9 10
12. Walk block, flat ground 1 2 3 4 5 6 7 8 9 10
13. Run a short distance 1 2 3 4 5 6 7 8 9 10
14. Run or jog 2 miles 1 2 3 4 5 6 7 8 9 10
15. Lift 10lb above shoulder 1 2 3 4 5 6 7 8 9 10
16. Lift 25lb box off floor 1 2 3 4 5 6 7 8 9 10

17. Lift 50lb bag of sand

1 2 3 4 5 6 7 8 9 10

Muscle Testing:**Gross Muscle Tests Lower Extremities**

Hip	L	R
Hip Flexion	3+/5	4-/5
Hip Extension	3+/5	4-/5
Hip Abduction	3+/5	4-/5
Hip Adduction	3+/5	4-/5
Quads	4-/5	4/5
HS	4-/5	4/5
R shoulder flex	3+/5	
L shoulder flex	3+/5	

Findings/ Comments: 8/10 Pain with manual resistance in all directions. hip strength L > R

Positional Tolerances

Note: 1 is unable / 10 is able

Crawling: 1 2 3 4 5 6 7 8 9 10

Squatting: 1 2 3 4 5 6 7 8 9 10

Kneeling: 1 2 3 4 5 6 7 8 9 10

Stooping: 1 2 3 4 5 6 7 8 9 10

Crouching: 1 2 3 4 5 6 7 8 9 10

Side Bridge Plank Hold Duration 0 Normal

Abnormal (per age)

Prone Plank Hold Duration 0 Normal

Abnormal (per age)

Single Leg Bridge Hold Duration 0 Normal

Abnormal (per age)

Forward Trunk Bending - # of Repetitions: 3

Normal

Abnormal (per age)

Limited by back pain

Stair climbing and standing - Duration / Repetition: 9 stairs/ minute

Use of rail. Very slow and antalgic. Using Right lower extremity one step at a time, unable to use left due to pain. Stopped due to pain/fatigue. 8/10 pain in thighs and knees

Five time sit to Stand Test – Duration / Repetition 20 seconds x 5. Slow, complaining of 6/10 pain in thighs and knees.

Two Square Agility Test (TSAT)

This is a test of dynamic agility. It involves stepping forward and back between two squares as quickly as safely possible. 30 seconds

Trial 1: 10 Trial 2: 10 Trial 3: 10 COV: <1%

Rating: High Moderate Low

Pain: Yes No

Walk Test 6 minutes –

Gait: 30 ft x 2 per lap

Trial 1: 11 Trial 2: 13 Trial 3: 12 COV: <1%

Rating: High Moderate Low

☒ Moderate to severe gait deviations.

☒ Pain reported in bilateral thighs and knees.

☐ Unpredictability of rhythm.

☒ Hesitant, slow, diminished propulsion, and lack of commitment in stepping and arm swing.

Wide base of support, waddling gait with decreased hip flexion during swing phase, foot flat with decreased propulsion during late stance phase. Complaints of pain hips, knee, ankles and lower back. Significantly slower pace and severe fatigue at end of time.

Lower Extremity Function Scale

20/80 demonstrates higher level of Disability

Proprioception/Balance

Single leg stance eyes open: Two trials:

Right 6 seconds,

Left 2 seconds

Findings:

Diminished X Normal

Single leg stance eyes closed:

Right 0 seconds,

Left 0 seconds,

Findings:

Diminished X Normal

Comments: Unable to perform eyes closed safely

Romberg eyes open:

30 seconds

Findings: Diminished Normal X

Romberg eyes closed:

30 seconds

Findings: Diminished Normal X

Comments:

Palpation

Identify areas of tenderness and pain at start of session, mid-way and when done.

Findings:

Large fat deposits/ lobular folds bilateral medial knees Left > Right. Extensive fat deposits

Bilateral hips to knees. Pain with light palpation throughout hips and knees which progressed throughout testing. Severe post test.

Large fat deposits bilateral upper arms Left > Right with pain with light palpation upper arms to elbows.

Testing for Arm Lipedema Only

1 being able / 10 being unable

Lifting (15 pound box)

floor to waist

1 2 3 4 5 6 7 8 9 10

waist to shoulder

1 2 3 4 5 6 7 8 9 10

overhead

1 2 3 4 5 6 7 8 9 10

Arm Strength and Fatigue – Describe

Unable to perform more than one arm or overhead lift due to weakness and fatigue. Significant muscle strain to lift box to shoulder and overhead position. Pain 8/10 bilateral upper arms

Grip Testing –

Grip / Pinch Five Level Grip

Trial 1: 42 Trial 2: 30 Trial 3: 28

COV <10%

AVG: 33

Findings – Diminished X Normal

Comments: Right hand dominant. tested with right hand.

Forward and Overhead Reaching – weight 15# Repetitions: 1 Normal Abnormal

Arm lift - # of repetitions - 1

Assessment Summary: See Examples

The patient did not exhibit any overt pain behaviors, and her validity tests (the hand grip strength tests) did not reflect any inconsistencies. Additionally, tests all suggest that the patient was putting forth a maximal effort and did not demonstrate any elevated psychometrics or pain magnification.

The patient presents with ever present tenderness to touch, which is exacerbated by activity. She is able to complete 6 minutes of walking with an increase in pain level to 8/10 and significant fatigue. Standing is limited (The patient is able to tolerate <10 minutes of

continuous standing before needing to sit or change positions to alleviate discomfort). Strength is limited. The patient demonstrates rapid loss of power during stair climbing and also demonstrates inability to squat to a functional level, kneel, stoop, crawl or crouch which significantly affects her abilities to perform self/household ADLs. She also demonstrates weakness and fatigue in the upper extremities as evidenced by being unable to lift more than 15 lbs from floor to waist or overhead. The patient fatigues rapidly in the lower extremities leading to poor resting postures and increased lumbar and hip flexion. By the end of testing, she reported increased soreness and achiness, especially in her upper thighs, hips and knees with any weight bearing activity and her upper arms and shoulders which affected her ability to perform sit to stand transfers. Swelling is persistent at this time.

Physical findings were consistent with her diagnosis of lipedema: disproportionate fat storage along the client's extremities, non-pitting edema in extremities that is painful with light touch, joint deformity and lobular folds. The client had reduced strength in her Bilateral shoulder, hips and knees Left side more affected than right. The client intermittently repositioned her standing posture due to pain in her legs. She ambulated with gait deviations using a wide base and had a slight balance impairment. The client had difficulty with activities involving repetitive bending, squatting and stair climbing. It is the opinion of this evaluator that the patient suffers from severe limitations and restrictions due to the condition of lipedema which dramatically affect mobility, gait, etc.

Post Lipedema Functional Test Fatigue

Mild

Moderate

Severe

Post Lipedema Functional Test Pain

Mild

Moderate

Severe

Date:

8/12/20

Evaluators Signature:

Sea MUA RPT

03/17/2020 14:37 Dr Fisher Office

(FAX)2106160581

P.001/005

SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. ¹⁰⁰⁹~~904~~ 78229

OFFICE (210) 616-0798

FAX (210) 616-0581

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
<i>Ross Brumitt</i>	<i>Jo Ann / Dr P. Fisher</i>
COMPANY:	DATE:
<i>(Patient's office)</i>	<i>03/17/2020</i>
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
<i>727-210-4600</i>	<i>(5)</i>
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:
<i>office visit / phone consult</i>	

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

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P.002/005

RX Date/Time

03/10/2020

11:17

7272104600

P.001



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INSTITUTE

Frank Averill, MD

Medical Director

802 N. Belcher Road

Clearwater, FL 33765

Phone 727.447.3000

Fax 727.210.4600

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Records Request

*pt*To: **Dr Fisher (210)616-0581**Pages: **1** (Including Cover)From: **Christina**Date: **03/10/20**RE: **Averill, Rose**
(Patient's Name)DOB: **10/26/1961**
(Patient's DOB)

	LAB REPORTS		IMAGING REPORTS	X	RECENT VISIT NOTE		SLEEP STUDIES
--	------------------------	--	----------------------------	----------	------------------------------	--	--------------------------

This patient has an appointment on **March 12, 2020**

Notes: **Please provide notes from 08/12/19**
and 01/10/20. Thank you!

Thank you and have a Blessed day!**CONFIDENTIALITY NOTICE:**

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Handwritten signature: Janel pte office

03/17/2020 14:37 Dr Fisher Office

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P.003/005



San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

Patient: Rose Averill
DOB: 10/26/1961

1/10/2020

Consultation: The patient is a 57-year-old lady whom I already consulted with via email and telephone in August. Significantly this patient has severe lipedema diagnosed approximately 2 years ago. She feels that she is probably had this for about 10 years although it is gotten significantly worse over the past 2 years. She feels that it came about after she had a hysterectomy in 2006. She has had 2 C-sections in the past. She remains quite mobile even with the severe lipedema that she has. In October 2019 she had liposuction of the lower legs. 3 L were removed. She unfortunately has quite a bit of swelling from this. Her major issues are her thighs and especially the medial knees which over the past year gotten significantly worse. She also is concerned about her upper arms. She has pain in all these areas. Her general health is excellent. In 1996 she underwent tummy tuck abdominal muscle repair and liposuction of the inner thighs. She has broken the left tibia in 2016 and had torn ACL and left meniscus tear after falling in 2006. She does not smoke. She has no allergies to medications.

Examination: She is 5 feet 7 inches tall weighs 292 pounds today. She has obvious lipedema of the thighs with what I believe are large lipomas of the left and right medial knee areas. The left side is considerably larger than that of the right. Well-healed small scars of the lower legs are noted following her liposuction in October of last year. The skin is nice and smooth although there is 1+ pitting edema along the lower leg.

Impression: Lipedema of the thighs and upper arms.

Recommendation: I recommended as previously discussed going ahead with liposuction of the thighs to be followed at a later date with further liposuction and if possible thigh lift at the same time. Consideration to performing liposuction of the upper arms at some point will be given as well. I have given her a prescription for Lasix to be taken once and possibly twice daily for the next 2 weeks to help reduce swelling in the lower legs.

Peter Fisher, M.D.
PF

DAVID J. FISHER, M.D.
Board Certified
Plastic Surgery

PETER FISHER, M.D.
Board Certified
Plastic Surgery



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03/17/2020 14:38 Dr Fisher Office

(FAX)2106160581

P.004/005

Rose Averill

Phone Consult 8/12/19

DOB: 10/26/61

Patient has confirmed diagnosis of Lipedema, stage 3, from Dr. Byrd 1 week ago and also her primary care physician 2 weeks ago. Dr. Fisher does also confirm the diagnosis and agrees most likely stage 3. Patient is interested in treatment with Dr. Fisher's aggressive liposuction technique.

Ms. Averill is 57yrs old, 5'7" and currently 285lbs. She has a history of 2 C-Sections, a tummy tuck with lipo of the inner thighs only in 1996, and she had a full hysterectomy in 2006. Says she did well with anesthesia each time, no problems she can recall. Currently on take supplements and has no allergies to meds. She states that she has been on a keto diet with intermitting fasting for 2 years and says she hasn't really had any weight loss. Patient says she was a very curvy teenager with very large thick thighs and recalls also having stretch marks develop early in childhood. Her mother she feels also had Lipedema even though there was never a diagnosis, says her mother's legs were similar to hers and also had very large "batwings" in her arms. Ms. Averill feels her progression has been at its worst the past few years, noticing that she is experiencing and fatigue as well as her mobility becoming a problem now. She states the swelling by the end of the day is almost intolerable. She says she feels the pain as soon as she wakes up and it continues on for the full day. She is still working, she runs her husbands Pulmonology office for him, but is really struggling.

Dr. Fisher was very up front that she needs multiple surgeries and he most likely will not be able to do them all. The patient carries most of the weight in her hips and thigh area, not much in the calves at all and doesn't show signs of ankle cuffing, though this is from pictures.

Patient is from Florida and brought up a Dr. Su in Florida who typically she says on works on 20 and 30-year old's but has agreed to liposuction her inner knee area and something she calls a "Celebrity Arm Lift". Ms. Averill is also stating she could have Dr. Byrd in Atlanta, GA perform the liposuction on her calves, she really wants Dr. Fisher to be the one to do her thighs. PF though she would need 3 surgeries with the first being hip to knee, second knee to ankle, and quite possibly the 3rd as a thigh lift, he isn't sure to say she will NEED a thigh lift, but feels she may WANT a thigh due to so much extra hanging skin that would be left.

Ms. Averill stated that she has family here in the area, a sister in Dallas and friends on Corpus that she can stay with while here or have come to San Antonio and stay here with her. She states again that she really wants Dr. Fisher to be her surgeon. She questioned if she also had Dr. Byrd do her thighs to get a start could Dr. Fisher finish her thighs and do a thigh lift at the same time. He stated he could maybe, it will just depend on how much has been removed and how much would be left for him. He said for now he is only going to quote her for Liposuction of the hip knee for now. He said that he can take a look or she can send photos following other procedures and we can amend the quote as needed. He stated that he was only going to send 1 quote. If there was a chance that a surgeon he is in talks with gives a definite answer and comes aboard to train with him he MIGHT be able to fit her in for a second surgery in Dec 2020, but said there is no guarantee on that and felt if she thought she could get surgery with other physicians she should look into that. She was well aware and verbally stated she understood that currently Dr. Fisher can only do 1 surgery on her. Dr. Fisher went through the compression garment needing to be on for 3-6 months, he prefers 6 months. The patient brought up the vast difference in size of her thighs to her calves and asked how she would find something that would work for her. He said that we can send some things to her for examples, but she may need a custom garment or possibly capri style with full compression thigh highs to put over the capri length. He spoke about the possibility of a blood transfusion and went through the number with her for his patients, 1 in 5 needing one. He confirmed with her that she does accept blood. She does. He brought the risk of bleeding, made sure she understood about dimpling, rippling and excess lax skin. Told her she would be doing nothing for 2 weeks because she will be laying with legs sky high in the air. She laughed and stated she understood everything.

Dr. Fisher asked her if she had any other questions he could answer for her and she said no, just cost. He let her know that Emily, the surgery scheduler, will be emailing her the quote and that if she decided she wanted to schedule she can contact her directly. He mentioned again if she does decide to have surgery with other physicians just to let him know and send updated photos. He also told her he thinks it's a great idea and that he has been impressed with Dr. Byrd's work. She thanked him for calling her. /HM

03/17/2020 14:38 Dr Fisher Office

(FAX)2106160581

P.005/005

ROSE'S MEDICATIONS

1. PROG 200 MG SR CAP- 1 CAPSULE BY MOUTH 1-2 HRS BEFORE BEDTIME
2. DIM-EVAIL- SERVING SIZE 1 CAPSULE: DIINDOLYLMETHANE 100 MG
3. FISHOIL 675- SERVING SIZE 2 CAPSULES: ULTRA PURE FISH OIL 2554 MG, EICOSAPENTAENOIC ACID 250 MG, DOCOSAHEXAENOIC ACID 1000 MG, OTHER OMEGA 3 FATTY ACIDS 100 MG
4. MULTI NUTRIENTS 2- SERVING SIZE 3 CAPSULES: VITAMIN A 10,000IU, VITAMIN C 425 MG, VITAMIN D 500 IU, VITAMIN E 200 IU, THIAMIN 20 MG, RIBOFLAVIN 7.5 MG, VITAMIN B6 7.5 MG, FOLATE METAFOLIN 200 MCG, VITAMIN B12 250 MCG, BIOTIN 200 MCG, PANTOTHENIC ACID 175 MG, CALCIUM 150 MG, IODINE 112.5 MCG, 137.5 MG, ZINC 7.5 MG, SELENIUM 100 MCG, MANGANESE 3 MG, CHROMIUM 100 MCG, MOLYBDENUM 50 MCG, POTASSIUM 37.5 MG, RIBOFLAVIN 5'PHOSPHATE 5 MG, NIACINAMIDE 55 MG, PYRIDOXAL 5'PHOSPHATE 5 MG, BORON 1.5 MG, VANADIUM 50 MCG
5. MAGNESIUM 150 MG- SERVING SIZE 2 CAPSULES: MAGNESIUM 300 MG
6. RELORA-PLEX – SERVING SIZE 2 CAPSULES: THIAMINE 10 MG, RIBOFLAVIN 10 MG, NIACINAMIDE 10 MG, VITAMIN B6 10 MG, FOLIC ACID 200 MCG, VITAMIN B12 100 MCG
7. SUPER B-COMPLEX – SERVING SIZE 1 CAPSULE: VITAMIN C 60 MG, THIAMIN 25 MG, RIBOFLAVIN 20 MG, NIACIN 25 MG, VITAMIN B6 5 MG, FOLIC ACID 400 MCG, VITAMIN B12 100 MCG, BIOTIN 1000 MCG, PANTOTHENIC ACID 5.5 MG, SODIUM 10 MG
8. ADRENO MEND- SERVING SIZE 2 CAPSULES: A PHYTOCRINE PROPRIETARY BLEND 1020 MG, SENSORIL ASHWAGANDHA EXTRACT 125 MG
9. UBIQUINOL COQ10- SERVING SIZE 1 CAPSULE: 100 MG
10. ADK 10- SERVING SIZE 1 CAPSULE: VITAMIN A 1.5 MG, VITAMIN D 250 MCG, VITAMIN K 500 MCG

BayCare Susan Cheek Needler Breast Center

400 Pinellas Street Suite 100 Clearwater, FL 33756 (727)298-6670

FINAL REPORT

Patient: AVERILL, ROSE C**DOB:** 10/26/1961**Sex:** F**Requesting:** Desai, Anup Natwarlal**Attending:** Desai, Anup Natwarlal**Interpreted By:** Robert Nmn Krupa, M.D.**CPI:** 101256420**MRN:** 2104682138**Account:** 1110582593**Patient Status:** Outpatient**Patient Location:** WIMSIAverill, Francis James
802 N Belcher Road
Clearwater, FL 33765

cc: Averill, Francis James

ACC: 32056612 DEXA HIP AND SPINE**Completed:** 2/18/20 4:46 pm

DEXA HIP AND SPINE

CLINICAL: M 85.88

TECHNIQUE: Bone density measurements were obtained for the lumbar spine and left hip and compared to the reference standard based on the WHO classification.

FINDINGS:

Lumbar spine levels L1-L4:

Bone mineral density 1.236 g/cm sq T-score 1.7

Left femoral neck:

Bone mineral density 0.964 g/cm sq T-score 1.0

Total left femur:

Bone mineral density 1.132 g/cm sq T-score 1.6

IMPRESSION: THIS PATIENT IS NORMAL ACCORDING TO WORLD HEALTH ORGANIZATION CRITERIA. FRACTURE RISK IS LOW. FOLLOWUP DEXA SCAN IS RECOMMENDED IN 2 YEARS. ✓

WHO T-score classification:

normal ?T-score at or above -1

osteopenia T-score between -1.0 and -2.5

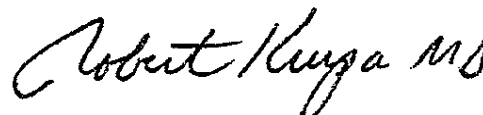
osteoporosis T-score below -2.5

NOTE:

1. Changes in BMD of less than 3% are in range or error and may not be accurate*
2. Always use DEXA testing in conjunction with clinical findings and patient history to determine optimal patient management.
3. T-score standards are based on reference values for white females; age 20-29 based on the NHA NES III database and may be less accurate for other groups of patients.
4. DEXA values may be less accurate in patients with degenerative changes, scoliosis, compression deformities etc.

Electronically signed by Robert Krupa, M.D. RADIOLOGIST on 2/19/2020 6:27 AM

Thank you for this referral,



Diplomat, American Board of Radiology



This document has been electronically signed by Francis Averill MD

Interpreted By: Robert Nmn Krupa, M.D.

2/19/2020 10:42:4

Name: AVERILL, ROSE C

Location: WIMSI

Patient Status: O

Exam: DEXA HIP AND SPINE

MRN: 2104682138

BayCare Susan Cheek Needler Breast Center

400 Pinellas Street Suite 100 Clearwater, FL 33756 (727)298-6670

FINAL REPORT

Transcribed By:	IA	2/19/20 6:29 am
Electronically Signed By:	Robert Nmn Krupa, M.D.	2/19/20 6:29 am

FAX TRANSMISSION COVER SHEETDATE: 12/12/19 TIME: 11:07

TO: _____

FAX #: 727 210 4600ATTN: DR FRANK AVERILL**FROM:**

**Marcia V. Byrd, M.D.
11050 Crabapple Road
Suite 105-B
Roswell, GA 30075
(770) 587-1711
Fax (770) 518-8810**

You should receive _____ page(s), including this cover sheet. If you do not receive all the pages, please call 770-587-1711.

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Dr. Marcia V. Byrd, M.D.
11050 Crabapple Rd., Bldg. B
Roswell, GA 30075
770-587-1711

DATE: August 30, 2019
TO: UnitedHealthcare
FROM: Dr. Marcia V. Byrd, M.D.
RE: Rose Averill / DOB 10/26/1961 / Member ID #912012181
POS: 11 (In office)

Attached please find documentation and photos for Reimbursement Purposes, for lymph-sparing lipectomy, for above named patient.

Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
Tax ID: 58-1452561

Letter of Medical Necessity

Date: August 30, 2019
To: United Healthcare
Patient: Rose Averill
DOB: 10/26/1961
Member Name: Rose Averill
Member ID: 912012181

Dear Madame/Sir,

I request that Ms. Averill be covered by insurance for suction assisted protein lipectomy (SAPL). Ms. Averill has lipedema, a disorder of excess fat cells that bind up fluid resulting in gross enlargement of the fat tissue primarily on the legs, arms, buttocks and abdomen. Lipedema is not rare but the diagnosis is not often made. It is also known as the painful fat syndrome and is almost exclusively found in women. The onset is generally puberty, pregnancy, menopause or times of unusual stressors. There may be a familial occurrence as well. Lipedema is often confused with lymphedema, but differs in many ways including lack of involvement of the hands and feet and the pain associated with it. Lymphedema is not painful.

Although therapies such as manual lymphatic drainage, wrapping, compression garments, exercise and diet along with supplemental medications are helpful, they cannot reduce the fat itself. The only definitive treatment currently for lipedema fat tissue is a lymph-sparing procedure via suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is the standard of care in that country. There is literature in regards to lipectomy for lipedema including the articles listed at the end of this letter. SAPL has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction that has also been used in the treatment of lipedema patients, WAL lessens the risk of fluid overload and the osmotic burden on the patient. As a result, WAL enables a safer and more extensive fat removal and treatment of more areas during the surgical procedure which cuts down the total number of procedures needed.

SAPL is Ms. Averill only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her day to day activities, improve her gait and to minimize future morbidities.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Marcia V. Byrd, M.D.

References:

1. Herbst, Karen L. MD, Rare Adipose Disorders Masquerading As Obesity. *ActaPharmacologicaSinica* 2012; 33: 155-72
2. Fife, Ce Et Al. Lipedema: A Frequently Misdiagnosed and Misunderstood Fatty Deposition Syndrome. *Advances in Skin and Wound Care*. 2010. 23: 90.
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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
Tax ID: 58-1452561

Date: 08/30/2019
To: United Healthcare
Patient: Rose Averill
DOB: 10/26/1961
Member ID: 912012181

Dear Madame/Sir,

Ms. Averill was recently evaluated in our office for treatment of Lipedema.

Lipedema has received a Medical Subject Heading (MeSH) code and application for ICD code is pending. The MeSH code for Lipedema is D065134.

Additional codes applicable are:

R 60.1	General edema
I 89.0	Edema due to lymphatic obstruction
M 79.609	Pain in limbs
R 20.8	Hyperalgesia, hyperpathia
R26.9	Unstable gait

Water Assisted Liposuction (WAL), a lymph-sparing liposuction procedure that has been proven to be the preferred method for removal of the abnormal diseased fat in lipedema patients is the procedure planned. WAL is the only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her profession as well as at home, improve her gait and minimize future morbidities.

There is no CPT code that adequately describes the removal of abnormal lipedema fat excision during the WAL procedure. However, the CPT code most applicable to WAL is:

CPT codes:

38999 Other procedures for Hemic or Lymphatic System

Attached you will find support material including history & physical, letter of medical necessity and photographs.

Please do not hesitate to contact me if additional information is required.

Sincerely,

Marcia V. Byrd, M.D.
Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors

Marcia V Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

INITIAL EVALUATION

Patient: Rose Averill
DOB: 10/26/1961
Date: 08/30/2019

Summary of the history 58-year-old female presenting for evaluation and discussion of lymph-sparing lipectomy (WAL) for the treatment of lipedema/lymphedema. She was diagnosed and is followed by

Swelling was noticed around puberty. Pain to light touch, easy bruising and swelling by the end of the day began shortly thereafter. Over the past few years she has also experienced progression of pain in knees bilaterally. She takes NSAID's on a daily basis for pain. She has tried many diet and exercise plans with weight loss noted only in nonaffected areas. She has increasing pain and swelling in the affected areas despite her continued efforts at non-surgical treatments.

History of Dercum's or Ehlers-Danlos syndrome: No

Areas of concern currently: Legs, arms, abdomen and buttocks

When and where swelling started: Swelling began after pregnancies and increased after hysterectomy.

Are affected areas painful to touch: Yes

Average daily pain on a scale from 1 to 10: 7/10

Pain level on a 'bad' day: 9/10

Is mobility limited? Difficulty with gait secondary to thickness and heaviness of thighs.

History of large bruising after slight bumps: Yes

Swelling by the end of the day: Yes

Pain resulting from contact with clothing: Yes

Number of pregnancies: G2 P2

Changes after pregnancy: Reduced ability to lose weight in affected areas, increase pain and difficulty with ambulation.

Clothing size: Upper body: M/L Lower body: 3X-4X

Joint problems: Torn meniscus bilateral knees, degenerative arthritis in large joints

Occupation: C.E.O of Medical Center

Previous therapies for lipedema/lymphedema: N/A

Compression Garments

Exercise

Diet

PMH: Hyperlipidemia and degenerative joint disease.

Surgical Hx: C-sections 1988, 1991, Abdominoplasty with Liposuction of inner thighs 1996, Hysterectomy 2005.

Medications: N/A

Allergies: No

FH: Mother: Lipedema, Heart disease, High cholesterol and Diabetes.

Father: Triple bypass, High cholesterol, High cholesterol, Diabetes and Stroke.

SH: Married. No use of tobacco. Drinks 3-4 glasses of wine a year. No exercise.

The Lower Extremity Functional Scale is 32. Scores range from 0 to 80. The lower the score the greater the dysfunction. (Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.)

PE:

Vital Signs: BP:165/80 P 74 reg. PO2: 97 BMI 46.4 Ht 5'6 ". WT287.1 lbs. Waist: 46".

Hips:59 1/4" Waist/hip ratio:0.77 Waist/height ratio: 0.69

General: Alert and oriented. NAD. Disproportionate upper and lower body with upper body being much smaller.

HEENT: Normal thyroid. No adenopathy.

Upper back: No dorsocervical fat pad present.

Mid-back: Minimal fat in the bra area without nodularity.

Lower back: Tender nodules and fat in the upper gluteal area.

Upper arms: Small amount of fat in the upper arms without tender nodules.

Forearms: Small amount of fat on the forearm without cuffing.

Hands: Negative for increased fat or tenderness. Stemmer sign negative.

Abdomen: Generalized adiposity. No nodules or tenderness in the abdominal area.

Buttocks: Dimpling in the buttocks, scattered nontender nodules.

Hips: Tender nodules bilaterally.

Thighs: Thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules. Non-pitting edema.

Medial knee: Tender nodules bilaterally. Slight valgus deformity.

Anterior lower leg: Fat pad medially just below the knee with tender nodules. Non-pitting edema

Posterior lower leg: Tenderness of the lower leg to the ankle without cuffing. Non-pitting edema.

Ankle: Thickness at the malleoli.

Feet: No swelling in feet bilaterally. Stemmer sign negative.

Assessment: 58-year-old female with late stage 2 lipedema involving the legs and buttocks. Her symptoms of diffuse pain in the soft tissues and marked decrease in mobility have been progressing at a rapid rate over the past couple of years. She is experiencing pain daily, continual enlargement of the affected areas despite diet and exercise and increasing difficulty with ADLs.

Plan:

1. Compression garment – Bioflect on a daily basis. To be worn while out of bed.
2. Low-carb diet with ketone monitoring and use of diary.
3. Walk 30 minutes per day. Swimming pool exercises advisable.
4. MLD done by occupational therapist. Advised not to have custom garments made at this time but wait until after surgery.
5. Patient advised to consider lymph-sparing liposuction. Due to the limitations of lidocaine dosing and maximal aspiration of fatty tissue it is estimated that it will require 4-5 water-jet assisted procedures to complete the treatment of her legs and buttocks. The patient understands that lymph-sparing liposuction is done to reduce pain, stop/slow progression and improve ambulation but it is not a cosmetic procedure.

Discussion: Lipedema, a disorder of excess fat cells that bind up fluid resulting in a gross enlargement of the fat tissue primarily on the hips, buttocks, legs and arms, is a medical entity originally described by Allen and Hines in 1940 at the Mayo Clinic. It is a MESH term in the National Library of Medicine and an ICD application has been submitted. Lipedema is not responsive to lifestyle changes and grows in such a manner as to impede mobility and damage joints. In lipedema, the lymphatic system is not functioning as well as it should secondary to it being surrounded by inflammatory disease tissues. Patients typically begin to have symptoms at puberty but are rarely diagnosed until they reach more advanced stages. Patients consistently complain of pain in the areas of fat accumulation, easy bruising, limitation of motion and as progression occurs alterations in gait with subsequent need for knee replacement in many cases. While we use palliative therapies to treat the fluid excess including manual lymphatic drainage, wrapping, compression garments, exercise and diet, supplements and medications that bind to receptors on the lymphatics and induce lymphatic pumping, we cannot reduce the fat itself. Ultimately, even if the patient is adherent to palliative protocol, development of lymphedema typically occurs. It is not uncommon for patients to have significant gait dysfunction or inability to ambulate without assistance often requiring joint replacements.

At this time, the only definitive treatment for lipedema is lymph-sparing excision through suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is their standard of care. Liposuction works effectively for lipedema to reduce lipedema fat and pain (Cornely et al., 2006; Schmeller et al., 2006; Warren et al., 2007). According to Dr. Staffan Rapprich from Darmstadt Clinics in Germany, whose sole practice is focused on SAPL for lipedema, the treatment is curative (Rapprich et al., 2011, 2012). I consider SAPL medically necessary to prevent progression, reduce the pain, improve the gait and prevent damage to joints. WAL (water jet assisted liposuction) is the preferred method to remove the abnormal fat in lipedema patients. It has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction devised by German surgeons for lipedema fat removal 20 years ago, WAL lessens the risk of fluid overload and the osmotic burden on the patient, and thus, enables a more extensive fat removal and a smaller number of procedures than the earlier tumescent method. Cosmetic improvement, if it occurs at all, is just a bonus. **This is not a cosmetic procedure.**

Marcia V Byrd, MD

Date

Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors.

Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

OPERATIVE NOTE

Name: Rose Averill

Date: 10/25/2019

Preoperative Diagnosis: Lipedema

Procedure: Lymph-sparing lipectomy utilizing Water-jet assisted Liposuction (WAL), Power assisted Liposuction (PAL), Vaser Liposuction (UAL)

Areas Treated: Calves to Ankles- Bilaterally and Circumferentially

Attending Surgeon: Marcia V Byrd MD

Indications: Progressive pain, swelling and decreased mobility which has been non-responsive to diet, exercise and other non-surgical measures.

Discussion: This lady presents for liposuction for the treatment of Lipedema. This procedure is not cosmetic but is intended to decrease her pain, improve her mobility/gait and prevent progression of the disease.

CPT code: 38999

Operative Summary:

Written consent was obtained prior to surgery, which included but was not limited to infection, bleeding, hematoma, seromas, asymmetries, contour irregularity, divots in the skin, DVT, pulmonary embolus. The patient understood and agreed to proceed. The patient was taken to the photo room where photos and markings of the areas were made then transferred to the surgical suite and placed supine on the operating table. After appropriate level of IV sedation was obtained the patient was prepped and draped in a sterile manner. The incisions for the liposuction cannulas were injected with tumescent solution with 30g needle then a 2 mm punch biopsy tool was used to make the incisions. Tumescent solution was infiltrated into the areas for lymph-sparing lipectomy. After this was allowed to take effect adipose tissue was then removed from the areas listed above using a combination of WAL, PAL and UAL in a manner to preserve the integrity of the lymphatics. Total extracted was 3500cc with a supernatant of 3200cc. Incisions closed with single mattress stitch of 4-0 plain gut. Dressings and compression garment were applied. The patient was transferred from the operating table to the recovery room having tolerated the procedure without difficulty.

Signature: _____
Marcia V. Byrd, MD

Date: _____

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Marcia V Byrd, MD

11050 Crabapple Road
Roswell, GA 30075
(770)587-1711

Page: 1

12/12/2019

Patient: Rose Averill
2140 Longbow Lane
Clearwater, FL 33764

Chart #: 26651AV0

Case #: 5348

Instructions:

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modifier	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
8/30/2019	Office Visit New Patient Lipedema	99205L1		000.00				1	150.00
8/30/2019	Visa/Mastercard payment	VISA						1	-150.00
9/5/2019	Visa/Mastercard payment	VISA						1	-1,000.00
9/13/2019	Visa/Mastercard payment	VISA						1	-1,000.00
10/11/2019	Visa/Mastercard payment	VISA						1	-8,550.00
10/25/2019	Lymph-sparing lipectomy	15879	22 50	R60.1	I 89.0	L92.9	R20.8	1	8,200.00
10/25/2019	Supplies	99070		R60.1	I 89.0	L92.9	R20.8	1	750.00
10/25/2019	IV sedation first 15 minutes	99152		R60.1	I 89.0	L92.9	R20.8	1	250.00
10/25/2019	IV sedation each additional 15	99153		R60.1	I 89.0	L92.9	R20.8	7	350.00
10/29/2019	MLD bilateral	97140		000.00				1	200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-2,000.00

12/13/2019 07:44:06



This has been electronically signed by Elizabeth Kurman ARNP-BC

Provider Information

Provider Name: Marcia V. Byrd MD
License: 023141
Insurance PIN:
SSN or EIN: 581452561

Total Charges: \$ 9900.00
Total Payments: -\$ 12900.00
Total Adjustments: \$ 0.00
Total Due This Visit: -\$ 3000.00
Total Account Balance: \$ 6,300.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____

Date: _____

FAX TRANSMISSION COVER SHEETDATE: 12/12/19 TIME: 11:07

TO: _____

FAX #: 727 210 4600ATTN: DR FRANK AVERILL**FROM:**

Marcia V. Byrd, M.D.
11050 Crabapple Road
Suite 105-B
Roswell, GA 30075
(770) 587-1711
Fax (770) 518-8810

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Dr. Marcia V. Byrd, M.D.
11050 Crabapple Rd., Bldg. B
Roswell, GA 30075
770-587-1711

DATE: August 30, 2019
TO: UnitedHealthcare
FROM: Dr. Marcia V. Byrd, M.D.
RE: Rose Averill / DOB 10/26/1961 / Member ID #912012181
POS: 11 (In office)

Attached please find documentation and photos for Reimbursement Purposes, for lymph-sparing lipectomy, for above named patient.

Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
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Letter of Medical Necessity

Date: August 30, 2019

To: United Healthcare

Patient: Rose Averill
DOB: 10/26/1961

Member Name: Rose Averill
Member ID: 912012181

Dear Madame/Sir,

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SAPL is Ms. Averill only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her day to day activities, improve her gait and to minimize future morbidities.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Marcia V. Byrd, M.D.

References:

1. Herbst, Karen L. MD, Rare Adipose Disorders Masquerading As Obesity. *ActaPharmacologicaSinica* 2012; 33: 155-72
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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
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Date: 08/30/2019
To: United Healthcare
Patient: Rose Averill
DOB: 10/26/1961
Member ID: 912012181

Dear Madame/Sir,

Ms. Averill was recently evaluated in our office for treatment of Lipedema.

Lipedema has received a Medical Subject Heading (MeSH) code and application for ICD code is pending. The MeSH code for Lipedema is D065134.

Additional codes applicable are:

R 60.1	General edema
I 89.0	Edema due to lymphatic obstruction
M 79.609	Pain in limbs
R 20.8	Hyperalgesia, hyperpathia
R26.9	Unstable gait

Water Assisted Liposuction (WAL), a lymph-sparing liposuction procedure that has been proven to be the preferred method for removal of the abnormal diseased fat in lipedema patients is the procedure planned. WAL is the only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her profession as well as at home, improve her gait and minimize future morbidities.

There is no CPT code that adequately describes the removal of abnormal lipedema fat excision during the WAL procedure. However, the CPT code most applicable to WAL is:

CPT codes:

38999 Other procedures for Hemic or Lymphatic System

Attached you will find support material including history & physical, letter of medical necessity and photographs.

Please do not hesitate to contact me if additional information is required.

Sincerely,

Marcia V. Byrd, M.D.
Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors

Marcia V Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

INITIAL EVALUATION

Patient: Rose Averill
DOB: 10/26/1961
Date: 08/30/2019

Summary of the history 58-year-old female presenting for evaluation and discussion of lymph-sparing lipectomy (WAL) for the treatment of lipedema/lymphedema. She was diagnosed and is followed by

Swelling was noticed around puberty. Pain to light touch, easy bruising and swelling by the end of the day began shortly thereafter. Over the past few years she has also experienced progression of pain in knees bilaterally. She takes NSAID's on a daily basis for pain. She has tried many diet and exercise plans with weight loss noted only in nonaffected areas. She has increasing pain and swelling in the affected areas despite her continued efforts at non-surgical treatments.

History of Dercum's or Ehlers-Danlos syndrome: No

Areas of concern currently: Legs, arms, abdomen and buttocks

When and where swelling started: Swelling began after pregnancies and increased after hysterectomy.

Are affected areas painful to touch: Yes

Average daily pain on a scale from 1 to 10: 7/10

Pain level on a 'bad' day: 9/10

Is mobility limited? Difficulty with gait secondary to thickness and heaviness of thighs.

History of large bruising after slight bumps: Yes

Swelling by the end of the day: Yes

Pain resulting from contact with clothing: Yes

Number of pregnancies: G2 P2

Changes after pregnancy: Reduced ability to lose weight in affected areas, increase pain and difficulty with ambulation.

Clothing size: Upper body: M/L Lower body: 3X-4X

Joint problems: Torn meniscus bilateral knees, degenerative arthritis in large joints

Occupation: C.E.O of Medical Center

Previous therapies for lipedema/lymphedema: N/A

Compression Garments

Exercise

Diet

PMH: Hyperlipidemia and degenerative joint disease.

Surgical Hx: C-sections 1988, 1991, Abdominoplasty with Liposuction of inner thighs 1996, Hysterectomy 2005.

Medications: N/A

Allergies: No

FH: Mother: Lipedema, Heart disease, High cholesterol and Diabetes.
Father: Triple bypass, High cholesterol, High cholesterol, Diabetes and Stroke.

SH: Married. No use of tobacco. Drinks 3-4 glasses of wine a year. No exercise.

The Lower Extremity Functional Scale is 32. Scores range from 0 to 80. The lower the score the greater the dysfunction. (Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.)

PE:

Vital Signs: BP:165/80 P 74 reg. PO2: 97 BMI 46.4 Ht 5'6 ". WT287.1 lbs. Waist: 46".

Hips:59 1/4" **Waist/hip ratio:**0.77 **Waist/height ratio:** 0.69

General: Alert and oriented. NAD. Disproportionate upper and lower body with upper body being much smaller.

HEENT: Normal thyroid. No adenopathy.

Upper back: No dorsocervical fat pad present.

Mid-back: Minimal fat in the bra area without nodularity.

Lower back: Tender nodules and fat in the upper gluteal area.

Upper arms: Small amount of fat in the upper arms without tender nodules.

Forearms: Small amount of fat on the forearm without cuffing.

Hands: Negative for increased fat or tenderness. Stemmer sign negative.

Abdomen: Generalized adiposity. No nodules or tenderness in the abdominal area.

Buttocks: Dimpling in the buttocks, scattered nontender nodules.

Hips: Tender nodules bilaterally.

Thighs: Thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules. Non-pitting edema.

Medial knee: Tender nodules bilaterally. Slight valgus deformity.

Anterior lower leg: Fat pad medially just below the knee with tender nodules. Non-pitting edema

Posterior lower leg: Tenderness of the lower leg to the ankle without cuffing. Non-pitting edema.

Ankle: Thickness at the malleoli.

Feet: No swelling in feet bilaterally. Stemmer sign negative.

Assessment: 58-year-old female with late stage 2 lipedema involving the legs and buttocks. Her symptoms of diffuse pain in the soft tissues and marked decrease in mobility have been progressing at a rapid rate over the past couple of years. She is experiencing pain daily, continual enlargement of the affected areas despite diet and exercise and increasing difficulty with ADLs.

Plan:

1. Compression garment – Bioflect on a daily basis. To be worn while out of bed.
2. Low-carb diet with ketone monitoring and use of diary.
3. Walk 30 minutes per day. Swimming pool exercises advisable.
4. MLD done by occupational therapist. Advised not to have custom garments made at this time but wait until after surgery.
5. Patient advised to consider lymph-sparing liposuction. Due to the limitations of lidocaine dosing and maximal aspiration of fatty tissue it is estimated that it will require 4-5 water-jet assisted procedures to complete the treatment of her legs and buttocks. The patient understands that lymph-sparing liposuction is done to reduce pain, stop/slow progression and improve ambulation but it is not a cosmetic procedure.

Discussion: Lipedema, a disorder of excess fat cells that bind up fluid resulting in a gross enlargement of the fat tissue primarily on the hips, buttocks, legs and arms, is a medical entity originally described by Allen and Hines in 1940 at the Mayo Clinic. It is a MESH term in the National Library of Medicine and an ICD application has been submitted. Lipedema is not responsive to lifestyle changes and grows in such a manner as to impede mobility and damage joints. In lipedema, the lymphatic system is not functioning as well as it should secondary to it being surrounded by inflammatory disease tissues. Patients typically begin to have symptoms at puberty but are rarely diagnosed until they reach more advanced stages. Patients consistently complain of pain in the areas of fat accumulation, easy bruising, limitation of motion and as progression occurs alterations in gait with subsequent need for knee replacement in many cases. While we use palliative therapies to treat the fluid excess including manual lymphatic drainage, wrapping, compression garments, exercise and diet, supplements and medications that bind to receptors on the lymphatics and induce lymphatic pumping, we cannot reduce the fat itself. Ultimately, even if the patient is adherent to palliative protocol, development of lymphedema typically occurs. It is not uncommon for patients to have significant gait dysfunction or inability to ambulate without assistance often requiring joint replacements.

At this time, the only definitive treatment for lipedema is lymph-sparing excision through suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is their standard of care. Liposuction works effectively for lipedema to reduce lipedema fat and pain (Cornely et al., 2006; Schmeller et al., 2006; Warren et al., 2007). According to Dr. Staffan Rapprich from Darmstadt Clinics in Germany, whose sole practice is focused on SAPL for lipedema, the treatment is curative (Rapprich et al., 2011, 2012). I consider SAPL medically necessary to prevent progression, reduce the pain, improve the gait and prevent damage to joints. WAL (water jet assisted liposuction) is the preferred method to remove the abnormal fat in lipedema patients. It has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction devised by German surgeons for lipedema fat removal 20 years ago, WAL lessens the risk of fluid overload and the osmotic burden on the patient, and thus, enables a more extensive fat removal and a smaller number of procedures than the earlier tumescent method. Cosmetic improvement, if it occurs at all, is just a bonus. **This is not a cosmetic procedure.**

Marcia V Byrd, MD

Date

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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

OPERATIVE NOTE

Name: Rose Averill

Date: 10/25/2019

Preoperative Diagnosis: Lipedema

Procedure: Lymph-sparing lipectomy utilizing Water-jet assisted Liposuction (WAL), Power assisted Liposuction (PAL), Vaser Liposuction (UAL)

Areas Treated: Calves to Ankles- Bilaterally and Circumferentially

Attending Surgeon: Marcia V Byrd MD

Indications: Progressive pain, swelling and decreased mobility which has been non-responsive to diet, exercise and other non-surgical measures.

Discussion: This lady presents for liposuction for the treatment of Lipedema. This procedure is not cosmetic but is intended to decrease her pain, improve her mobility/gait and prevent progression of the disease.

CPT code: 38999

Operative Summary:

Written consent was obtained prior to surgery, which included but was not limited to infection, bleeding, hematoma, seromas, asymmetries, contour irregularity, divots in the skin, DVT, pulmonary embolus. The patient understood and agreed to proceed. The patient was taken to the photo room where photos and markings of the areas were made then transferred to the surgical suite and placed supine on the operating table. After appropriate level of IV sedation was obtained the patient was prepped and draped in a sterile manner. The incisions for the liposuction cannulas were injected with tumescent solution with 30g needle then a 2 mm punch biopsy tool was used to make the incisions. Tumescent solution was infiltrated into the areas for lymph-sparing lipectomy. After this was allowed to take effect adipose tissue was then removed from the areas listed above using a combination of WAL, PAL and UAL in a manner to preserve the integrity of the lymphatics. Total extracted was 3500cc with a supernatant of 3200cc. Incisions closed with single mattress stitch of 4-0 plain gut. Dressings and compression garment were applied. The patient was transferred from the operating table to the recovery room having tolerated the procedure without difficulty.

Signature: _____
Marcia V. Byrd, MD

Date: _____

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Marcia V Byrd, MD

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Roswell, GA 30075
(770)587-1711

Page: 1

12/12/2019

Patient: Rose Averill
2140 Longbow Lane
Clearwater, FL 33764

Chart #: 26651AV0

Case #: 5348

Instructions:

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modifier	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
8/30/2019	Office Visit New Patient Lipedema	99205LI		000.00				1	150.00
8/30/2019	Visa/Mastercard payment	VISA						1	-150.00
9/5/2019	Visa/Mastercard payment	VISA						1	-1,000.00
9/13/2019	Visa/Mastercard payment	VISA						1	-1,000.00
10/11/2019	Visa/Mastercard payment	VISA						1	-8,550.00
10/25/2019	Lymph-sparing lipectomy	15879	22 50	R60.1	I 89.0	L92.9	R20.8	1	8,200.00
10/25/2019	Supplies	99070		R60.1	I 89.0	L92.9	R20.8	1	750.00
10/25/2019	IV sedation first 15 minutes	99152		R60.1	I 89.0	L92.9	R20.8	1	250.00
10/25/2019	IV sedation each additional 15	99153		R60.1	I 89.0	L92.9	R20.8	7	350.00
10/29/2019	MLD bilateral	97140		000.00				1	200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-2,000.00

Provider Information

Provider Name: Marcia V. Byrd MD
License: 023141
Insurance PIN:
SSN or EIN: 581452561

Total Charges: \$ 9900.00

Total Payments: -\$ 12900.00

Total Adjustments: \$ 0.00

Total Due This Visit: -\$ 3000.00

Total Account Balance: \$ 6,300.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

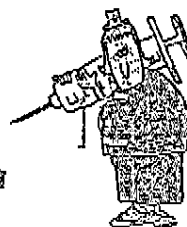
Patient Signature: _____

Date: _____

Aug. 8. 2017 1:14PM

No. 2608 P. 1

SURGICAL ASSOCIATES OF WEST FLORIDA
1840 MEASE DRIVE SUITE 301
SAFETY HARBOR, FLORIDA 34695
PHONE (727) 712-3233 X 1130
FAX (727) 712-1853
MARK ZUZGA, DO RVT

TO: RoseFROM: Dr. ZuzgaDATE: 8-8-17TOTAL PAGES: 11Fax
PHONE NUMBER: 210-4600REGARDING: Records - the post US report
has not be dictated yet by Dr. Zuzga.Denise

Aug. 8. 2017 1:14PM

No. 2608 P. 2

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Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zuzga, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/07/17

CHIEF COMPLAINT: Painful varicosities left greater than right.

I saw Rose in consultation. She is a very pleasant 55-year-old female who presents for evaluation for lower extremity pain, impending venous ulcerations, bulging varicosities, venous edema, and leg fatigue, itching, burning, and unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications left greater than right. Due to the acute exacerbation of the symptoms, she presents for evaluation.

CURRENT MEDICATIONS: Thyroid medication, prednisone, doxycycline, probiotic, and Omega 3.

ALLERGIES: None.

PAST SURGICAL HISTORY: Hysterectomy and knee surgery.

PAST MEDICAL HISTORY: High cholesterol and Lyme disease.

FAMILY HISTORY: Diabetes.

SOCIAL HISTORY: Minimal alcohol.

REVIEW OF SYSTEMS: A 12-step review of systems was performed. Pertinent findings can be reviewed in the patient's chart and reviewed with the patient.

PHYSICAL EXAMINATION: Blood pressure, see nurse's notes, heart rate 80 and respirations 12. Well developed, well nourished, well hydrated, and in no acute distress. No scleral icterus. Palpable femoral and pedal pulses. Lower extremity shows bulging varicosities, hemosiderin deposits left greater than right with associated telangiectasias, and swelling. Heart is regular. Lungs are clear. No abdominal masses, tenderness, hepatosplenomegaly, or hernia. Head, neck, spine, ribs, and pelvis show good range of motion, stability, muscle strength and tone. Cranial nerves II through XII are grossly intact and normal. Good judgment and insight. No lymphadenopathy in the neck, axilla or groin.

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Aug. 8. 2017 1:15PM

No. 2608 P. 3

RE: Rose Averill

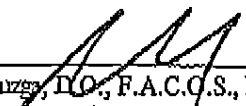
June 07, 2017

Page 2

IMPRESSION: Bilateral left greater than right lower extremity hemosiderin deposits, bulging varicosities, itching, burning, leg fatigue, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with daily pain with unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4.

PLAN: Venous duplex. Return after this is performed.

X


Mark A. Zurzga, D.O., F.A.C.C.S., R.V.T.

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Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zurza, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/27/17

PROCEDURE PERFORMED: Bilateral venous duplex

Left venous duplex was performed showing severe reflux of the left greater saphenous vein throughout its course from saphenofemoral junction down in the proximal greater saphenous vein measuring 14 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course. There was reflux in the left accessory greater saphenous vein; however, size dimensions are only 5.4 mm. Minimal reflux noted in the left lesser saphenous vein. The deep system was intact without evidence of DVT. Good proximal and distal augmentation.

IMPRESSION: Severe reflux of left greater saphenous vein throughout its course from saphenofemoral junction down, size is greater than 14 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

Right venous duplex was performed showing significant reflux of the right greater saphenous vein throughout its course from saphenofemoral junction down in the proximal greater saphenous vein measuring 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course. There was significant reflux of right accessory greater saphenous vein with size dimensions of 6.9 mm with greater than 2 seconds of reflux from saphenofemoral junction down throughout its course. Minimal reflux noted in the right lesser saphenous vein. The deep system was intact without evidence of DVT. Good proximal and distal augmentation.

IMPRESSION:

1. Severe reflux of right greater saphenous vein throughout its course from saphenofemoral junction down, size is 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

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No. 2608 P. 5


RE: Rose Averill

June 27, 2017

Page 2

2. Significant reflux of right accessory greater saphenous vein, size is greater than 6 mm with greater than 2 seconds of reflux from its origin down throughout its course.

X


Mark A. Zizza, D.O., F.A.C.O.S., R.V.T.

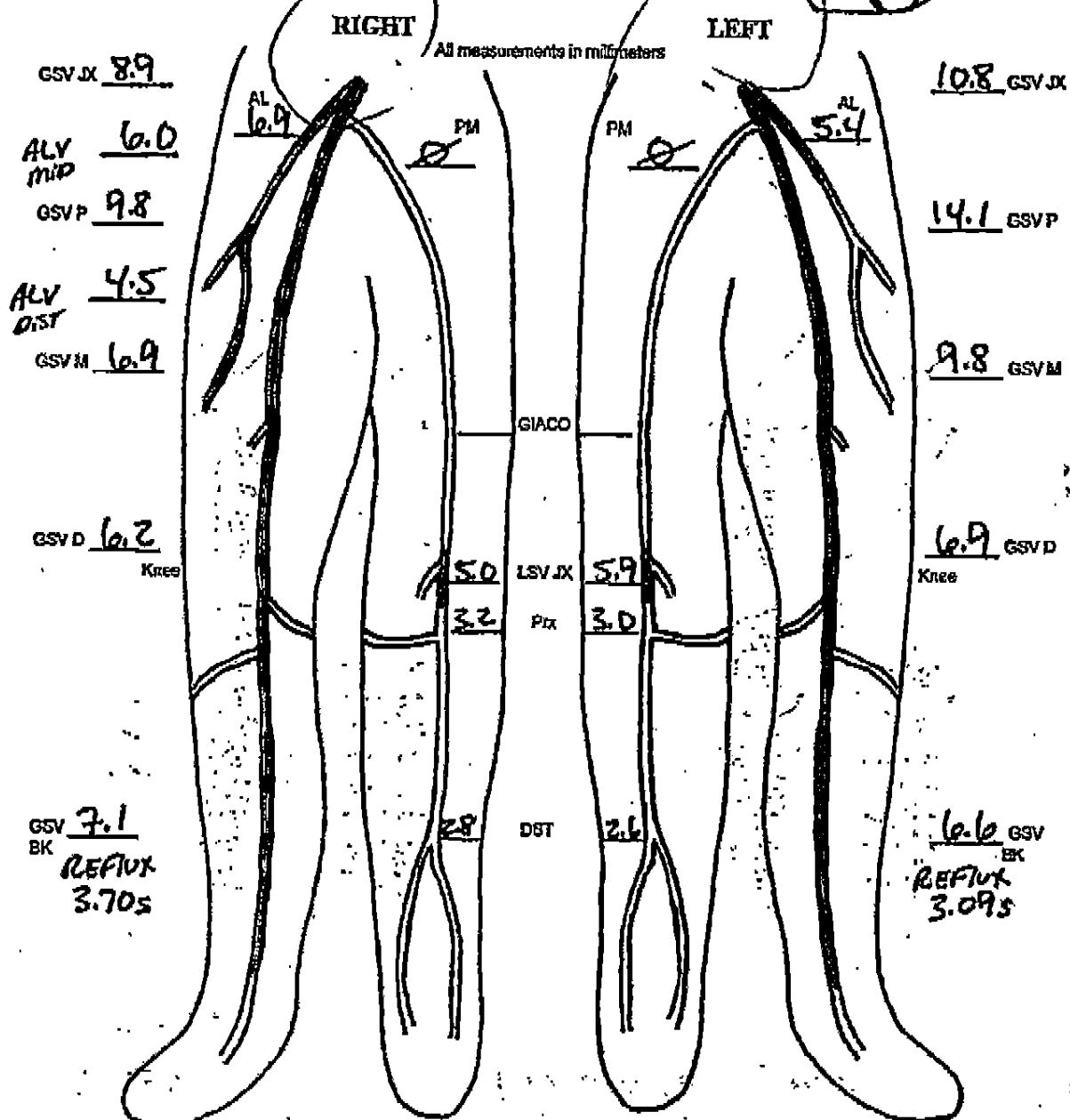
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Aug. 8. 2017 1:15PM

No. 2608 P. 6

*Surgical Associates of West Florida*Name AVERILL, ROSE Date 6/27/2017MR# 221304 Sonographer Pamela Bell, CCSPhysician ZUZGA Clinical History 

Aug. 8. 2017 1:16PM

No. 2608 P. 7

*Surgical Associates of West Florida*Name AVERILL, ROSE Date 6/27/2017MR# 221304 Sonographer Pamela Bell, RCSPhysician ZUZGA Clinical History _____

RIGHT LEG

	COMPRESS?	REFLUX?
GSV JX	YES	3.03s
PRX	YES	3.78s
MID	YES	3.76s
DST	YES	3.05s
ALV PRX	YES	3.58s
ALV MID	YES	3.10s
ALV DST	YES	3.33s
LSV JX	YES	2.02s
PRX	YES	—
DST	YES	—

CFV	YES	
SFV PRX	YES	
MID	YES	
DST	YES	
POP V	YES	
PTV		
ATV		
PERON V		

LEFT LEG

	COMPRESS?	REFLUX?
GSV JX	YES	3.13s
PRX	YES	3.20s
MID	YES	3.45s
DST	YES	3.40s
ALV	YES	2.74s
PMV		
GIACO		
LSV JX	YES	1.75s
PRX	YES	—
DST	YES	—

CFV	YES	
SFV PRX	YES	
MID	YES	
DST	YES	
POP V	YES	
PTV		
ATV		
PERON V		

Aug. 8. 2017 1:16PM

No. 2608 P. 8

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Robert S. Davidson, MD.

Robert T. Roth, MD.
Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zuzga, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/28/17

CHIEF COMPLAINT: Followup of ultrasound.

I saw Rose in followup today. She is a very pleasant female with lower extremity extensive venous stasis changes, swelling, pain, venous edema, itching and burning. She has tried and failed conservative management with compression stockings with venous clinical severity score of 14, CEAP score of 4. Venous ultrasound was performed showing severe reflux of bilateral greater saphenous veins from saphenofemoral junction down size measuring greater than 7 mm bilaterally with greater than 3 seconds of reflux from saphenofemoral junction down. Lengthy discussion we had with the patient the arteriovenous insufficiency, radiofrequency ablation; I feel she is an excellent candidate for radiofrequency ablation of bilateral greater saphenous veins with failed medical management with continued symptoms of pain, swelling, localized tenderness. I reviewed the ultrasound today in the office.

PHYSICAL EXAMINATION: Vital signs are stable, afebrile. Well developed, well nourished, well hydrated, and in no acute distress. No scleral icterus. No carotid, abdominal, or femoral bruits. Palpable femoral and pedal pulses. Lower extremity shows bulging varicosities, venous stasis changes, skin pigmentation changes, inflammation. Heart is regular. Lungs are clear. No abdominal masses, tenderness, hepatosplenomegaly, or hernia. Head, neck, spine, ribs, and pelvis show good range of motion, stability, muscle strength and tone. Cranial nerves II through XII are grossly intact and normal. Good judgment and insight. No lymphadenopathy in the neck, axilla or groin.

IMPRESSION: Bilateral lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, skin pigmentation changes, inflammation with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of bilateral greater saphenous vein from saphenofemoral junction down size measuring greater than 7 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

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No. 2608 P. 9

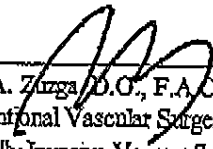
RE: Rose Averill

June 28, 2017

Page 2

PLAN: Radiofrequency ablation of bilateral greater saphenous vein.

X


Mark A. Zurga, D.O., F.A.C.O.S., R.V.T.

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Aug. 8. 2017 1:17PM

No. 2608 P. 10

**PATIENT:** Rose Averill**CHART#:** 221304**DOB:** 10/26/61**DATE:** 07/15/17**IN-OFFICE RADIOFREQUENCY ABLATION AND CLOSURE OF THE LEFT GREATER SAPHENOUS VEIN**

PREOPERATIVE DIAGNOSES: Left lower extremity pain, swelling, edema, dilated varicosities, bulging, itching, burning, skin pigmentation changes with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of the left greater saphenous vein from saphenofemoral junction down size measuring greater than 14 mm with proximal greater saphenous vein with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

POSTOPERATIVE DIAGNOSES: Left lower extremity pain, swelling, edema, dilated varicosities, bulging, itching, burning, skin pigmentation changes with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of the left greater saphenous vein from saphenofemoral junction down size measuring greater than 14 mm with proximal greater saphenous vein with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

IN-OFFICE PROCEDURE: Radiofrequency ablation and closure of left greater saphenous vein.

ANESTHESIA: Tumescence mixture of 450 cc of normal saline, 50 cc of 1% lidocaine, and 5 cc of bicarb.

DESCRIPTION OF OPERATION AND FINDINGS: After proper consent was obtained and placed in chart, the patient's left lower extremity was sterilized and prepped in usual fashion. Under ultrasound guidance, access was gained to distal left greater saphenous vein with micropuncture needle at which time the #7-French sheath was introduced. The radiofrequency ablation catheter was inserted at the saphenofemoral junction and pulled back 2 cm. Using 175 cc of tumescence anesthesia mixture, the entire left greater saphenous vein to undergo radiofrequency ablation was anesthetized. The patient underwent 14 RF cycles at 120 degrees and 10 watts as the #7-French sheath and radiofrequency ablation catheter was removed, local pressure was applied. The patient remained stable throughout the procedure and walked out of the office in stable condition.

X

Mark A. Zuzga, D.O., F.A.C.O.S., R.V.T.

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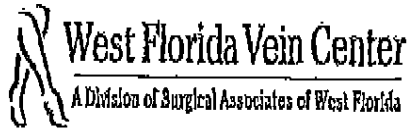
Phone: (727) 712-3233 • Fax: (727) 712-1333

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Aug. 8. 2017 1:18PM

No. 2608 P. 11

**PATIENT:** Rose Averill**CHART#:** 221304**DOB:** 10/26/61**DATE:** 07/22/17**IN-OFFICE RADIOFREQUENCY ABLATION AND CLOSURE OF THE RIGHT GREATER SAPHENOUS VEIN**

PREOPERATIVE DIAGNOSES: Right lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, unresponsive to greater than six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4 with ultrasound documentation of severe reflux of the right greater saphenous vein from the saphenofemoral junction down size measuring greater than 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

POSTOPERATIVE DIAGNOSES: Right lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, unresponsive to greater than six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4 with ultrasound documentation of severe reflux of the right greater saphenous vein from the saphenofemoral junction down size measuring greater than 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

IN-OFFICE PROCEDURE: Radiofrequency ablation and closure of right greater saphenous vein.

ANESTHESIA: Tumescence mixture of 450 cc of normal saline, 50 cc of 1% lidocaine, and 5 cc of bicarb.

DESCRIPTION OF OPERATION AND FINDINGS: After proper consent was obtained and placed in chart, the right lower extremity was sterilized and prepped in usual fashion. Under ultrasound guidance, access was gained to distal right greater saphenous vein with micropuncture needle at which time the #7-French sheath was introduced. The radiofrequency ablation catheter was inserted at the saphenofemoral junction and pulled back 2 cm. Using 220 cc of tumescent anesthesia mixture, the entire right greater saphenous vein to undergo radiofrequency ablation was anesthetized. The patient underwent 10 RF cycles at 120 degrees and 10 watts as the #7-French sheath and radiofrequency ablation catheter was removed, local pressure was applied. The patient remained stable throughout the procedure and walked out of the office in stable condition.

X

Mark A. Zyga, D.O., F.A.C.O.S., R.V.T.

Interventional Vascular Surgery

Minimally Invasive Venous Surgery

MAZ/Med/jai/wah

8/10/2017 1

e-mail: info@WestFloridaVeinCenter.com • www.WestFloridaVeinCenter.com

430 Morion Plant St. • PIAK Bldg. Ste. 301 • Clearwater, Florida 33756
Phone: (727) 712-3233 • Fax: (727) 712-1853

1840 Mease Dr., Ste. 201 • Safety Harbor, Florida 34695
Phone: (727) 712-3233 • Fax: (727) 712-1853



Frank Averill, MD

802 N. Belcher Road
Clearwater, FL 33785

Phone 727.447.3000

Fax 727.210.4600

www.StFrancisMed.com

"Giving of ourselves...so you receive...the best care."

FAX COVER SHEET

To: Dr Jamie Schwartz

Pages: _____ (Include cover)

Fax: _____

From: Dr Francis Averill

Phone: _____

Date: _____

RE: Rose Averill
(Patient's Name)

DOB: 10/26/1961
(Patient's DOB)

- ☐ URGENT
 ☐ FOR REVIEW
 ☐ PLEASE COMMENT
 ☐ PLEASE REPLY
☐ Patient's Labs
 ☐ Patient's Radiology
 ☐ Patient's Last Office Visit
 ☐ Other Patient Information

Notes: _____

Thank you and have a Blessed day!

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6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 001 OF 013

F A X S H E E T

Date: 06/13/2023 10:27:39 AM
To: DR.AVERILL
Subject: Patient Document
Fax Number: 7272104600
To Company:
From Name: Aviles,Abby
From Company: Louis Aviles M.D., PL
From Facility: Louis Aviles M.D., PL
Support Contact:
Number of Page(s): 13

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6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 002 OF 013
COMMAND HEALTH - 9725600300

BARDMOOR OUTPATIENT CENTER

8787 Bryan Dairy Road
Largo, FL 33777
727-394-5300

OPERATIVE NOTE

PATIENT NAME: AVERILL, ROSE C.

MEDICAL RECORD #: 6526890

DATE: 05/19/2023

DATE OF BIRTH: 10/26/1961

OPERATING PHYSICIAN: LOUIS AVILES, M.D.

PROCEDURE: An EGD with biopsy.

PREOPERATIVE DIAGNOSIS: Longstanding gastroesophageal reflux disease, longstanding heartburn.

POSTOPERATIVE DIAGNOSIS: The findings include the following:

1. Normal-appearing area of the hypopharynx.
2. Normal-appearing proximal and mid esophagus.
3. Minimally irregular squamocolumnar junction at around 40 cm and that was going to be biopsied.
4. A small sliding hiatal hernia noted on retroflexed view.
5. Scant erythema noted in the area of the antrum and that was biopsied.
6. Normal-appearing duodenal bulb, descending, 3rd and 4th portions of the duodenum.

ESTIMATED BLOOD LOSS: Less than 1 mL. There is no withdrawal time associated with this report.

BIOPSIES: Specimens include the following: Bottle A is antrum for chronic gastritis and bottle B is EG junction/squamocolumnar junction at 40 cm.

INDICATION: Ms. Averill is a pleasant 61-year-old woman who comes in today for an upper endoscopy. She has had longstanding history of reflux and in light of that, she is here for an EGD. She gave consent for the procedure. Monitoring included pulse oximetry, blood pressure, and EKG. Patient received supplemental O2 via nasal cannula.

MEDICATIONS GIVEN: TIVA.

ASA CLASSIFICATION: She was an ASA 3.

PROCEDURAL STATEMENT: The patient was placed in a left lateral position. The forward viewing scope was introduced under direct vision down a normal-appearing proximal and mid esophagus. A brief look at the area of the arytenoids showed that this was normal. Her vocal cords also appeared to be normal. The proximal and mid esophagus were normal lining. We saw the squamocolumnar junction at around 40 cm minimally irregular. The stomach itself inflated appropriately. The rugae appeared to be normal. In the area of the antrum, there was some scant erythema. We went through the open pylorus into the duodenal bulb, descending duodenum, 3rd and 4th portions of duodenum. These areas were normal. We did see some clear

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 003 OF 013
COMMAND HEALTH - 9725600300

BARDMOOR OUTPATIENT CENTER

8787 Bryan Dairy Road
Largo, FL 33777
727-394-5300

OPERATIVE NOTE**PATIENT NAME:** AVERILL, ROSE C.**MEDICAL RECORD #:** 6526890**DATE:** 05/19/2023**DATE OF BIRTH:** 10/26/1961**OPERATING PHYSICIAN:** LOUIS AVILES, M.D.

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IMPRESSION: Ms. Averill now status post upper endoscopy with the findings described above including the mild esophagitis, the small sliding hiatal hernia and scant gastritis.

PLAN: The plan is for her to continue on her current medications. Further recommendations will be based on the final pathology. She did tolerate the procedure. She was monitored and will be subsequently discharged home once the criteria are met.

Electronically Signed 05/19/2023 09:40 PM
LOUIS AVILES, M.D.

LA/ja/6757144-258199

D: 05/19/2023

T: 05/19/2023

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 004 OF 013
COMMAND HEALTH - 9725600300

BARDMOOR OUTPATIENT CENTER

8787 Bryan Dairy Road
Largo, FL 33777
727-394-5300

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6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 005 OF 013
COMMAND HEALTH - 9725600300

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Electronically Signed 05/19/2023 09:40 PM
LOUIS AVILES, M.D.

LA/ja/6757144-258199

D: 05/19/2023

T: 05/19/2023

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 006 OF 013
COMMAND HEALTH - 9725600300

BARDMOOR OUTPATIENT CENTER

8787 Bryan Dairy Road

Largo, FL 33777

727-394-5300

OPERATIVE NOTE**PATIENT NAME:** AVERILL, ROSE C.**MEDICAL RECORD #:** 6526890**DATE:** 07/22/2022**DATE OF BIRTH:** 10/26/1961**OPERATING PHYSICIAN:** LOUIS AVILES, M.D.**PROCEDURE PERFORMED:** Colonoscopy, with cold snare polypectomy.**PREOPERATIVE DIAGNOSIS:** Colon cancer screening.**POSTOPERATIVE DIAGNOSIS:**

1. A single small hemorrhoidal tag noted.
2. Good sphincter tone.
3. Small internal hemorrhoids, grade 1, noted on retroflexed view.
4. Excellent preparation, with a 9/9 on the Boston Prep Scale.
5. Rare small diverticulum noted mainly in the descending colon.
6. A single sessile polyp noted in what appeared to be the transverse colon, removed via cold snare polypectomy, retrieved, and placed into bottle A.
7. Level of insertion was area of the cecum, with photographic documentation of the appendiceal orifice.

ESTIMATED BLOOD LOSS: Less than 1 mL.**MEDICATIONS:** TIVA. ASA III.**WITHDRAWAL TIME:** Approximately 24 minutes.**SPECIMENS:** Bottle A.

INDICATIONS: Ms. Averill is a pleasant 60-year-old woman who comes in now for a screening colonoscopy. She gave consent for the procedure. Monitoring included pulse oximetry, blood pressure, and EKG. The patient received supplemental O2 via nasal cannula.

PROCEDURAL STATEMENT: The patient was placed in the left lateral position. A digital rectal revealed no perianal pathology. She did have what appeared to be just a single tiny tag noted. She had good sphincter tone. The pediatric colonoscope was introduced. She had an excellent preparation. We did a retroflexed view, which showed grade 1 internal hemorrhoids. The colonoscope at this point was very carefully advanced forward, and again she had an excellent preparation. We did see scattered and rare diverticulum. The colonoscope was carefully advanced forward, and during advancement, we encountered a single sessile polyp in what appeared to be the transverse colon. Once we removed the polyp using cold snare polypectomy and retrieved it, placed in bottle A, we then advanced the colonoscope all the way to the cecum. The cecum was identified by the appendiceal orifice. I did not intubate the distal terminal ileum, but we did see the valve. The colonoscope was slowly withdrawn, and we

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 007 OF 013
COMMAND HEALTH - 9725600300

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727-394-5300

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examined areas of the cecum, ascending, transverse, descending, sigmoid, and rectosigmoid areas. Again, this was an approximately 24-minute withdrawal, and once we were in the rectum, at this point the CO2 was removed. The colonoscope was removed. She did tolerate the procedure and was sent to our recovery area.

IMPRESSION: Ms. Averill is now status post a colonoscopy, with the findings described above.

RECOMMENDATIONS: High-fiber diet and fiber supplements as needed. Based on today's findings, repeat colonoscopy in 5 years. The polyp itself appeared to be benign, and she did tolerate the procedure, was monitored, and can be subsequently discharged home once the criteria are met.

Electronically Signed 07/23/2022 05:36 AM

LOUIS AVILES, M.D.

LA/tr/6478120-239081

D: 07/22/2022

T: 07/22/2022

cc: Anup Desai, MD

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 008 OF 013
COMMAND HEALTH - 9725600300

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Largo, FL 33777

727-394-5300

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6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 009 OF 013
COMMAND HEALTH - 9725600300

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Largo, FL 33777

727-394-5300

OPERATIVE NOTE**PATIENT NAME:** AVERILL, ROSE C.**MEDICAL RECORD #:** 6526890**DATE:** 07/22/2022**DATE OF BIRTH:** 10/26/1961**OPERATING PHYSICIAN:** LOUIS AVILES, M.D.

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Electronically Signed 07/23/2022 05:36 AM

LOUIS AVILES, M.D.

LA/tr/6478120-239081

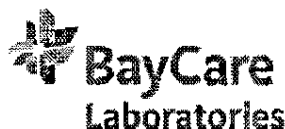
D: 07/22/2022

T: 07/22/2022

cc: Anup Desai, MD

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 010 OF 013
5/23/2023 14:48 #8002292273 BayCare Health System RRD→17274479255

2/3



FIN#: 106010093291
MR#: 2104682138
DOB/Sex: 10/26/1961 / Female

Name: AVERILL, ROSE C
Facility: BARD SURG CNTR

Customer Service: 727-394-6748

Ordering Physician: Aviles ,Louis MD

Copy To:

SURGICAL PATHOLOGY REPORT

Accession:
PS-23-0006155

Collected:
5/19/2023 07:34 EDT

Received:
5/20/2023 07:34 EDT

Pathologist:

Kowal ,Noel A MD

Surgical Pathology Final Report

DIAGNOSIS

A. STOMACH, ANTRUM, BIOPSY:

- GASTRIC ANTRAL AND OXYNTIC MUCOSA WITH REACTIVE GASTROPATHY.

B. GASTROESOPHAGEAL JUNCTION, 40 CM, BIOPSY:

- SQUAMOUS AND GASTRIC MUCOSA WITH HISTOLOGIC CHANGES OF REFLUX ESOPHAGITIS.

GROSS DESCRIPTION

Received are 2 specimens.

Specimen A consists of multiple gray to gray-tan, mucosal covered polypoid portions of tissue measuring from 0.4 to 0.7 cm. Entirely submitted.

Specimen B consists of multiple portions of gray to gray-tan soft tissue measuring 0.2 to 0.5 cm. Entirely submitted.

PERFORMING LOCATIONS/CODES/SIGNATURES

Gross examination performed at Morton Plant Hospital, 300 Pinellas St., Clearwater, FL 33756.

RH/st (1115964)

Microscopic interpretation performed at Morton Plant North Bay Hospital, 6600 Madison St., New Port Richey, FL 34652.

Pathology Direct Line: 727-843-4538

NAK/so (1116477)

Reviewed, Approved and Electronically Signed By: Kowal , Noel A MD

Verified: 05/23/2023 14:42

NAK/SMT

Report to: Aviles ,Louis MD
1007 Jeffords St
Ste 102
Clearwater, FL 33756-4082

Distribution:
XR - AP OR FAX1 - ORDER2
Patient Type: MP Outreach
Admit Dr: Aviles ,Louis MD

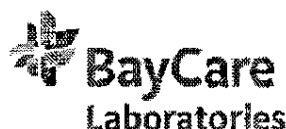
Client: BARDMOOR SURG CENTER ORL
8787 BRYAN DAIRY RD #300
LARGO, FL 33777-

5/23/2023 14:48 EDT

Page 1 of 1

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., FL TO: 7272104600 PAGE: 011 OF 013
7/27/2022 10:57 8002292273 BayCare Health System RRD → 17274479255

3/5



FIN#: 106005666284
MR#: 2104682138
DOB/Sex: 10/26/1961 / Female

Name: AVERILL, ROSE C
Facility: BARD SURG CNTR

Customer Service: 727-394-6748

Ordering Physician: Aviles ,Louis MD

Copy To:

SURGICAL PATHOLOGY REPORT

Accession:
PS-22-0008821

Collected:
7/22/2022 07:06 EDT

Received:
7/23/2022 07:06 EDT

Pathologist:

Schaefer ,George D MD

Surgical Pathology Final Report

DIAGNOSIS

TRANSVERSE COLON POLYP:

- FRAGMENTS OF TUBULAR ADENOMA.
- NEGATIVE FOR HIGH-GRADE DYSPLASIA.

GROSS DESCRIPTION

Received is a pink-tan, mucosal covered polypoid portion of tissue measuring 1.1 x 0.4 x 0.3 cm. The specimen is sectioned and entirely submitted.

PERFORMING LOCATIONS/CODES/SIGNATURES

Gross examination performed at Morton Plant Hospital, 300 Pinellas St., Clearwater, FL 33756.

RJI/so (956027)

Microscopic interpretation performed at: Morton Plant Hospital, 300 Pinellas St., Clearwater, FL 33756

Phone: 727-462-7062

GDS/so (956746)

Reviewed, Approved and Electronically Signed By: Schaefer , George D MD

Verified: 07/26/2022 09:28

GDS/SO

Report to: Aviles ,Louis MD
1007 Jeffords St
Ste 102
Clearwater, FL 33756-4082

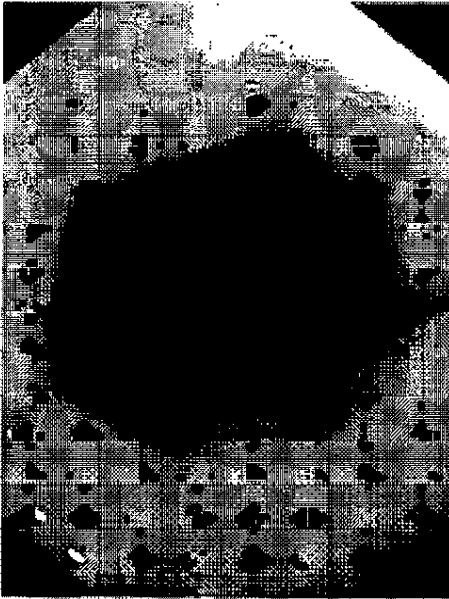
Distribution:
XR - AP OR FAX1 - ORDER2
Patient Type: MP Outreach
Admit Dr: Aviles ,Louis MD

Client: BARDMOOR SURG CENTER ORL
8787 BRYAN DAIRY RD #300
LARGO, FL 33777-

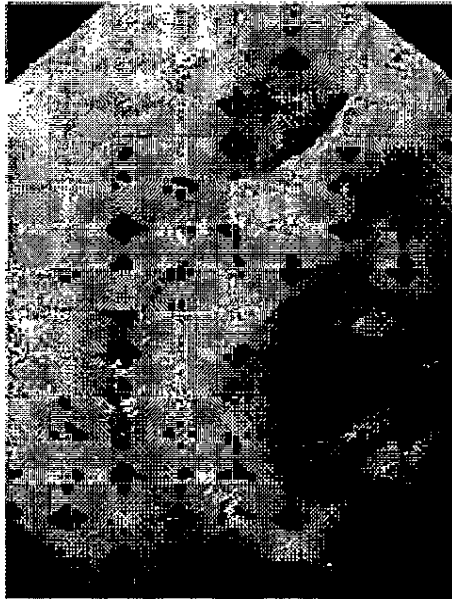
7/26/2022 14:47 EDT

Page 1 of 1

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 012 OF 013



SCA



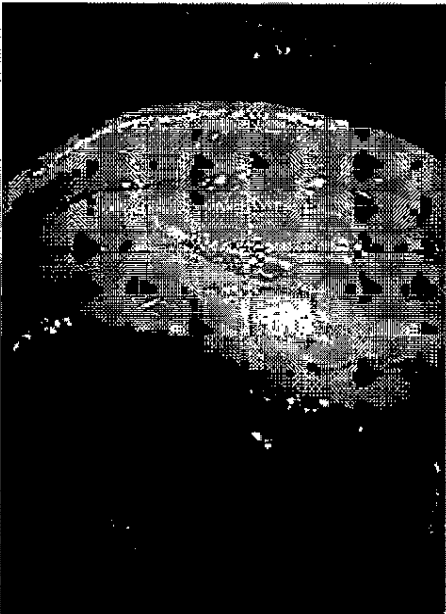
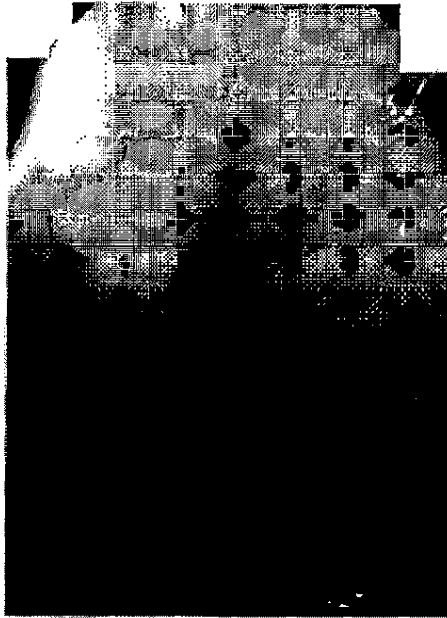
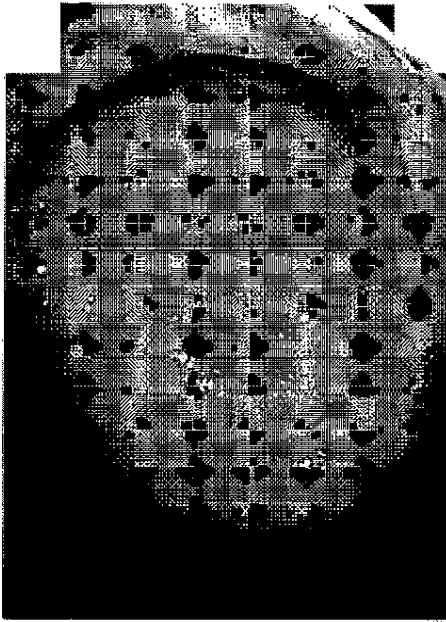
VICKI 01/03

SUNNY
1/11

NAME: AVERILL, ROSE C
DOB: 10/26/61 AGE: 61 SEX: F
DR: LOUIS AVILES
MRN: 6526890 DOS: 05/19/2023

E6D

6/13/2023 10:45 AM FROM: Fax Louis Aviles M.D., PL TO: 7272104600 PAGE: 013 OF 013



NAME: AVERILL, ROSE C
DOB: 10/26/61 AGE: 60 SEX: F
DR: LOUIS AVILES
MRN: 6526890 DOS: 07/22/2022
Colon

St.Francis Sleep Allergy & Lung Institute
802 N Belcher Road
Clearwater FL 337652103
Phone: 727-447-3000 Fax: 727-210-4600

Visit Note

Provider:

Performing: Regina Pruitt, PA

Supervising: Francis Averill, MD

Encounter Date: Feb 22, 2022

Patient: Averill, Rose (AVERO000)

Sex: F

DOB: Oct 26, 1961 Age: 60 Year 3 Month 3 Week

Race: White

Address: 802 belcher rd, Clearwater FL 337652103

Primary Dr.: Anup Desai, MD

Insurance:

UNITED HEALTHCARE (PP) Insurance ID: 912012181

Description: GENERAL

Chief Complaint:

***** Knee pain**

HPI:

***** Pt is a 61 year old female with PMH**

Lipidema

Prediabetes

Morbid obesity

Hyperlipidemia

Osteoarthritis of knee joints

allergic rhinitis

presents with c/o knee pain

describedd as a constant pain around her knees

Worse woith weight bearing and walking

Has lipidema with decreased ROM of knees

Hx OSA

Currently on CPAP

Gets benefit from CPAP

Feels more rested on CPAP

Current Medication:

1 Advil 200 Mg Liqui-gel Capsule SIG: As needed

2 Allegra Allergy 60 Mg Tablet SIG: As needed

3 Claritin 10 Mg Liqui-gel Cap SIG: As needed

4 Montelukast Sod 10 Mg Tablet SIG: once daily

ROS:

Cardiovascular: Patient denies: high blood pressure, heart attack, heart murmur, irregular heart beat, heart valve disorder, orthopnea, pacemaker, palpitations, varicose veins, edema, congenital heart disease, cold/blue hands, claudication, chest pressure, chest pain, and arrhythmia.

Constitutional: Patient Denies: loss of appetite, chills, fever, night sweats, fatigue/exhaustion, generalized weakness, headaches, malaise, recent weight gain, recent weight loss.

Skin: Patient Denies: rashes, itching, hives, acne, and ecchymosis.

ENT: Patient Denies: nasal congestion, runny nose, post nasal drainage, nosebleed, deviated septum, sinus problem, dental problems, dry mouth, mouth ulcers, hoarseness of voice, earache, ear drainage, hearing loss, ringing in ears, and vertigo.

GI: Patient Denies: abdominal pain, constipation, diarrhea, nausea, vomiting, difficulty swallowing, belching/flatulence, heartburn/reflux, blood in stool.

GU: Patient Denies: decreased urinary stream, dysuria, frequency, urgency, painful urination, urinary retention, hematuria, incontinence, nocturia, kidney stones, bladder cancer and prostate cancer.

Hematologic: Patient Denies: anemia, bleeding disorder, blood clots in legs, and blood clots in lung.

Musculoskeletal: (+) arthritis: ; (+) bone pain ; (+) joint pain: ; (+) limitation of motion: ; (+) muscle cramps: ; (+) muscle pain: ; (+) stiffness: .

Neurologic: Patient Denies: stroke, seizures, tremors, headaches, head injury, memory loss, dizziness, loss of coordination, numbness/tingling, speech impairment, and syncope.

Psychiatric: Patient Denies: agitation, anxiety, depression, irritability, mood changes, confusion, suicidal thoughts, history of suicide attempts, and sleep disturbances.

RESPIRATORY: Patient Denies: asthma, bronchitis, chest congestion, chest constriction, choking feeling, cough, chest pain, chest pain worst with deep breaths, chronic cough dyspnea, hemoptysis, orthopnea, persistent cough, pneumonia, recurrent URI's, shortness of breaths, sighing, sleep apnea, snoring, sore throat, tuberculosis, wheezing, chest tightness, and insomnia.

Lipedema: Pain, Fatigue, Fluid retention, Sensitive to touch, Easy bruising, Loss of mobility, Joint Pain.

Vital Signs:

Weight: 292 lbs

Temperature: 99.1 F (Tympanic)

BP: 128/77(Right Arm)(Sitting)

Pulse: 65

Oxygen: 97(Room air)

Examination:

General: obese.

Skin: moist, subcutaneous inspection normal and no rashes or lesions.

Head: normocephalic, atraumatic, no history or any evidence of head trauma and no alopecia.

Eyes: no abnormalities, pupils are equal, round and reactive to light and accommodation, extraocular muscles are intact and no conjunctival injection.

Ears: tympanic membranes are intact with good hearing acuity and canals clear.

Nose: normal nasal mucosa with no significant swelling or discharge, septum is midline, turbinates are not enlarged and sinuses are nontender.

Neck: supple, non-tender, trachea is midline, the thyroid is not enlarged with no masses, no JVD and no bruits.

Cardiac: regular rate and rhythm, no murmurs, rubs or gallops, no heaves and peripheral pulses are normal bilaterally.

Lungs: symmetric chest with normal excursion and expansion, no increased use of accessory muscles, normal diaphragmatic excursion, normal percussion of the chest with normal percussion note, no tactile fremitus elicited on palpation and auscultation reveals no rales, rhonchi, wheezes or rubs.

Abdomen: soft and nontender, no organomegaly, no masses, normal bowel sounds and no rebound.

Extremities: decreased ROM, lipdemia depositis.

Lymphatics: grossly normal and no palpable lymph nodes.

Neurologic: grossly intact, cranial nerves are intact, alert and oriented x3 and normal mood and affect.

Lipedema: Bilateral swelling / edema, Fat pads, Ankle cuff.

*** Disproportionate upper and lower body with upper body being much smaller

Tender nodules and fat in the upper gluteal area

small amount of fat in the upper arms without tender nodules

small amount of fat in the forearm without cuffing

hands negative stemmer sign

hips with tender nodules bilaterally

thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules
non pitting edema

Epworth Sleepiness:

Date:

Sitting & Reading: 3.

Watching Television: 3.

Sitting inactive in public place- for example a theater or a meeting: 2.

As a passenger in a car for an hour without a break: 2.

Lying down to rest in the afternoon: 3.

Sitting and talking to someone: 0.

Sitting quietly after lunch (When you've had no alcohol): 2.

In a car while stop in traffic: 0.

Total: 15

Interpretation:

0-10 = Normal range for healthy adults

11-14 = Mild sleepiness

15-17 = Moderate sleepiness

18 + = Severe sleepiness.

Diagnosis:

M25.561 Pain in right knee

G47.33 Obstructive sleep apnea (adult) (pediatric)

R60.1 Lipidema

R20.8 Other disturbances of skin sensation

I89.0 Lymphedema, not elsewhere classified

M79.609 Pain in unspecified limb

R26.9 Unspecified abnormalities of gait and mobility

Prescription:

1 Lidocaine 5% Patch SIG: Apply ONE PATCH Q 12 HRS As needed QTY: 30.00

Plan:

*** Order PSG

If OSAS order CPAP titration study

Recommend B12 injections for energy

Current medications documented and reviewed.

Advised not to drive if sleepy or drowsy.

Advised of risks of EDS and OSAS.

Advised regarding sleep hygiene.

Current medications documented and reviewed.

Influenza immunization previously received.

Pneumococcal vaccination has not been given nor previously received.

Keto low carb diet

walk 30 mins daily

Water exercise

RTC in 3 weeks

CC:

Dr Jamie Schwartz : 02/05/2024

This visit note has been electronically signed off by following providers.

This visit note has been electronically signed off by Francis Averill, MD.

This visit note has been electronically signed off by Regina Pruitt, PA.

Sharecare - HDS

Fax Cover Sheet

Subject Sharecare EDelivery
To 17272104600
From
Date 2021-08-05 15:01:39 EDT

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

- Tear of medial meniscus of knee - Onset: 06/09/2017, Left
- Tear of medial meniscus of knee - Onset: 12/13/2018

Family History

Reviewed Family History

- Mother**
- Arthritis
 - Malignant neoplastic disease
 - Diabetes mellitus
 - Obesity
- Father**
- Cerebrovascular accident
 - Diabetes mellitus
 - Heart disease
 - Hypertensive disorder

Social History

Reviewed Social History

AFO Social History

Education: Post Graduate

General stress level: High

Marital status: Married

Live alone or with others?: with others

Single or multi-level home/work?: single level home

Smoking Status: Never smoker

Non-smoker

Alcohol intake: Occasional

Caffeine intake: Occasional

Exercise level: Occasional

Seat belts used routinely: Y

Advance directive: N

Chewing tobacco: none

Number of children: 2

Hand Dominance: Right

Are you currently employed?: Y

Work related injury?: N

Auto related injury?: N

If injured, is litigation ongoing?: N

Surgical History

Reviewed Surgical History

- * Hysterectomy - 2003
- * Cesarean Section - 1991
- * Cesarean Section - 1988

Past Medical History

Reviewed Past Medical History

Back Pain: Y

Fractures: Y

High Cholesterol: Y

Obesity: Y

Sleep Apnea: Y

Urinary Tract Infection: Y

Varicose Veins: Y

Screening

None recorded.

HPI

Knee

Reported by
patient.

Location: right

Quality: aching; stabbing; constant; worsening

Duration: november 2nd

Context: exiting a plane, felt pain

Alleviating Factors: ice; rest; elevation

Aggravating Factors: upstairs; downstairs

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Associated Symptoms: **weakness; numbness; tingling; swelling; radiation down leg**

Previous Surgery: none

Prior Imaging: x ray (2 weeks)

Previous Injections: none

Previous PT: none

Working: regular duty

Notes: patient states right knee and leg pain and tightness/ using walker and cane

ROS

Constitutional:Constitutional: no fever, fatigue, or significant weight change and happy/content, good appetite, and normal activity level.

Eyes:Eyes: no eye pain, redness, itchiness, swelling, or discharge; no blurry vision; and normal movement.

ENMT:ENMT: no ear pain or discharge and no drooling, congestion, hoarseness, hearing loss, sinus pressure, facial swelling, sore throat, or mouth lesions.

Cardiovascular:Cardiovascular: no chest pain and normal heart rate.

Chest/Breasts:Breasts: no lumps, tenderness, or discharge.

Respiratory:Respiratory: no cough, wheezing, chest tightness, or pain with respiration and normal respiration.

Gastrointestinal:GI: no nausea, vomiting, diarrhea, constipation, difficulty swallowing, abdominal pain, blood in stools, or mucous in stool.

Genitourinary:GU: no discharge, blood in urine, pain with urination, increase in frequency of urination, voiding urgency, or vaginal discharge.

Musculoskeletal:Musculoskeletal: no myalgia, trauma, soft tissue swelling, joint swelling, or previous injuries and moves all extremities well.

Skin:Skin: no skin dryness, lesions, growths, or lumps and no pain, itchiness, flaking, redness, rash, hives, swelling, bruising, diaper rash, or insect bites.

Neurological symptoms:Neuro: no numbness, weakness, tingling, burning, headache, dizziness, shooting pain, or loss of consciousness.

Psychiatric:Psych: no depression, anxiety, insomnia, stress, or loss of interest.

Endocrine:Endocrine: normal drinking and no temperature intolerance.

Allergic/Immunologic:Allergy/Immunologic: no sneezing or runny nose.

Physical Exam

Patient is a 57-year-old female.

General:Appearance well-nourished and NAD. Gait limp . Orientation oriented to person, place, problem, and time. Mood appropriate mood and affect. Skin no suspicious lesions. Peripheral Vascular no clubbing, cyanosis, or edema. Lymphatics lymphedema absent.

Sensory Exam:Lower extremity sensation normal.

Reflexes:Deep Tendon Reflexes Normal.

Hips:Inspection Right Hip Normal. Inspection Left Hip Normal. Palpation Right Hip tenderness none. Palpation Left Hip tenderness none. ROM Right Hip normal . ROM Left Hip normal .

Knees:Inspection Right Knee: no deformity, mass, warmth, or erythema;effusion yes mild and swelling yes mild; and prepatellar bursitis no. Inspection Left Knee: no deformity, mass, warmth, or erythema; effusion yes mild and swelling yes mild; and prepatellar bursitis no. Soft Tissue Palpation Right Knee: no tenderness of the quadriceps tendon, the patellar tendon, the medial collateral ligament, the lateral collateral ligament, the pes anserinus, the popliteal fossa, or the gastrocnemius; Retro

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

patella crepitus and tenderness. Soft Tissue Palpation Left Knee: no tenderness of the quadriceps tendon, the patellar tendon, the medial collateral ligament, the lateral collateral ligament, the pes anserinus, the popliteal fossa, or the gastrocnemius; **Normal.** Bony Palpation Right Knee: no tenderness of the medial tibial plateau, the lateral tibial plateau, the superior pole patella, the inferior pole patella, or the tibial tubercle and **tenderness of the medial joint line.** Bony Palpation Left Knee: no tenderness of the medial tibial plateau, the lateral tibial plateau, the superior pole patella, the inferior pole patella, or the tibial tubercle and **tenderness of the medial joint line.** ROM Right Knee: normal, flexion normal, extension normal, and **crepitus yes.** ROM Left Knee: normal, flexion normal, extension normal, and **crepitus yes.** Stability Right Knee: no laxity or subluxation and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, Lachman test negative, and reverse Lachman test negative; **Normal.** Stability Left Knee: no laxity or subluxation and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, Lachman test negative, and reverse Lachman test negative; **Normal.** Special Tests Right Knee: patella compression test negative and apprehension sign negative and Apley's compression test negative and **McMurray's test positive.** Special Tests Left Knee: patella compression test negative and apprehension sign negative and Apley's compression test negative and **McMurray's test positive.** Strength Right Knee: no hamstring weakness or quadriceps weakness and flexion 5/5 and extension 5/5. Strength Left Knee: no hamstring weakness or quadriceps weakness and flexion 5/5 and extension 5/5.

Assessment / Plan

Osteoarthritis of knee

M17.12: Unilateral primary osteoarthritis, left knee

Tear of medial meniscus of knee- Left

S83.231A: Complex tear of medial meniscus, current injury, right knee, initial encounter

PHYSICAL THERAPY REFERRAL - Schedule Within: provider's discretion

Evaluate & Treat: yes Visits per Week: 2-3

Number of Weeks: 4-6 Modalities: pm

Side: LEFT Range of Motion:
yes

Strengthening: yes

Discussion Notes

The patient is a 57 year old female here today for a follow up regarding her right knee. DOI 11/2/18. The patient states her knee has gotten worse over the last few months. She states she has been having a lot of muscle tightness around her knee. She has been taking both Motrin and Tylenol to manage her pain. I ordered physical therapy. I ordered a handicap parking sticker. I will follow up with the patient in 1 month.

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Michael J Smith, MD, 04/03/2019.

Encounter performed and documented by Michael J Smith, MD

Encounter reviewed & signed by Michael J Smith, MD on 04/03/2019 at 4:02pm

Imaging Results

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

US VENOUS LOWER EXTREMITY BILATERAL (#11354659, Final, 07/19/2019 3:49pm)

Patient: AVERILL, ROSE C DOB: 10/26/1961
Gender: F

MRN: 2104682138
Account: 1109351742

Completed Date: 07/19/2019

US VENOUS LOWER EXTREMITY BILATERAL

CLINICAL INDICATION: Bilateral leg pain and edema

COMPARISON: Lower extremity ultrasound venous Doppler November 21, 2018

TECHNIQUE: Gray scale imaging with graded compression and spectral and color Doppler evaluation was performed.

FINDINGS:

RIGHT:

There is normal Doppler waveform and color Doppler flow at the right common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

LEFT:

There is normal Doppler waveform and color Doppler flow at the left common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler, MD Radiologist

Transcribed By: IA 07/19/2019

Electronically Signed By: Kevin Michael Kuppler, MD Radiologist 07/19/2019 03:53:00 pm

XR, FOOT 07/19/2019 - RIGHT (#11350353)

Interpretation:	Review of x-ray taken on 07/19/2019 at AFO CLINIC shows:
Foot:	
Findings:	Radiographic Findings: no fracture and no dislocation.

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

XR, TIBIA + FIBULA 07/19/2019 - RIGHT (#11350347)

Interpretation:	Review of xr, tibia + fibula taken on 07/19/2019 at AFO CLINIC shows:
	Lower Leg:
	Radiographic Findings: no fracture and no dislocation.

XR, ANKLE 07/19/2019 - LEFT (#11350329)

Interpretation:	Review of xr, ankle taken on 07/19/2019 at AFO CLINIC shows:
	Ankle:
	Radiographic Findings: no fracture and no dislocation.

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AVERILL, ROSE (Id #711165, dob: 10/26/1961)

US, DOPPLER, VENOUS (#11354926, 07/19/2019 12:00am)

Baycare Health Sys 7/19/2019 4:37:48 PM PAGE 1/002 Fax Server



FAX COVER SHEET

From:

Centricity RIS-IC Application

To:

Smith, Michael

BCMPH

Fax: 000-000-0000

Phone: 727-462-7540

Date: 7/19/2019 4:37:40 PM

Fax: 7275227412

Phone:

Pages (Including Cover): 2

Note:

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Baycare Health Sys 7/19/2019 4:37:48 PM PAGE: 2/002 Fax Server

BayCare Morton Plant Hospital

390 Pinellas Street Clearwater, FL 33755 (727) 462-7540

FINAL REPORT

Patient: AVERILL, ROSE C

DOB: 10/26/1961 Sex: F

Requesting: Smith, Michael J

Attending: Smith, Michael J

Interpreted By: Kevin Michael Kuppler

CPE: 101256420

MRN: 2104682138

Account: 1109351742

Patient Status: Outpatient

Patient Location: UL TMH

Smith, Michael J
4600 4th Street North
Saint Petersburg, FL 33703

ACC: 30883915

US VENOUS LOWER EXTREMITY BILATERAL

Completed: 7/19/19 3:49 pm

US VENOUS LOWER EXTREMITY BILATERAL

CLINICAL INDICATION: Bilateral leg pain and edema

COMPARISON: Lower extremity ultrasound venous Doppler November 21, 2018

TECHNIQUE: Gray scale imaging with graded compression and spectral and color Doppler evaluation was performed.

FINDINGS:

RIGHT:

There is normal Doppler waveform and color Doppler flow at the right common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

LEFT:

There is normal Doppler waveform and color Doppler flow at the left common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler

Electronically Signed By: Kevin Michael Kuppler

7/19/19 3:53 pm

Transcribed By: IA

7/19/19 3:53 pm

Name: AVERILL, ROSE C

Location: UL TMH

Patient Status: O

Exam: US VENOUS LOWER EXTREMITY BILATERAL

MRN: 2104682138

Printed: 8/21/2019 4:37 PM

Page 1 of 1

8/21/2019

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AVERILL, ROSE (Id #711165, dob: 10/26/1961)

US, DOPPLER, VENOUS (#11354794, 07/19/2019 12:00am)

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FAX COVER SHEET

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Smith, Michael

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AVERILL, ROSE (id #711165, dob: 10/26/1961)

Baycare Health Sys 7/19/2019 4:07:38 PM PAGE 2/002 Fax Server

BayCare Motion Plant Hospital

300 Pinellas Street Clearwater, FL 33755 (727)482-7540

FINAL REPORT

Patient: AVERILL, ROSE C

DOB: 10/26/1961

Sex: F

Requesting: Smith, Michael J

Attending: Smith, Michael J

Interpreted By: Kevin Michael Kuppler

CPI: 101256420

MRN: 2104682138

Account: 1103351742

Patient Status: Outpatient

Patient Location: ULTMH

Smith, Michael J

4600 4th Street North

Saint Petersburg, FL 33703

ACC: 30883915 US VENOUS LOWER EXTREMITY BILATERAL

Completed 7/19/19 3:49 pm

US VENOUS LOWER EXTREMITY BILATERAL

CLINICAL INDICATION: Bilateral leg pain and edema

COMPARISON: Lower extremity ultrasound venous Doppler November 21, 2013

TECHNIQUE: Gray scale imaging with graded compression and spectral and color Doppler evaluation was performed.

FINDINGS:

RIGHT:

There is normal Doppler waveform and color Doppler flow at the right common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

LEFT:

There is normal Doppler waveform and color Doppler flow at the left common femoral, femoral, popliteal, anterior tibial, posterior tibial, peroneal and greater saphenous veins. In addition there is normal compressibility of the common femoral, femoral and popliteal veins. There is no ultrasound evidence of deep venous thrombosis.

IMPRESSION:

No sonographic evidence of acute deep vein thrombosis in the bilateral lower extremities.

Electronically signed by Kevin M Kuppler on 7/19/2019 3:51 PM

Thank you for this referral.

Interpreted By: Kevin Michael Kuppler

Transcribed By: LA

7/19/19 3:53 pm

Electronically Signed By: Kevin Michael Kuppler

7/19/19 3:53 pm

Name: AVERILL, ROSE C

Location: ULTMH

Patient Status: O

Exam: US VENOUS LOWER EXTREMITY BILATERAL

MRN: 2104682138

Printed: 07/19/2019 4:08PM

Page 1 of 1

07/19/2019

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AVERILL, ROSE (id #3585604, dob: 10/26/1961)

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 08/02/2021

Patient

Name	AVERILL, ROSE (59yo, F) ID# 3585604	Appt. Date/Time	08/02/2021 09:15AM
DOB	10/26/1961	Service Dept.	AFO CLINIC
Provider	MICHAEL SMITH, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 912012181 Policy/Group # : 6F4546 Prescription: OPTUMRX COMMERCIAL - Member is eligible, details		

Chief Complaint

Followup: Tear of medial meniscus of knee

Patient's Care Team

Primary Care Provider: ANUP DESAI: 908 S FORT HARRISON AVE, CLEARWATER, FL 33756-3904, Ph (727) 442-5138, Fax (727) 461-5011 NPI: 1346348778

Patient's Pharmacies

WALGREENS DRUG STORE #06293 (ERX): 1505 S BELCHER RD, CLEARWATER, FL 33764, Ph (727) 536-7552, Fax (727) 536-7262

Vitals

08/02/2021 09:39 am

Wt: 280 lbs (127.01 kg)

Ht: 5 ft 6 in (167.64 cm)

BMI: 45.2

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

acyclovir 200 mg capsule TAKE 1 CAPSULE BY MOUTH FIVE TIMES PER DAY	07/22/21 filled
ALPRAZolam 0.25 mg tablet TAKE 1 TO 3 TABLETS BY MOUTH PRIOR TO PROCEDURE	03/03/21 filled
azithromycin 250 mg tablet	11/27/20 filled
cephALEXin 500 mg capsule TK 1 C PO QID FOR 5 DAYS	09/18/20 filled
furosemide 20 mg tablet	08/24/20 filled
methyIPREDNISolone 4 mg tablets in a dose pack FOLLOW PACKAGE DIRECTIONS	04/23/21 filled
Omega 3 start 06/09/2017	06/09/17 started
potassium chloride ER 20 mEq tablet,extended release(part/cryst)	08/27/20 filled
proGESTerone start 07/19/2019	07/19/19 started

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AVERILL, ROSE (Id #3585604, dob: 10/26/1961)

triamcinolone acetonide 0.1 % topical cream

09/17/20 filled

Vitamin D3 125 mcg (5,000 unit) tablet

08/04/15 filled

Take 1 tablet every day by oral route.

Vaccines

None recorded.

Problems

Reviewed Problems

- Acute pain - Onset: 07/27/2017
- Osteoarthritis of hip - Onset: 08/02/2021
- Osteoarthritis of knee - Onset: 06/09/2017
- Knee pain
- Degeneration of lumbosacral intervertebral disc - Onset: 08/02/2021
- Fracture of tibial plateau
- Tear of medial meniscus of knee - Onset: 12/13/2018
- Tear of medial meniscus of knee - Onset: 06/09/2017, Left
- Sprain of ankle - Onset: 07/19/2019
- Trochanteric bursitis of left hip - Onset: 08/02/2021

Family History

Reviewed Family History

Social History

Reviewed Social History

**Gender Identity and LGBTQ
Identity**

Surgical History

Reviewed Surgical History

- Cesarean section
- Hysterectomy

GYN History

(not configured)

Past Medical History

Reviewed Past Medical History

HPI

Hip(s)

Reported by
patient.

Location: left

Quality: sharp

Severity: moderate

Duration: 6 weeks

Timing: cannot identify

Context: cannot identify

Aggravating Factors: walking; bending/squatting; ROM

Knee Pain/Injury

Reported by
patient.

Location: right; medial

Duration: 6 weeks

Severity: moderate

Quality: aching; sharp

Context: cannot identify

Timing: chronic

Aggravating Factors: bending/squatting; upstairs; downstairs

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AVERILL, ROSE (id #3585604, dob: 10/26/1961)

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no dry eyes, no irritation, and no vision change. She reports no difficulty hearing and no ear pain. She reports no teeth problems. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, and no coughing up blood. She reports no abdominal pain, no vomiting, normal appetite, no diarrhea, and not vomiting blood. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, and no swelling in the extremities. She reports no abnormal mole, no jaundice, and no rashes. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, and no headaches. She reports no swollen glands, no bruising, and no history of blood clots. She reports no runny nose, no sinus pressure, no itching, no hives, no frequent sneezing, and no metal or contact allergies.

Physical Exam

Patient is a 59-year-old female.

Constitutional: General Appearance: NAD and morbidly obese.

Gait and Station: Appearance: antalgic gait.

Cardiovascular System: Arterial Pulses Right: **Normal Pulses**. Arterial Pulses Left: **Normal Pulses**. Edema Right: none and no edema. Edema Left: none and no edema. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: **No Adenopathy**. Inspection/Palpation Left: **No Adenopathy**.

Knees: Inspection Right: no deformity, mass, induration, warmth, erythema, or swelling. Inspection Left: no deformity, mass, induration, warmth, erythema, or swelling. Bony Palpation Right: no tenderness of the inferior pole patella, the superior pole patella, the tibial tubercle, or the head of fibula and **tenderness of the lateral joint line and the medial joint line**. Bony Palpation Left: no tenderness of the superior pole patella, the inferior pole patella, the tibial tubercle, or the head of fibula and **tenderness of the medial joint line and the lateral joint line**. Soft Tissue Palpation Right: no tenderness of the quadriceps tendon, the prepatellar bursa, the patellar tendon, the medial collateral ligament, the pes anserinus, the lateral collateral ligament, the gastrocnemius, or the infrapatellar tendon. Soft Tissue Palpation Left: no tenderness of the quadriceps tendon, the prepatellar bursa, the patellar tendon, the medial collateral ligament, the pes anserinus, the lateral collateral ligament, the gastrocnemius, or the infrapatellar tendon. Active Range of Motion Right: **limited and crepitus**. Active Range of Motion Left: **limited and crepitus**. Passive Range of Motion Right: **limited**. Passive Range of Motion Left: **limited**. Stability Right: no laxity or ligamentous instability and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, and Lachman test negative. Stability Left: no laxity or ligamentous instability and anterior drawer sign negative, posterior drawer sign negative, pivot shift test negative, and Lachman test negative. Special Tests Right: **McMurray's test positive and Apley's compression test positive**. Special Tests Left: **McMurray's test positive and Apley's compression test positive**. Strength Right: extension 5/5; **Normal Strength**. Strength Left: extension 5/5; **Normal Strength**.

Skin: Right Lower Extremity: normal. Left Lower Extremity: normal. Lumbosacral Spine: normal skin.

Neurologic: Coordination: heel-to-shin normal. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2); **Normal Reflexes**. Knee Reflex Left: normal (2); **Normal Reflexes**. Sensation on the Right: T12 normal, L2 normal, L4 normal, S2 normal, L5 normal, S1 normal, and normal distal extremities; **Normal Sensation**. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, S2 normal, L5 normal, S1 normal, and normal distal extremities; **Normal Sensation**. Special Tests on the Right: seated straight leg raising test negative.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Lumbar Spine: Inspection: normal alignment and alignment and no induration, ecchymosis, or swelling. Bony Palpation: no tenderness of the spinous process, the paraspinals, the sacrum, the coccyx, or the transverse process and **tenderness of the spinous process at L 3**. Special Tests: seated straight leg raising test negative. Soft Tissue Palpation on the Right: no tenderness of the iliolumbar region and **tenderness of the paraspinal region at L (Paraspinal tenderness throughout)**. Soft Tissue Palpation on the Left: no tenderness of the iliolumbar region and **tenderness of the paraspinal region at L (Paraspinal tenderness throughout)**. Active Range of Motion: flexion normal, extension normal, and lateral flexion normal. Passive Range of Motion: flexion normal, extension normal, and lateral flexion normal.

Hip/Pelvis Appearance: Inspection: normal axial alignment.

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AVERILL, ROSE (id #3585604, dob: 10/26/1961)

Hips: Bony Palpation Right: no tenderness of the iliac crest, the ASIS, the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation Left: no tenderness of the iliac crest, the ASIS, the sciatic notch, or the SI joint and tenderness of the greater trochanter. Active Range of Motion Right: normal, flexion normal, extension normal, internal rotation normal, and external rotation normal. Active Range of Motion Left: normal, flexion normal, extension normal, internal rotation normal, and external rotation normal; Painful range of motion. Passive Range of Motion Right: normal. Passive Range of Motion Left: pain elicited by motion. Strength Right: normal 5/5. Strength Left: normal 5/5.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Procedure Documentation

AFO Corticosteroid Injection Trochanteric:

After discussion of the risks and benefits, the patient elected to proceed with a cortisone injection into the left trochanteric hip. Confirmed that the patient does not have history of prior adverse reactions, active infections, or relevant allergies. There was no erythema, or warmth, and the skin was clear.

The skin was prepped. A 22 gauge needle was inserted into the joint. The site was injected with a mixture of _80_ mg DepoMedrol and 2_ cc Lidocaine. Gloves were worn.

The patient tolerated the procedure well and was instructed to avoid strenuous activity for the next 24-48 hours and to use ice, NSAIDs, or Acetaminophen for pain as needed. The patient will call immediately with any concerns, signs of infection or allergic reaction.

Assessment / Plan

. Pain of left hip joint

M25.552: Pain in left hip

- XR, HIP + PELVIS, UNILATERAL, 2 OR 3 VIEW
Side:
LEFT

. Low back pain

M54.5: Low back pain

- XR, LUMBAR SPINE - Note to Imaging Facility: 3 views
Views (X-RAY, LUMBAR SPINE): AP Lateral Spot

. Pain in right knee

M25.561: Pain in right knee

- XR, KNEE - Note to Imaging Facility: AP, Lateral and Sunrise
Side: Views (X-RAY, KNEE): AP, Lateral and
RIGHT Sunrise

. Trochanteric bursitis of left hip

M70.62: Trochanteric bursitis, left hip

. Degeneration of lumbosacral intervertebral disc

M51.37: Other intervertebral disc degeneration, lumbosacral region

. Osteoarthritis of hip

M16.12: Unilateral primary osteoarthritis, left hip

- HIP ARTHRITIS: CARE INSTRUCTIONS
- OSTEOARTHRITIS: CARE INSTRUCTIONS

Osteoarthritis of knee

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AVERILL, ROSE (Id #3585604, dob: 10/26/1961)

• Osteoarthritis of knee

M17.0: Bilateral primary osteoarthritis of knee

• KNEE ARTHRITIS: CARE INSTRUCTIONS

XR, LUMBAR SPINE

- Views (X-RAY, LUMBAR SPINE): AP Lateral Spot

Review of xr, lumbar spine taken on 08/02/2021 at AFO CLINIC shows:

Imaging Studies:

Degenerative disk disease: **diffusely moderate.**
Facet arthropathy: no facet disease.
Compression fracture: no fracture.
Sagittal alignment: no sagittal deformity.
Spondylolisthesis: no spondylolisthesis.
Scoliosis: no scoliosis.
Instability on flexion/extension views: no instability on flexion/extension views.
Prior Surgery: no evidence of prior surgery.
Congenital abnormalities: no congenital abnormalities.

XR, HIP + PELVIS, UNILATERAL, 2 OR 3 VIEW

- Side: LEFT

Review of xr, hip + pelvis, unilateral, 2 or 3 view taken on 08/02/2021 at AFO CLINIC shows:

Imaging Studies:

Degenerative changes: no degenerative changes.
Fracture: no fracture.

XR, KNEE

- Side: RIGHT, Views (X-RAY, KNEE): AP, Lateral and Sunrise

Review of xr, knee taken on 08/02/2021 at AFO CLINIC shows:

See:

Side: Bilateral.
General Radiographic Findings: **osteophytes lateral tibial plateau, osteophytes lateral femoral condyle, osteophytes medial tibial plateau, and osteophytes medial femoral condyle** but no fracture and no dislocation; grade IV DJD bilateral.
AP/ PA Findings: Good Stress Correction and Intermediate Stress Correction.

Discussion Notes

59-year-old here for lumbar spine, bilateral knees, left hip

The patient is morbidly obese. Her BMI is 45. The patient says her biggest problem is lipidemia. She has been to 2 specialists, one in Georgia and one in Texas who treated her lipidemia which was not successful. Eventually she will need a knee replacement but she is not a surgical candidate due to her obesity. I injected her left hip 80 mg depo medrol Placed her on naprosyn 500 mg bid. Reevaluate her in a month.

Return to Office

- Michael Smith, MD for FOLLOW UP 10 at AFO CLINIC on 08/30/2021 at 09:15 AM

Encounter Sign-Off

Encounter signed-off by Michael Smith, MD, 08/05/2021.

Encounter performed and documented by Michael Smith, MD

Encounter reviewed & signed by Michael Smith, MD on 08/05/2021 at 11:02am



Healing The Generations, Inc.

"A Strictly Hands-On Therapy Services Provider for Children and Adults"

FAX COVER SHEET

Date: _____

To: Elizabeth Kuman ARNP-BC

From: Wouter Vanderhorst, P.T., Certified Lymphedema Therapist

Fax: 210-4600 Phone: 447-3000

RE: Rose Averill

Comments: Dear Elizabeth

Please review the following evaluation, plan of care or FYI materials, if you agree, please sign and fax back to: 727-536-6006.

- ☒ Physical Therapy/Lymphedema Evaluation and Treatment Plan
☐ Physical Therapy/Lymphedema Medicare 30 Day Re-Certification
☐ Physical Therapy/Lymphedema FYI, no reply needed

If you have any questions regarding the attached information, please call us at 727-535-6746. Thank you.

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☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Massage Therapy

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Healing The Generations, Inc.

Elizabeth Kurman
 This has been electronically signed by Elizabeth Kurman ARNP-BC

Strictly Hands-On Therapy Services Provider for Children and Adults

PHYSICAL THERAPY PLAN OF CARE LYMPHEDEMA MANAGEMENT

9/11/2020 17:04:48

Patient Name: <i>Rose Averill</i>	Phone #: 538-0263
Diagnosis/Current Complaints/Symptoms:	<i>Lipedema lymph 189.0</i>
Re/Certification From: 9/01/2020	Through: 9/30/2020

PROCEDURE/MODALITIES

- | | |
|---|--|
| <input type="checkbox"/> Evaluation | <input checked="" type="checkbox"/> Home Exercise Program |
| <input checked="" type="checkbox"/> Lymphatic Drainage | <input checked="" type="checkbox"/> Therapeutic Activities |
| <input checked="" type="checkbox"/> ADL/Patient Education | <input checked="" type="checkbox"/> Therapeutic Exercises |
| <input checked="" type="checkbox"/> Complete Decongestive Therapy | <input type="checkbox"/> Palliative Care |

Frequency: *Biweekly status post liposuction surgery*

LONG TERM OUTCOME (GOALS)

- ☒ Mobilization of protein rich fluids, reduce swelling
- ☒ Mobilization of fibrotic tissue, soften and improve skin conditioning
- ☐ Wound Care per MD specifications, with complete healing
- ☒ Skin Care with moisturizing cream, to soften and improve skin conditioning
- ☒ Compression therapy with bandages, to maintain and reduce swelling
- ☒ Measure and fit for compression garment, for long term phase 2 management
- ☐ Teaching of self Manual Lymph Drainage for long term phase 2 management
- ☒ Independent home exercise program, regarding remedial exercises.
- ☒ Maintain the patient's improvement and prevent or slow further deterioration resulting in hospitalization and increase health care cost
- ☒ Education towards the disease process and treatment options.
- ☒ Proper nail care as needed, including clipping and polishing.

Rehab potential: <input type="checkbox"/> Excellent <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair	
Telephone order: Physician/Therapist:	Date: Time:
Therapist Signature: <input checked="" type="checkbox"/> <i>Wouter Vanderhorst,</i> P.T., C.L.T. - A.L.M. 9/09/2020	<input type="checkbox"/> <i>Nadine Verdebout,</i> P.T., C.L.T.

I hereby certify the need for the treatments to benefit the patient and reduce health care cost.

Physician Signature: <input checked="" type="checkbox"/>	Date: <input checked="" type="checkbox"/>
Physician Name (Print): <input checked="" type="checkbox"/>	

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Phone: (727) 535-6746 • Fax (727) 536-6006

Email: info@healingthegenerations.com • www.healingthegenerations.com

08/28/2020 11:28 Dr Fisher Office

(FAX)2106160581

P.001/006

SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. 1009 904 78229

OFFICE (210) 616-0798

FAX (210) 616-0581

FACSIMILE TRANSMITTAL SHEET

TO: Att: Katarsha	FROM: Jo Ann Z
St Francis Medical Ctr.	DATE: 08/28/2020
COMPANY:	
FAX NUMBER: 727-447-3000	TOTAL NO. OF PAGES INCLUDING COVER: (6)
PHONE NUMBER: 727-210-4600	SENDER'S REFERENCE NUMBER:
RE: Rose Aveill	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

operative Report
Rabs

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P.002/006



San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

Patient: Rose Averill
DOB: 10/26/1961

8/20/2020

Operative Procedure:
Suction lipectomy lipedema thighs.

8/28/2020

Is the patient's first postoperative note. She is doing well. She did bleed a lot at the time of liposuction but fortunately never became symptomatic enough to require a transfusion. She has had a lot of pain although today she feels considerably better. Significant swelling is noted with ecchymoses along the posterior lower thigh. The garment is fitting quite tightly. She did start the Lasix and then doubled up on her dose at my request. Although she feels that urine output is not very high it is very clear. She plans on returning back to Florida on Sunday. At this stage she feels she is up for that. She will add compression hose to her lower legs for the trip. Further instructions were discussed with her and her husband who was on the phone with us during this follow-up visit. She will keep me updated on how she is coming along as well as their reduction in swelling. We need to make a decision on what our next surgical plan will be buttock and 90 do that when I see some photos of how her thighs look in approximately 6-10 weeks time.

Peter Fisher, M.D.
PF

DAVID J. FISHER, M.D.
Board Certified
Plastic Surgery

PETER FISHER, M.D.
Board Certified
Plastic Surgery



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08/28/2020 11:29 Dr Fisher Office

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P.003/006

METHODIST SPECIALTY AND TRANSPLANT HOSPITAL

8026 FLOYD CURL DRIVE
SAN ANTONIO, TX 78229PATIENT'S NAME: AVERILL, ROSE
DOB: 10/26/61 AGE: 58 SEX: F
ATTENDING PHYS: Dr. Peter Fisher, MD
REPORT TYPE: OPERATIVE REPORTUNIT NO: N00989520
ACCOUNT NO: N362973236
PT TYPE: DIS IN
ROOM NO: N.510DATE OF ADMISSION: 08/20/20
DATE OF DISCHARGE: 08/22/20

DATE OF SURGERY: 08/20/2020

TIME OF SURGERY:
(See anesthesia record.)PREOPERATIVE DIAGNOSIS:
Lipedema of the thighs.POSTOPERATIVE DIAGNOSIS:
Lipedema of the thighs.SURGICAL PROCEDURE(S) PERFORMED:
Suction lipectomy, lipedema thighs.NAME OF SURGEON:
Peter Fisher, MDASSISTANT(S):
Matthew Bindewald, MDANESTHESIOLOGIST:
Richard Emery, MDTYPE OF ANESTHESIA ADMINISTERED:
General anesthetic.SPECIMEN(S) REMOVED:
None.ESTIMATED BLOOD LOSS:
600mL

HISTORY:

The patient is a 58-year-old lady who has developed significant lipedema of the thighs with massive what looked like possibly lipomas of the medial aspects of the knees, worse on the right than the left. The patient has previously had liposuction of the thighs elsewhere, but comes for more aggressive suctioning of the significant lipedema which causes pain and discomfort.

DESCRIPTION OF PROCEDURE:

The patient was brought to operating suite where following induction of general anesthesia, Foley catheter was placed and the patient was placed on the

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236



Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

08/28/2020 11:29 Dr Fisher Office

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P.004/006

operating table in the prone position where she was appropriately positioned, padded, and prepped and draped in standard fashion. Markings were made for multiple stab incisions along the posterior thigh and hip areas. These were infiltrated with 0.25% Marcaine with epinephrine and incised sharply with an 11-blade. Tumescent solution of 1L Ringer's lactate, 1 unit epinephrine was infiltrated using approximately a liter and half. Suctioning was then performed. Of note, the medial knee aspect; specifically on the left side more than the right, bled considerably more. I feel like the most likely reason was that this area was probably an angioliipoma and had considerable amount of vascularity, which the epinephrine was not able to effect. I removed approximately 1750 from the right posterior thigh and 1800 from the left posterior thigh. Incisions were closed with interrupted 5-0 fast absorbing sutures and the patient was then placed on the operating table in the supine position, appropriately positioned, padded, prepped and draped in standard fashion. Again, multiple stab incisions were made over the preoperative marks that I had made; some of them from our old stab incisions where she had liposuction, having infiltrated with 0.25% Marcaine with epinephrine. Once again, same tumescent solution was used, infiltrating approximately 2L into each thigh. Suctioning was then again performed at this time using #4 Mercedes cannula and #3 Mercedes cannula at a more superficial level. Much more aggressiveness was placed around the knees. Again, unfortunately a considerable amount of bleeding was noted in the left medial knee more so than that of the right. This is the reason, estimated blood loss of 600mL. Total of 3600 was removed from the right thigh and 3100 from the left thigh. Both knees and as high up to the hip as possible was wrapped with 6-inch Ace wraps, having closed the incisions with interrupted 5-0 fast absorbing sutures. The patient was given 2.5L of crystalloid, made approximately 200mL of urine. She was now awakened, extubated, transferred to recovery room in stable condition. Her Ace wrappings were removed in recovery room where she remained stable. Hemoglobin obtained in the recovery room, was 13.1.

Peter Fisher, MD

IN: IOP/N.MR/FISPE
DD: 08/20/2020 2246
DT: 08/20/2020 2315
Job #: 5620839
Cc:

Authenticated by Peter Fisher, MD On 08/24/2020 08:35:36 AM

cpcs rpt#: 0820-0097



PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236

Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

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Electronically Signed by Peter Fisher, MD on 08/24/20 at 0836

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236

Patient Care Inquiry **LIVE** (PCI: OE Database COCSN)

08/28/2020 11:29 Dr Fisher Office

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P.006/006



Report Status: Final

AVERILL, ROSE

Patient Information	Specimen Information	Client Information
AVERILL, ROSE DOB: 10/26/1961 AGE: 58 Gender: F Fasting: U Phone: 727.424.3402 Patient ID: 10261961RCA Health ID: 8573001399519469	Specimen: TM026439K Requisition: 0002495 Collected: 07/31/2020 / 13:33 EDT Received: 07/31/2020 / 22:16 EDT Reported: 07/31/2020 / 23:12 EDT (* A Copy From)	Client #: Not Given 9999999 PETER FISHER MD 7950 FLOYD CURL DR STE 1009 SAN ANTONIO, TX 78229

COMMENTS: FASTING:UNKNOWN

Test Name	In Range	Out Of Range	Reference Range	Lab
BASIC METABOLIC PANEL				TP
GLUCOSE	92		65-99 mg/dL	
Fasting reference interval				
UREA NITROGEN (BUN)	13		7-25 mg/dL	
CREATININE	0.61		0.50-1.05 mg/dL	
For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.				
eGFR NON-AFR. AMERICAN	100		> OR = 60 mL/min/1.73m2	
eGFR AFRICAN AMERICAN	116		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	140		135-146 mmol/L	
POTASSIUM	3.9		3.5-5.3 mmol/L	
CHLORIDE	100		98-110 mmol/L	
CARBON DIOXIDE	27		20-32 mmol/L	
CALCIUM	9.3		8.6-10.4 mg/dL	
CBC (INCLUDES DIFF/PLT)				TP
WHITE BLOOD CELL COUNT	4.8		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	5.00		3.80-5.10 Million/uL	
HEMOGLOBIN	14.4		11.7-15.5 g/dL	
HEMATOCRIT	43.3		35.0-45.0 %	
MCV	86.6		80.0-100.0 fL	
MCH	28.8		27.0-33.0 pg	
MCHC	33.3		32.0-36.0 g/dL	
RDW	13.6		11.0-15.0 %	
PLATELET COUNT	201		140-400 Thousand/uL	
MPV	10.0		7.5-12.5 fL	
ABSOLUTE NEUTROPHILS	2765		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	1608		850-3900 cells/uL	
ABSOLUTE MONOCYTES	379		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	29		15-500 cells/uL	
ABSOLUTE BASOPHILS	19		0-200 cells/uL	
NEUTROPHILS	57.6		%	
LYMPHOCYTES	33.5		%	
MONOCYTES	7.9		%	
EOSINOPHILS	0.6		%	
BASOPHILS	0.4		%	

PERFORMING SITE:

TP QUEST DIAGNOSTICS-TAMPA, 4225 E. FOWLER AVE, TAMPA, FL 33617-2026 Laboratory Director: GLEN L HORTIN, MD, PhD, CLIA: 10D0291120

Your request to have a duplicate copy faxed has been acknowledged.
 Queued to: 12106160581

* ST FRANCIS SLEEP ALLERGY has requested a copy of this report be sent to you. Ordering Physician: AVERILL, FRANCIS J

ACHIEVE

PHYSICAL THERAPY
AT LAKEWOOD RANCH

Lipedema Functional Assessment

Patient Name: Rose Averill

Date of Birth: 10/26/1961

History

Client has long history of Lipedema with extensive fat storage in her extremities which is painful to the touch. She has had difficulty with functional mobility due to pain, weakness and fatigue. The patient has had substantial weight loss in the past which did not change the girth of her extremities. She is currently working as the CEO of her own company with extensive time in a sedentary position. She is limited to sitting <20 minute in an office without changing position and elevating her legs due to pain in her extremities and fatigue. History also include Lyme disease '16, B meniscal tear, R achilles tear, vascular ablation of lower legs, Lipedema procedure lower legs. She does report unsteady gait with fear of falling. She currently uses a cane or walker at home or work as needed.

Chief Complaint:

Pain in her upper and lower extremities, especially upper arms, upper thighs and hips. Tender to touch in extremities. Weakness and fatigue. Limited to sitting <20 minutes or walking <1 block.

Pain Profile 1 being lowest / 10 being highest

Worst pain over last 30 days

1 2 3 4 5 6 7 8 9 10

Current Pain

1 2 3 4 5 6 7 8 9 10

Post FCE pain

1 2 3 4 5 6 7 8 9 10

ACHIEVELWR.COM

ACHIEVELWR@YAHOO.COM

OFFICE: (941) 727-2667 • FAX: (941) 727-2669

10910 SR 70 EAST • SUITE 104 • LAKEWOOD RANCH, FL 34202

Vital Signs

Blood Pressure Pretest 150/80 Midtest 148/80 Post Test 142/84
Heart Rate Pretest 74 Midtest 83 Post Test 77

Effort and Cooperation:

X gave maximum, consistent effort.
_____ did not give maximum, consistent effort in all tests

Activity Tolerances - 1 being most able - 10 being unable

1. Vigorous run/lift tasks 1 2 3 4 5 6 7 8 9 10
2. Walk more than 1 mile 1 2 3 4 5 6 7 8 9 10
3. Climb a flight of stairs 1 2 3 4 5 6 7 8 9 10
4. Lift or carry groceries 1 2 3 4 5 6 7 8 9 10
5. Bend, kneel, stoop 1 2 3 4 5 6 7 8 9 10
6. Vacuum or yard chores 1 2 3 4 5 6 7 8 9 10
8. Hand wash dishes/pots 1 2 3 4 5 6 7 8 9 10
9. Get up from floor 1 2 3 4 5 6 7 8 9 10
10. Sitting for activities 1 2 3 4 5 6 7 8 9 10
11. Travel long distances 1 2 3 4 5 6 7 8 9 10
12. Walk block, flat ground 1 2 3 4 5 6 7 8 9 10
13. Run a short distance 1 2 3 4 5 6 7 8 9 10
14. Run or jog 2 miles 1 2 3 4 5 6 7 8 9 10
15. Lift 10lb above shoulder 1 2 3 4 5 6 7 8 9 10
16. Lift 25lb box off floor 1 2 3 4 5 6 7 8 9 10

17. Lift 50lb bag of sand

1 2 3 4 5 6 7 8 9 10

Muscle Testing:**Gross Muscle Tests Lower Extremities**

Hip	L	R
Hip Flexion	3+/5	4-/5
Hip Extension	3+/5	4-/5
Hip Abduction	3+/5	4-/5
Hip Adduction	3+/5	4-/5
Quads	4-/5	4/5
HS	4-/5	4/5
R shoulder flex	3+/5	
L shoulder flex	3+/5	

Findings/ Comments: 8/10 Pain with manual resistance in all directions. hip strength L > R

Positional Tolerances

Note: 1 is unable / 10 is able

Crawling: 1 2 3 4 5 6 7 8 9 10

Squatting: 1 2 3 4 5 6 7 8 9 10

Kneeling: 1 2 3 4 5 6 7 8 9 10

Stooping: 1 2 3 4 5 6 7 8 9 10

Crouching: 1 2 3 4 5 6 7 8 9 10

Side Bridge Plank Hold Duration 0 Normal

Abnormal (per age)

Prone Plank Hold Duration 0 Normal

Abnormal (per age)

Single Leg Bridge Hold Duration 0 Normal

Abnormal (per age)

Forward Trunk Bending - # of Repetitions: 3

Normal

Abnormal (per age)

Limited by back pain

Stair climbing and standing - Duration / Repetition: 9 stairs/ minute

Use of rail. Very slow and antalgic. Using Right lower extremity one step at a time, unable to use left due to pain. Stopped due to pain/fatigue. 8/10 pain in thighs and knees

Five time sit to Stand Test – Duration / Repetition 20 seconds x 5. Slow, complaining of 6/10 pain in thighs and knees.

Two Square Agility Test (TSAT)

This is a test of dynamic agility. It involves stepping forward and back between two squares as quickly as safely possible. 30 seconds

Trial 1: 10 Trial 2: 10 Trial 3: 10 COV: <1%

Rating: High Moderate Low

Pain: Yes No

Walk Test 6 minutes –

Gait: 30 ft x 2 per lap

Trial 1: 11 Trial 2: 13 Trial 3: 12 COV: <1%

Rating: High Moderate Low

☒ Moderate to severe gait deviations.

☒ Pain reported in bilateral thighs and knees.

☐ Unpredictability of rhythm.

☒ Hesitant, slow, diminished propulsion, and lack of commitment in stepping and arm swing.

Wide base of support, waddling gait with decreased hip flexion during swing phase, foot flat with decreased propulsion during late stance phase. Complaints of pain hips, knee, ankles and lower back. Significantly slower pace and severe fatigue at end of time.

Lower Extremity Function Scale

20/80 demonstrates higher level of Disability

Proprioception/Balance

Single leg stance eyes open: Two trials:

Right 6 seconds,

Left 2 seconds

Findings:

Diminished X Normal

Single leg stance eyes closed:

Right 0 seconds,

Left 0 seconds,

Findings:

Diminished X Normal

Comments: Unable to perform eyes closed safely

Romberg eyes open:

30 seconds

Findings: Diminished Normal X

Romberg eyes closed:

30 seconds

Findings: Diminished Normal X

Comments:

Palpation

Identify areas of tenderness and pain at start of session, mid-way and when done.

Findings:

Large fat deposits/ lobular folds bilateral medial knees Left > Right. Extensive fat deposits

Bilateral hips to knees. Pain with light palpation throughout hips and knees which progressed throughout testing. Severe post test.

Large fat deposits bilateral upper arms Left > Right with pain with light palpation upper arms to elbows.

Testing for Arm Lipedema Only

1 being able / 10 being unable

Lifting (15 pound box)

floor to waist

1 2 3 4 5 6 7 8 9 10

waist to shoulder

1 2 3 4 5 6 7 8 9 10

overhead

1 2 3 4 5 6 7 8 9 10

Arm Strength and Fatigue – Describe

Unable to perform more than one arm or overhead lift due to weakness and fatigue. Significant muscle strain to lift box to shoulder and overhead position. Pain 8/10 bilateral upper arms

Grip Testing –

Grip / Pinch Five Level Grip

Trial 1: 42 Trial 2: 30 Trial 3: 28

COV <10%

AVG: 33

Findings – Diminished X Normal

Comments: Right hand dominant, tested with right hand.

Forward and Overhead Reaching – weight 15# Repetitions: 1 Normal Abnormal

Arm lift - # of repetitions - 1

Assessment Summary: See Examples

The patient did not exhibit any overt pain behaviors, and her validity tests (the hand grip strength tests) did not reflect any inconsistencies. Additionally, tests all suggest that the patient was putting forth a maximal effort and did not demonstrate any elevated psychometrics or pain magnification.

The patient presents with ever present tenderness to touch, which is exacerbated by activity. She is able to complete 6 minutes of walking with an increase in pain level to 8/10 and significant fatigue. Standing is limited (The patient is able to tolerate <10 minutes of

continuous standing before needing to sit or change positions to alleviate discomfort). Strength is limited. The patient demonstrates rapid loss of power during stair climbing and also demonstrates inability to squat to a functional level, kneel, stoop, crawl or crouch which significantly affects her abilities to perform self/household ADLs. She also demonstrates weakness and fatigue in the upper extremities as evidenced by being unable to lift more than 15 lbs from floor to waist or overhead. The patient fatigues rapidly in the lower extremities leading to poor resting postures and increased lumbar and hip flexion. By the end of testing, she reported increased soreness and achiness, especially in her upper thighs, hips and knees with any weight bearing activity and her upper arms and shoulders which affected her ability to perform sit to stand transfers. Swelling is persistent at this time.

Physical findings were consistent with her diagnosis of lipedema: disproportionate fat storage along the client's extremities, non-pitting edema in extremities that is painful with light touch, joint deformity and lobular folds. The client had reduced strength in her Bilateral shoulder, hips and knees Left side more affected than right. The client intermittently repositioned her standing posture due to pain in her legs. She ambulated with gait deviations using a wide base and had a slight balance impairment. The client had difficulty with activities involving repetitive bending, squatting and stair climbing. It is the opinion of this evaluator that the patient suffers from severe limitations and restrictions due to the condition of lipedema which dramatically affect mobility, gait, etc.

Post Lipedema Functional Test Fatigue

Mild

Moderate

Severe

Post Lipedema Functional Test Pain

Mild

Moderate

Severe

Date:

8/12/20

Evaluators Signature:

Sea MUA RPT

03/17/2020 14:37 Dr Fisher Office

(FAX)2106160581

P.001/005

SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. ¹⁰⁰⁹~~904~~ 78229

OFFICE (210) 616-0798

FAX (210) 616-0581

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
<i>Ross Brumitt</i>	<i>Jo Ann / Dr P. Fisher</i>
COMPANY:	DATE:
<i>(Patient's office)</i>	<i>03/17/2020</i>
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
<i>727-210-4600</i>	<i>(5)</i>
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:
<i>office visit / phone consult</i>	

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

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DAVID FISHER, M.D.

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PETER FISHER, M.D.

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PLASTIC & RECONSTRUCTIVE

03/17/2020 14:37 Dr Fisher Office

(FAX)2106160581

P.002/005

RX Date/Time

03/10/2020

11:17

7272104600

P.001



St. Francis
SLEEP, ALLERGY & LUNG
INSTITUTE

Frank Averill, MD

Medical Director

802 N. Belcher Road

Clearwater, FL 33765

Phone 727.447.3000

Fax 727.210.4600

www.StFrancisMed.com*"Giving of ourselves...so you receive...excellent care."*

Records Request

*pt*To: **Dr Fisher (210)616-0581**Pages: **1** (Including Cover)From: **Christina**Date: **03/10/20**RE: **Averill, Rose**
(Patient's Name)DOB: **10/26/1961**
(Patient's DOB)

	LAB REPORTS		IMAGING REPORTS	X	RECENT VISIT NOTE		SLEEP STUDIES
--	------------------------	--	----------------------------	----------	------------------------------	--	--------------------------

This patient has an appointment on **March 12, 2020**

Notes: **Please provide notes from 08/12/19**
and 01/10/20. Thank you!

Thank you and have a Blessed day!**CONFIDENTIALITY NOTICE:**

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Handwritten signature: Janel pte office

03/17/2020 14:37 Dr Fisher Office

(FAX)2106160581

P.003/005



San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

Patient: Rose Averill
DOB: 10/26/1961

1/10/2020

Consultation: The patient is a 57-year-old lady whom I already consulted with via email and telephone in August. Significantly this patient has severe lipedema diagnosed approximately 2 years ago. She feels that she is probably had this for about 10 years although it is gotten significantly worse over the past 2 years. She feels that it came about after she had a hysterectomy in 2006. She has had 2 C-sections in the past. She remains quite mobile even with the severe lipedema that she has. In October 2019 she had liposuction of the lower legs. 3 L were removed. She unfortunately has quite a bit of swelling from this. Her major issues are her thighs and especially the medial knees which over the past year gotten significantly worse. She also is concerned about her upper arms. She has pain in all these areas. Her general health is excellent. In 1996 she underwent tummy tuck abdominal muscle repair and liposuction of the inner thighs. She has broken the left tibia in 2016 and had torn ACL and left meniscus tear after falling in 2006. She does not smoke. She has no allergies to medications.

Examination: She is 5 feet 7 inches tall weighs 292 pounds today. She has obvious lipedema of the thighs with what I believe are large lipomas of the left and right medial knee areas. The left side is considerably larger than that of the right. Well-healed small scars of the lower legs are noted following her liposuction in October of last year. The skin is nice and smooth although there is 1+ pitting edema along the lower leg.

Impression: Lipedema of the thighs and upper arms.

Recommendation: I recommended as previously discussed going ahead with liposuction of the thighs to be followed at a later date with further liposuction and if possible thigh lift at the same time. Consideration to performing liposuction of the upper arms at some point will be given as well. I have given her a prescription for Lasix to be taken once and possibly twice daily for the next 2 weeks to help reduce swelling in the lower legs.

Peter Fisher, M.D.
PF

DAVID J. FISHER, M.D.
Board Certified
Plastic Surgery

PETER FISHER, M.D.
Board Certified
Plastic Surgery



MEMBERS OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

03/17/2020 14:38 Dr Fisher Office

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P.004/005

Rose Averill

Phone Consult 8/12/19

DOB: 10/26/61

Patient has confirmed diagnosis of Lipedema, stage 3, from Dr. Byrd 1 week ago and also her primary care physician 2 weeks ago. Dr. Fisher does also confirm the diagnosis and agrees most likely stage 3. Patient is interested in treatment with Dr. Fisher's aggressive liposuction technique.

Ms. Averill is 57yrs old, 5'7" and currently 285lbs. She has a history of 2 C-Sections, a tummy tuck with lipo of the inner thighs only in 1996, and she had a full hysterectomy in 2006. Says she did well with anesthesia each time, no problems she can recall. Currently on take supplements and has no allergies to meds. She states that she has been on a keto diet with intermitting fasting for 2 years and says she hasn't really had any weight loss. Patient says she was a very curvy teenager with very large thick thighs and recalls also having stretch marks develop early in childhood. Her mother she feels also had Lipedema even though there was never a diagnosis, says her mother's legs were similar to hers and also had very large "batwings" in her arms. Ms. Averill feels her progression has been at its worst the past few years, noticing that she is experiencing and fatigue as well as her mobility becoming a problem now. She states the swelling by the end of the day is almost intolerable. She says she feels the pain as soon as she wakes up and it continues on for the full day. She is still working, she runs her husbands Pulmonology office for him, but is really struggling.

Dr. Fisher was very up front that she needs multiple surgeries and he most likely will not be able to do them all. The patient carries most of the weight in her hips and thigh area, not much in the calves at all and doesn't show signs of ankle cuffing, though this is from pictures.

Patient is from Florida and brought up a Dr. Su in Florida who typically she says on works on 20 and 30-year old's but has agreed to liposuction her inner knee area and something she calls a "Celebrity Arm Lift". Ms. Averill is also stating she could have Dr. Byrd in Atlanta, GA perform the liposuction on her calves, she really wants Dr. Fisher to be the one to do her thighs. PF though she would need 3 surgeries with the first being hip to knee, second knee to ankle, and quite possibly the 3rd as a thigh lift, he isn't sure to say she will NEED a thigh lift, but feels she may WANT a thigh due to so much extra hanging skin that would be left.

Ms. Averill stated that she has family here in the area, a sister in Dallas and friends on Corpus that she can stay with while here or have come to San Antonio and stay here with her. She states again that she really wants Dr. Fisher to be her surgeon. She questioned if she also had Dr. Byrd do her thighs to get a start could Dr. Fisher finish her thighs and do a thigh lift at the same time. He stated he could maybe, it will just depend on how much has been removed and how much would be left for him. He said for now he is only going to quote her for Liposuction of the hip knee for now. He said that he can take a look or she can send photos following other procedures and we can amend the quote as needed. He stated that he was only going to send 1 quote. If there was a chance that a surgeon he is in talks with gives a definite answer and comes aboard to train with him he MIGHT be able to fit her in for a second surgery in Dec 2020, but said there is no guarantee on that and felt if she thought she could get surgery with other physicians she should look into that. She was well aware and verbally stated she understood that currently Dr. Fisher can only do 1 surgery on her. Dr. Fisher went through the compression garment needing to be on for 3-6 months, he prefers 6 months. The patient brought up the vast difference in size of her thighs to her calves and asked how she would find something that would work for her. He said that we can send some things to her for examples, but she may need a custom garment or possibly capri style with full compression thigh highs to put over the capri length. He spoke about the possibility of a blood transfusion and went through the number with her for his patients, 1 in 5 needing one. He confirmed with her that she does accept blood. She does. He brought the risk of bleeding, made sure she understood about dimpling, rippling and excess lax skin. Told her she would be doing nothing for 2 weeks because she will be laying with legs sky high in the air. She laughed and stated she understood everything.

Dr. Fisher asked her if she had any other questions he could answer for her and she said no, just cost. He let her know that Emily, the surgery scheduler, will be emailing her the quote and that if she decided she wanted to schedule she can contact her directly. He mentioned again if she does decide to have surgery with other physicians just to let him know and send updated photos. He also told her he thinks it's a great idea and that he has been impressed with Dr. Byrd's work. She thanked him for calling her. /HM

03/17/2020 14:38 Dr Fisher Office

(FAX)2106160581

P.005/005

ROSE'S MEDICATIONS

1. PROG 200 MG SR CAP- 1 CAPSULE BY MOUTH 1-2 HRS BEFORE BEDTIME
2. DIM-EVAIL- SERVING SIZE 1 CAPSULE: DIINDOLYLMETHANE 100 MG
3. FISHOIL 675- SERVING SIZE 2 CAPSULES: ULTRA PURE FISH OIL 2554 MG, EICOSAPENTAENOIC ACID 250 MG, DOCOSAHEXAENOIC ACID 1000 MG, OTHER OMEGA 3 FATTY ACIDS 100 MG
4. MULTI NUTRIENTS 2- SERVING SIZE 3 CAPSULES: VITAMIN A 10,000IU, VITAMIN C 425 MG, VITAMIN D 500 IU, VITAMIN E 200 IU, THIAMIN 20 MG, RIBOFLAVIN 7.5 MG, VITAMIN B6 7.5 MG, FOLATE METAFOLIN 200 MCG, VITAMIN B12 250 MCG, BIOTIN 200 MCG, PANTOTHENIC ACID 175 MG, CALCIUM 150 MG, IODINE 112.5 MCG, 137.5 MG, ZINC 7.5 MG, SELENIUM 100 MCG, MANGANESE 3 MG, CHROMIUM 100 MCG, MOLYBDENUM 50 MCG, POTASSIUM 37.5 MG, RIBOFLAVIN 5'PHOSPHATE 5 MG, NIACINAMIDE 55 MG, PYRIDOXAL 5'PHOSPHATE 5 MG, BORON 1.5 MG, VANADIUM 50 MCG
5. MAGNESIUM 150 MG- SERVING SIZE 2 CAPSULES: MAGNESIUM 300 MG
6. RELORA-PLEX – SERVING SIZE 2 CAPSULES: THIAMINE 10 MG, RIBOFLAVIN 10 MG, NIACINAMIDE 10 MG, VITAMIN B6 10 MG, FOLIC ACID 200 MCG, VITAMIN B12 100 MCG
7. SUPER B-COMPLEX – SERVING SIZE 1 CAPSULE: VITAMIN C 60 MG, THIAMIN 25 MG, RIBOFLAVIN 20 MG, NIACIN 25 MG, VITAMIN B6 5 MG, FOLIC ACID 400 MCG, VITAMIN B12 100 MCG, BIOTIN 1000 MCG, PANTOTHENIC ACID 5.5 MG, SODIUM 10 MG
8. ADRENO MEND- SERVING SIZE 2 CAPSULES: A PHYTOCRINE PROPRIETARY BLEND 1020 MG, SENSORIL ASHWAGANDHA EXTRACT 125 MG
9. UBIQUINOL COQ10- SERVING SIZE 1 CAPSULE: 100 MG
10. ADK 10- SERVING SIZE 1 CAPSULE: VITAMIN A 1.5 MG, VITAMIN D 250 MCG, VITAMIN K 500 MCG

BayCare Susan Cheek Needler Breast Center

400 Pinellas Street Suite 100 Clearwater, FL 33756 (727)298-6670

FINAL REPORT

Patient: AVERILL, ROSE C**DOB:** 10/26/1961**Sex:** F**Requesting:** Desai, Anup Natwarlal**Attending:** Desai, Anup Natwarlal**Interpreted By:** Robert Nmn Krupa, M.D.**CPI:** 101256420**MRN:** 2104682138**Account:** 1110582593**Patient Status:** Outpatient**Patient Location:** WIMSIAverill, Francis James
802 N Belcher Road
Clearwater, FL 33765

cc: Averill, Francis James

ACC: 32056612 DEXA HIP AND SPINE**Completed:** 2/18/20 4:46 pm

DEXA HIP AND SPINE

CLINICAL: M 85.88

TECHNIQUE: Bone density measurements were obtained for the lumbar spine and left hip and compared to the reference standard based on the WHO classification.

FINDINGS:

Lumbar spine levels L1-L4:

Bone mineral density 1.236 g/cm sq T-score 1.7

Left femoral neck:

Bone mineral density 0.964 g/cm sq T-score 1.0

Total left femur:

Bone mineral density 1.132 g/cm sq T-score 1.6

IMPRESSION: THIS PATIENT IS NORMAL ACCORDING TO WORLD HEALTH ORGANIZATION CRITERIA. FRACTURE RISK IS LOW. FOLLOWUP DEXA SCAN IS RECOMMENDED IN 2 YEARS. ✓

WHO T-score classification:

normal ?T-score at or above -1

osteopenia T-score between -1.0 and -2.5

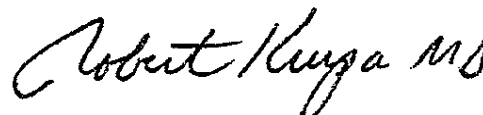
osteoporosis T-score below -2.5

NOTE:


1. Changes in BMD of less than 3% are in range or error and may not be accurate*
2. Always use DEXA testing in conjunction with clinical findings and patient history to determine optimal patient management.
3. T-score standards are based on reference values for white females; age 20-29 based on the NHA NES III database and may be less accurate for other groups of patients.
4. DEXA values may be less accurate in patients with degenerative changes, scoliosis, compression deformities etc.

Electronically signed by Robert Krupa, M.D. RADIOLOGIST on 2/19/2020 6:27 AM

Thank you for this referral,



Diplomat, American Board of Radiology



This document has been electronically signed by Francis Averill MD

Interpreted By: Robert Nmn Krupa, M.D.**2/19/2020 10:42:4****Name:** AVERILL, ROSE C**Location:** WIMSI**Patient Status:** O**Exam:** DEXA HIP AND SPINE**MRN:** 2104682138

BayCare Susan Cheek Needler Breast Center

400 Pinellas Street Suite 100 Clearwater, FL 33756 (727)298-6670

FINAL REPORT

Transcribed By:	IA	2/19/20 6:29 am
Electronically Signed By:	Robert Nmn Krupa, M.D.	2/19/20 6:29 am

FAX TRANSMISSION COVER SHEETDATE: 12/12/19 TIME: 11:07

TO: _____

FAX #: 727 210 4600ATTN: DR FRANK AVERILL**FROM:**

**Marcia V. Byrd, M.D.
11050 Crabapple Road
Suite 105-B
Roswell, GA 30075
(770) 587-1711
Fax (770) 518-8810**

You should receive _____ page(s), including this cover sheet. If you do not receive all the pages, please call 770-587-1711.

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Dr. Marcia V. Byrd, M.D.
11050 Crabapple Rd., Bldg. B
Roswell, GA 30075
770-587-1711

DATE: August 30, 2019
TO: UnitedHealthcare
FROM: Dr. Marcia V. Byrd, M.D.
RE: Rose Averill / DOB 10/26/1961 / Member ID #912012181
POS: 11 (In office)

Attached please find documentation and photos for Reimbursement Purposes, for lymph-sparing lipectomy, for above named patient.

Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
Tax ID: 58-1452561

Letter of Medical Necessity

Date: August 30, 2019
To: United Healthcare
Patient: Rose Averill
DOB: 10/26/1961
Member Name: Rose Averill
Member ID: 912012181

Dear Madame/Sir,

I request that Ms. Averill be covered by insurance for suction assisted protein lipectomy (SAPL). Ms. Averill has lipedema, a disorder of excess fat cells that bind up fluid resulting in gross enlargement of the fat tissue primarily on the legs, arms, buttocks and abdomen. Lipedema is not rare but the diagnosis is not often made. It is also known as the painful fat syndrome and is almost exclusively found in women. The onset is generally puberty, pregnancy, menopause or times of unusual stressors. There may be a familial occurrence as well. Lipedema is often confused with lymphedema, but differs in many ways including lack of involvement of the hands and feet and the pain associated with it. Lymphedema is not painful.

Although therapies such as manual lymphatic drainage, wrapping, compression garments, exercise and diet along with supplemental medications are helpful, they cannot reduce the fat itself. The only definitive treatment currently for lipedema fat tissue is a lymph-sparing procedure via suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is the standard of care in that country. There is literature in regards to lipectomy for lipedema including the articles listed at the end of this letter. SAPL has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction that has also been used in the treatment of lipedema patients, WAL lessens the risk of fluid overload and the osmotic burden on the patient. As a result, WAL enables a safer and more extensive fat removal and treatment of more areas during the surgical procedure which cuts down the total number of procedures needed.

SAPL is Ms. Averill only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her day to day activities, improve her gait and to minimize future morbidities.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Marcia V. Byrd, M.D.

References:

1. Herbst, Karen L. MD, Rare Adipose Disorders Masquerading As Obesity. *ActaPharmacologicaSinica* 2012; 33: 155-72
2. Fife, Ce Et Al. Lipedema: A Frequently Misdiagnosed and Misunderstood Fatty Deposition Syndrome. *Advances in Skin and Wound Care*. 2010. 23: 90.
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4. Langendoen, Et Al, Lipoedema: From Clinical Presentation To Therapy. *British J Derm* 2009; 164; 5.
5. Rapprich S, Dingler A, Podd M. Liposuction Is An Effective Treatment For Lipedema. *Jddg*, 2011; 9: 33-40.
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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
Tax ID: 58-1452561

Date: 08/30/2019
To: United Healthcare
Patient: Rose Averill
DOB: 10/26/1961
Member ID: 912012181

Dear Madame/Sir,

Ms. Averill was recently evaluated in our office for treatment of Lipedema.

Lipedema has received a Medical Subject Heading (MeSH) code and application for ICD code is pending. The MeSH code for Lipedema is D065134.

Additional codes applicable are:

R 60.1	General edema
I 89.0	Edema due to lymphatic obstruction
M 79.609	Pain in limbs
R 20.8	Hyperalgesia, hyperpathia
R26.9	Unstable gait

Water Assisted Liposuction (WAL), a lymph-sparing liposuction procedure that has been proven to be the preferred method for removal of the abnormal diseased fat in lipedema patients is the procedure planned. WAL is the only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her profession as well as at home, improve her gait and minimize future morbidities.

There is no CPT code that adequately describes the removal of abnormal lipedema fat excision during the WAL procedure. However, the CPT code most applicable to WAL is:

CPT codes:

38999 Other procedures for Hemic or Lymphatic System

Attached you will find support material including history & physical, letter of medical necessity and photographs.

Please do not hesitate to contact me if additional information is required.

Sincerely,

Marcia V. Byrd, M.D.

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Marcia V Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

INITIAL EVALUATION

Patient: Rose Averill
DOB: 10/26/1961
Date: 08/30/2019

Summary of the history 58-year-old female presenting for evaluation and discussion of lymph-sparing lipectomy (WAL) for the treatment of lipedema/lymphedema. She was diagnosed and is followed by

Swelling was noticed around puberty. Pain to light touch, easy bruising and swelling by the end of the day began shortly thereafter. Over the past few years she has also experienced progression of pain in knees bilaterally. She takes NSAID's on a daily basis for pain. She has tried many diet and exercise plans with weight loss noted only in nonaffected areas. She has increasing pain and swelling in the affected areas despite her continued efforts at non-surgical treatments.

History of Dercum's or Ehlers-Danlos syndrome: No

Areas of concern currently: Legs, arms, abdomen and buttocks

When and where swelling started: Swelling began after pregnancies and increased after hysterectomy.

Are affected areas painful to touch: Yes

Average daily pain on a scale from 1 to 10: 7/10

Pain level on a 'bad' day: 9/10

Is mobility limited? Difficulty with gait secondary to thickness and heaviness of thighs.

History of large bruising after slight bumps: Yes

Swelling by the end of the day: Yes

Pain resulting from contact with clothing: Yes

Number of pregnancies: G2 P2

Changes after pregnancy: Reduced ability to lose weight in affected areas, increase pain and difficulty with ambulation.

Clothing size: Upper body: M/L Lower body: 3X-4X

Joint problems: Torn meniscus bilateral knees, degenerative arthritis in large joints

Occupation: C.E.O of Medical Center

Previous therapies for lipedema/lymphedema: N/A

Compression Garments

Exercise

Diet

PMH: Hyperlipidemia and degenerative joint disease.

Surgical Hx: C-sections 1988, 1991, Abdominoplasty with Liposuction of inner thighs 1996, Hysterectomy 2005.

Medications: N/A

Allergies: No

FH: Mother: Lipedema, Heart disease, High cholesterol and Diabetes.

Father: Triple bypass, High cholesterol, High cholesterol, Diabetes and Stroke.

SH: Married. No use of tobacco. Drinks 3-4 glasses of wine a year. No exercise.

The Lower Extremity Functional Scale is 32. Scores range from 0 to 80. The lower the score the greater the dysfunction. (Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.)

PE:

Vital Signs: BP:165/80 P 74 reg. PO2: 97 BMI 46.4 Ht 5'6 ". WT287.1 lbs. Waist: 46".

Hips:59 1/4" Waist/hip ratio:0.77 Waist/height ratio: 0.69

General: Alert and oriented. NAD. Disproportionate upper and lower body with upper body being much smaller.

HEENT: Normal thyroid. No adenopathy.

Upper back: No dorsocervical fat pad present.

Mid-back: Minimal fat in the bra area without nodularity.

Lower back: Tender nodules and fat in the upper gluteal area.

Upper arms: Small amount of fat in the upper arms without tender nodules.

Forearms: Small amount of fat on the forearm without cuffing.

Hands: Negative for increased fat or tenderness. Stemmer sign negative.

Abdomen: Generalized adiposity. No nodules or tenderness in the abdominal area.

Buttocks: Dimpling in the buttocks, scattered nontender nodules.

Hips: Tender nodules bilaterally.

Thighs: Thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules. Non-pitting edema.

Medial knee: Tender nodules bilaterally. Slight valgus deformity.

Anterior lower leg: Fat pad medially just below the knee with tender nodules. Non-pitting edema.

Posterior lower leg: Tenderness of the lower leg to the ankle without cuffing. Non-pitting edema.

Ankle: Thickness at the malleoli.

Feet: No swelling in feet bilaterally. Stemmer sign negative.

Assessment: 58-year-old female with late stage 2 lipedema involving the legs and buttocks. Her symptoms of diffuse pain in the soft tissues and marked decrease in mobility have been progressing at a rapid rate over the past couple of years. She is experiencing pain daily, continual enlargement of the affected areas despite diet and exercise and increasing difficulty with ADLs.

Plan:

1. Compression garment – Bioflect on a daily basis. To be worn while out of bed.
2. Low-carb diet with ketone monitoring and use of diary.
3. Walk 30 minutes per day. Swimming pool exercises advisable.
4. MLD done by occupational therapist. Advised not to have custom garments made at this time but wait until after surgery.
5. Patient advised to consider lymph-sparing liposuction. Due to the limitations of lidocaine dosing and maximal aspiration of fatty tissue it is estimated that it will require 4-5 water-jet assisted procedures to complete the treatment of her legs and buttocks. The patient understands that lymph-sparing liposuction is done to reduce pain, stop/slow progression and improve ambulation but it is not a cosmetic procedure.

Discussion: Lipedema, a disorder of excess fat cells that bind up fluid resulting in a gross enlargement of the fat tissue primarily on the hips, buttocks, legs and arms, is a medical entity originally described by Allen and Hines in 1940 at the Mayo Clinic. It is a MESH term in the National Library of Medicine and an ICD application has been submitted. Lipedema is not responsive to lifestyle changes and grows in such a manner as to impede mobility and damage joints. In lipedema, the lymphatic system is not functioning as well as it should secondary to it being surrounded by inflammatory disease tissues. Patients typically begin to have symptoms at puberty but are rarely diagnosed until they reach more advanced stages. Patients consistently complain of pain in the areas of fat accumulation, easy bruising, limitation of motion and as progression occurs alterations in gait with subsequent need for knee replacement in many cases. While we use palliative therapies to treat the fluid excess including manual lymphatic drainage, wrapping, compression garments, exercise and diet, supplements and medications that bind to receptors on the lymphatics and induce lymphatic pumping, we cannot reduce the fat itself. Ultimately, even if the patient is adherent to palliative protocol, development of lymphedema typically occurs. It is not uncommon for patients to have significant gait dysfunction or inability to ambulate without assistance often requiring joint replacements.

At this time, the only definitive treatment for lipedema is lymph-sparing excision through suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is their standard of care. Liposuction works effectively for lipedema to reduce lipedema fat and pain (Cornely et al., 2006; Schmeller et al., 2006; Warren et al., 2007). According to Dr. Staffan Rapprich from Darmstadt Clinics in Germany, whose sole practice is focused on SAPL for lipedema, the treatment is curative (Rapprich et al., 2011, 2012). I consider SAPL medically necessary to prevent progression, reduce the pain, improve the gait and prevent damage to joints. WAL (water jet assisted liposuction) is the preferred method to remove the abnormal fat in lipedema patients. It has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction devised by German surgeons for lipedema fat removal 20 years ago, WAL lessens the risk of fluid overload and the osmotic burden on the patient, and thus, enables a more extensive fat removal and a smaller number of procedures than the earlier tumescent method. Cosmetic improvement, if it occurs at all, is just a bonus. **This is not a cosmetic procedure.**

Marcia V Byrd, MD

Date

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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

OPERATIVE NOTE

Name: Rose Averill

Date: 10/25/2019

Preoperative Diagnosis: Lipedema

Procedure: Lymph-sparing lipectomy utilizing Water-jet assisted Liposuction (WAL), Power assisted Liposuction (PAL), Vaser Liposuction (UAL)

Areas Treated: Calves to Ankles- Bilaterally and Circumferentially

Attending Surgeon: Marcia V Byrd MD

Indications: Progressive pain, swelling and decreased mobility which has been non-responsive to diet, exercise and other non-surgical measures.

Discussion: This lady presents for liposuction for the treatment of Lipedema. This procedure is not cosmetic but is intended to decrease her pain, improve her mobility/gait and prevent progression of the disease.

CPT code: 38999

Operative Summary:

Written consent was obtained prior to surgery, which included but was not limited to infection, bleeding, hematoma, seromas, asymmetries, contour irregularity, divots in the skin, DVT, pulmonary embolus. The patient understood and agreed to proceed. The patient was taken to the photo room where photos and markings of the areas were made then transferred to the surgical suite and placed supine on the operating table. After appropriate level of IV sedation was obtained the patient was prepped and draped in a sterile manner. The incisions for the liposuction cannulas were injected with tumescent solution with 30g needle then a 2 mm punch biopsy tool was used to make the incisions. Tumescent solution was infiltrated into the areas for lymph-sparing lipectomy. After this was allowed to take effect adipose tissue was then removed from the areas listed above using a combination of WAL, PAL and UAL in a manner to preserve the integrity of the lymphatics. Total extracted was 3500cc with a supernatant of 3200cc. Incisions closed with single mattress stitch of 4-0 plain gut. Dressings and compression garment were applied. The patient was transferred from the operating table to the recovery room having tolerated the procedure without difficulty.

Signature: _____
Marcia V. Byrd, MD

Date: _____

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Marcia V Byrd, MD

11050 Crabapple Road
Roswell, GA 30075
(770)587-1711

Page: 1

12/12/2019

Patient: Rose Averill
2140 Longbow Lane
Clearwater, FL 33764

Chart #: 26651AV0

Case #: 5348

Instructions:

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modifier	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
8/30/2019	Office Visit New Patient Lipedema	99205L1		000.00				1	150.00
8/30/2019	Visa/Mastercard payment	VISA						1	-150.00
9/5/2019	Visa/Mastercard payment	VISA						1	-1,000.00
9/13/2019	Visa/Mastercard payment	VISA						1	-1,000.00
10/11/2019	Visa/Mastercard payment	VISA						1	-8,550.00
10/25/2019	Lymph-sparing lipectomy	15879	22 50	R60.1	I 89.0	L92.9	R20.8	1	8,200.00
10/25/2019	Supplies	99070		R60.1	I 89.0	L92.9	R20.8	1	750.00
10/25/2019	IV sedation first 15 minutes	99152		R60.1	I 89.0	L92.9	R20.8	1	250.00
10/25/2019	IV sedation each additional 15	99153		R60.1	I 89.0	L92.9	R20.8	7	350.00
10/29/2019	MLD bilateral	97140		000.00				1	200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-2,000.00

12/13/2019 07:44:06



This has been electronically signed by Elizabeth Kurman ARNP-BC

Provider Information

Provider Name: Marcia V. Byrd MD
License: 023141
Insurance PIN:
SSN or EIN: 581452561

Total Charges: \$ 9900.00
Total Payments: -\$ 12900.00
Total Adjustments: \$ 0.00
Total Due This Visit: -\$ 3000.00
Total Account Balance: \$ 6,300.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____

Date: _____

FAX TRANSMISSION COVER SHEETDATE: 12/12/19 TIME: 11:07

TO: _____

FAX #: 727 210 4600ATTN: DR FRANK AVERILL**FROM:**

Marcia V. Byrd, M.D.
11050 Crabapple Road
Suite 105-B
Roswell, GA 30075
(770) 587-1711
Fax (770) 518-8810

You should receive _____ page(s), including this cover sheet. If you do not receive all the pages, please call 770-587-1711.

Confidentiality Note: The information contained in this fax message is being transmitted to and is intended only for the use of the individual named above. If the reader of this message is not the intended recipient, you are hereby advised that any dissemination, distribution or copy of this fax is strictly prohibited. If you have received this fax in error, please immediately notify us by phone and destroy this message.

Dr. Marcia V. Byrd, M.D.
11050 Crabapple Rd., Bldg. B
Roswell, GA 30075
770-587-1711

DATE: August 30, 2019
TO: UnitedHealthcare
FROM: Dr. Marcia V. Byrd, M.D.
RE: Rose Averill / DOB 10/26/1961 / Member ID #912012181
POS: 11 (In office)

Attached please find documentation and photos for Reimbursement Purposes, for lymph-sparing lipectomy, for above named patient.

Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
UPIN: D-29062
NPI: 1932112703
Tax ID: 58-1452561

Letter of Medical Necessity

Date: August 30, 2019

To: United Healthcare

Patient: Rose Averill
DOB: 10/26/1961

Member Name: Rose Averill
Member ID: 912012181

Dear Madame/Sir,

I request that Ms. Averill be covered by insurance for suction assisted protein lipectomy (SAPL). Ms. Averill has lipedema, a disorder of excess fat cells that bind up fluid resulting in gross enlargement of the fat tissue primarily on the legs, arms, buttocks and abdomen. Lipedema is not rare but the diagnosis is not often made. It is also known as the painful fat syndrome and is almost exclusively found in women. The onset is generally puberty, pregnancy, menopause or times of unusual stressors. There may be a familial occurrence as well. Lipedema is often confused with lymphedema, but differs in many ways including lack of involvement of the hands and feet and the pain associated with it. Lymphedema is not painful.

Although therapies such as manual lymphatic drainage, wrapping, compression garments, exercise and diet along with supplemental medications are helpful, they cannot reduce the fat itself. The only definitive treatment currently for lipedema fat tissue is a lymph-sparing procedure via suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is the standard of care in that country. There is literature in regards to lipectomy for lipedema including the articles listed at the end of this letter. SAPL has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction that has also been used in the treatment of lipedema patients, WAL lessens the risk of fluid overload and the osmotic burden on the patient. As a result, WAL enables a safer and more extensive fat removal and treatment of more areas during the surgical procedure which cuts down the total number of procedures needed.

SAPL is Ms. Averill only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her day to day activities, improve her gait and to minimize future morbidities.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Marcia V. Byrd, M.D.

References:

1. Herbst, Karen L. MD, Rare Adipose Disorders Masquerading As Obesity. *ActaPharmacologicaSinica* 2012; 33: 155-72
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To: United Healthcare
Patient: Rose Averill
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Member ID: 912012181

Dear Madame/Sir,

Ms. Averill was recently evaluated in our office for treatment of Lipedema.

Lipedema has received a Medical Subject Heading (MeSH) code and application for ICD code is pending. The MeSH code for Lipedema is D065134.

Additional codes applicable are:

R 60.1	General edema
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Water Assisted Liposuction (WAL), a lymph-sparing liposuction procedure that has been proven to be the preferred method for removal of the abnormal diseased fat in lipedema patients is the procedure planned. WAL is the only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her profession as well as at home, improve her gait and minimize future morbidities.

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Attached you will find support material including history & physical, letter of medical necessity and photographs.

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Marcia V. Byrd, M.D.
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Marcia V Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

INITIAL EVALUATION

Patient: Rose Averill
DOB: 10/26/1961
Date: 08/30/2019

Summary of the history 58-year-old female presenting for evaluation and discussion of lymph-sparing lipectomy (WAL) for the treatment of lipedema/lymphedema. She was diagnosed and is followed by

Swelling was noticed around puberty. Pain to light touch, easy bruising and swelling by the end of the day began shortly thereafter. Over the past few years she has also experienced progression of pain in knees bilaterally. She takes NSAID's on a daily basis for pain. She has tried many diet and exercise plans with weight loss noted only in nonaffected areas. She has increasing pain and swelling in the affected areas despite her continued efforts at non-surgical treatments.

History of Dercum's or Ehlers-Danlos syndrome: No

Areas of concern currently: Legs, arms, abdomen and buttocks

When and where swelling started: Swelling began after pregnancies and increased after hysterectomy.

Are affected areas painful to touch: Yes

Average daily pain on a scale from 1 to 10: 7/10

Pain level on a 'bad' day: 9/10

Is mobility limited? Difficulty with gait secondary to thickness and heaviness of thighs.

History of large bruising after slight bumps: Yes

Swelling by the end of the day: Yes

Pain resulting from contact with clothing: Yes

Number of pregnancies: G2 P2

Changes after pregnancy: Reduced ability to lose weight in affected areas, increase pain and difficulty with ambulation.

Clothing size: Upper body: M/L Lower body: 3X-4X

Joint problems: Torn meniscus bilateral knees, degenerative arthritis in large joints

Occupation: C.E.O of Medical Center

Previous therapies for lipedema/lymphedema: N/A

Compression Garments

Exercise

Diet

PMH: Hyperlipidemia and degenerative joint disease.

Surgical Hx: C-sections 1988, 1991, Abdominoplasty with Liposuction of inner thighs 1996, Hysterectomy 2005.

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Allergies: No

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Father: Triple bypass, High cholesterol, High cholesterol, Diabetes and Stroke.

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The Lower Extremity Functional Scale is 32. Scores range from 0 to 80. The lower the score the greater the dysfunction. (Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.)

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Assessment: 58-year-old female with late stage 2 lipedema involving the legs and buttocks. Her symptoms of diffuse pain in the soft tissues and marked decrease in mobility have been progressing at a rapid rate over the past couple of years. She is experiencing pain daily, continual enlargement of the affected areas despite diet and exercise and increasing difficulty with ADLs.

Plan:

1. Compression garment – Bioflect on a daily basis. To be worn while out of bed.
2. Low-carb diet with ketone monitoring and use of diary.
3. Walk 30 minutes per day. Swimming pool exercises advisable.
4. MLD done by occupational therapist. Advised not to have custom garments made at this time but wait until after surgery.
5. Patient advised to consider lymph-sparing liposuction. Due to the limitations of lidocaine dosing and maximal aspiration of fatty tissue it is estimated that it will require 4-5 water-jet assisted procedures to complete the treatment of her legs and buttocks. The patient understands that lymph-sparing liposuction is done to reduce pain, stop/slow progression and improve ambulation but it is not a cosmetic procedure.

Discussion: Lipedema, a disorder of excess fat cells that bind up fluid resulting in a gross enlargement of the fat tissue primarily on the hips, buttocks, legs and arms, is a medical entity originally described by Allen and Hines in 1940 at the Mayo Clinic. It is a MESH term in the National Library of Medicine and an ICD application has been submitted. Lipedema is not responsive to lifestyle changes and grows in such a manner as to impede mobility and damage joints. In lipedema, the lymphatic system is not functioning as well as it should secondary to it being surrounded by inflammatory disease tissues. Patients typically begin to have symptoms at puberty but are rarely diagnosed until they reach more advanced stages. Patients consistently complain of pain in the areas of fat accumulation, easy bruising, limitation of motion and as progression occurs alterations in gait with subsequent need for knee replacement in many cases. While we use palliative therapies to treat the fluid excess including manual lymphatic drainage, wrapping, compression garments, exercise and diet, supplements and medications that bind to receptors on the lymphatics and induce lymphatic pumping, we cannot reduce the fat itself. Ultimately, even if the patient is adherent to palliative protocol, development of lymphedema typically occurs. It is not uncommon for patients to have significant gait dysfunction or inability to ambulate without assistance often requiring joint replacements.

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Marcia V Byrd, MD

Date

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Marcia V. Byrd, M.D.
11050 Crabapple Road, Bldg B
Roswell, GA 30075
(770) 587-1711

OPERATIVE NOTE

Name: Rose Averill

Date: 10/25/2019

Preoperative Diagnosis: Lipedema

Procedure: Lymph-sparing lipectomy utilizing Water-jet assisted Liposuction (WAL), Power assisted Liposuction (PAL), Vaser Liposuction (UAL)

Areas Treated: Calves to Ankles- Bilaterally and Circumferentially

Attending Surgeon: Marcia V Byrd MD

Indications: Progressive pain, swelling and decreased mobility which has been non-responsive to diet, exercise and other non-surgical measures.

Discussion: This lady presents for liposuction for the treatment of Lipedema. This procedure is not cosmetic but is intended to decrease her pain, improve her mobility/gait and prevent progression of the disease.

CPT code: 38999

Operative Summary:

Written consent was obtained prior to surgery, which included but was not limited to infection, bleeding, hematoma, seromas, asymmetries, contour irregularity, divots in the skin, DVT, pulmonary embolus. The patient understood and agreed to proceed. The patient was taken to the photo room where photos and markings of the areas were made then transferred to the surgical suite and placed supine on the operating table. After appropriate level of IV sedation was obtained the patient was prepped and draped in a sterile manner. The incisions for the liposuction cannulas were injected with tumescent solution with 30g needle then a 2 mm punch biopsy tool was used to make the incisions. Tumescent solution was infiltrated into the areas for lymph-sparing lipectomy. After this was allowed to take effect adipose tissue was then removed from the areas listed above using a combination of WAL, PAL and UAL in a manner to preserve the integrity of the lymphatics. Total extracted was 3500cc with a supernatant of 3200cc. Incisions closed with single mattress stitch of 4-0 plain gut. Dressings and compression garment were applied. The patient was transferred from the operating table to the recovery room having tolerated the procedure without difficulty.

Signature: _____
Marcia V. Byrd, MD

Date: _____

Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors.

Marcia V Byrd, MD

11050 Crabapple Road
Roswell, GA 30075
(770)587-1711

Page: 1

12/12/2019

Patient: Rose Averill
2140 Longbow Lane
Clearwater, FL 33764

Chart #: 26651AV0**Case #:** 5348**Instructions:**

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modifier	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
8/30/2019	Office Visit New Patient Lipedema	99205LI		000.00				1	150.00
8/30/2019	Visa/Mastercard payment	VISA						1	-150.00
9/5/2019	Visa/Mastercard payment	VISA						1	-1,000.00
9/13/2019	Visa/Mastercard payment	VISA						1	-1,000.00
10/11/2019	Visa/Mastercard payment	VISA						1	-8,550.00
10/25/2019	Lymph-sparing lipectomy	15879	22 50	R60.1	I 89.0	L92.9	R20.8	1	8,200.00
10/25/2019	Supplies	99070		R60.1	I 89.0	L92.9	R20.8	1	750.00
10/25/2019	IV sedation first 15 minutes	99152		R60.1	I 89.0	L92.9	R20.8	1	250.00
10/25/2019	IV sedation each additional 15	99153		R60.1	I 89.0	L92.9	R20.8	7	350.00
10/29/2019	MLD bilateral	97140		000.00				1	200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-2,000.00

Provider Information

Provider Name: Marcia V. Byrd MD
License: 023141
Insurance PIN:
SSN or EIN: 581452561

Total Charges: \$ 9900.00**Total Payments:** -\$ 12900.00**Total Adjustments:** \$ 0.00**Total Due This Visit:** -\$ 3000.00**Total Account Balance:** \$ 6,300.00

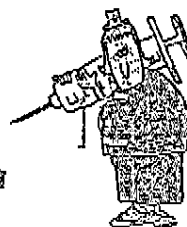
Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____**Date:** _____

Aug. 8. 2017 1:14PM

No. 2608 P. 1

SURGICAL ASSOCIATES OF WEST FLORIDA
1840 MEASE DRIVE SUITE 301
SAFETY HARBOR, FLORIDA 34695
PHONE (727) 712-3233 X 1130
FAX (727) 712-1853
MARK ZUZGA, DO RVT

TO: RoseFROM: Dr. ZuzgaDATE: 8-8-17TOTAL PAGES: 11Fax
PHONE NUMBER: 210-4600REGARDING: Records - the post US report
has not be dictated yet by Dr. Zuzga.Denise

Aug. 8. 2017 1:14PM

No. 2608 P. 2

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Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zuzga, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/07/17

CHIEF COMPLAINT: Painful varicosities left greater than right.

I saw Rose in consultation. She is a very pleasant 55-year-old female who presents for evaluation for lower extremity pain, impending venous ulcerations, bulging varicosities, venous edema, and leg fatigue, itching, burning, and unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications left greater than right. Due to the acute exacerbation of the symptoms, she presents for evaluation.

CURRENT MEDICATIONS: Thyroid medication, prednisone, doxycycline, probiotic, and Omega 3.

ALLERGIES: None.

PAST SURGICAL HISTORY: Hysterectomy and knee surgery.

PAST MEDICAL HISTORY: High cholesterol and Lyme disease.

FAMILY HISTORY: Diabetes.

SOCIAL HISTORY: Minimal alcohol.

REVIEW OF SYSTEMS: A 12-step review of systems was performed. Pertinent findings can be reviewed in the patient's chart and reviewed with the patient.

PHYSICAL EXAMINATION: Blood pressure, see nurse's notes, heart rate 80 and respirations 12. Well developed, well nourished, well hydrated, and in no acute distress. No scleral icterus. Palpable femoral and pedal pulses. Lower extremity shows bulging varicosities, hemosiderin deposits left greater than right with associated telangiectasias, and swelling. Heart is regular. Lungs are clear. No abdominal masses, tenderness, hepatosplenomegaly, or hernia. Head, neck, spine, ribs, and pelvis show good range of motion, stability, muscle strength and tone. Cranial nerves II through XII are grossly intact and normal. Good judgment and insight. No lymphadenopathy in the neck, axilla or groin.

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Aug. 8. 2017 1:15PM

No. 2608 P. 3

RE: Rose Averill

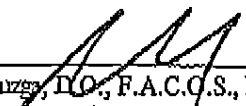
June 07, 2017

Page 2

IMPRESSION: Bilateral left greater than right lower extremity hemosiderin deposits, bulging varicosities, itching, burning, leg fatigue, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with daily pain with unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4.

PLAN: Venous duplex. Return after this is performed.

X


Mark A. Zurzga, D.O., F.A.C.C.S., R.V.T.

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Aug. 8. 2017 1:15PM

No. 2608 P. 4

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Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zurza, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/27/17

PROCEDURE PERFORMED: Bilateral venous duplex

Left venous duplex was performed showing severe reflux of the left greater saphenous vein throughout its course from saphenofemoral junction down in the proximal greater saphenous vein measuring 14 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course. There was reflux in the left accessory greater saphenous vein; however, size dimensions are only 5.4 mm. Minimal reflux noted in the left lesser saphenous vein. The deep system was intact without evidence of DVT. Good proximal and distal augmentation.

IMPRESSION: Severe reflux of left greater saphenous vein throughout its course from saphenofemoral junction down, size is greater than 14 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

Right venous duplex was performed showing significant reflux of the right greater saphenous vein throughout its course from saphenofemoral junction down in the proximal greater saphenous vein measuring 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course. There was significant reflux of right accessory greater saphenous vein with size dimensions of 6.9 mm with greater than 2 seconds of reflux from saphenofemoral junction down throughout its course. Minimal reflux noted in the right lesser saphenous vein. The deep system was intact without evidence of DVT. Good proximal and distal augmentation.

IMPRESSION:

1. Severe reflux of right greater saphenous vein throughout its course from saphenofemoral junction down, size is 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

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Aug. 8. 2017 1:15PM

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RE: Rose Averill

June 27, 2017

Page 2

2. Significant reflux of right accessory greater saphenous vein, size is greater than 6 mm with greater than 2 seconds of reflux from its origin down throughout its course.

X


Mark A. Zizza, D.O., F.A.C.O.S., R.V.T.

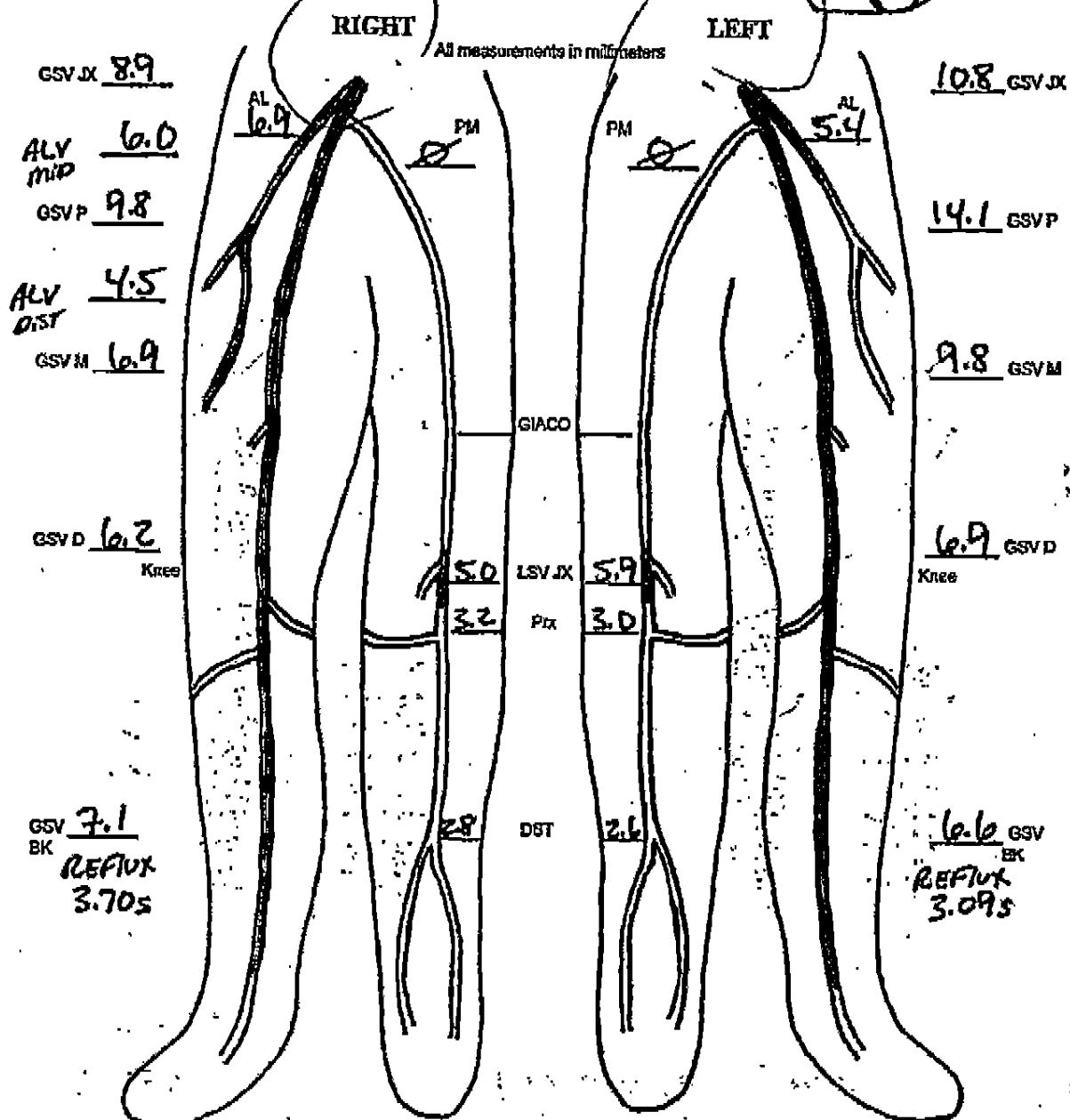
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MAZ/Med/dev/wah

Aug. 8. 2017 1:15PM

No. 2608 P. 6

*Surgical Associates of West Florida*Name AVERILL, ROSE Date 6/27/2017MR# 221304 Sonographer Pamela Bell, CCSPhysician ZUZGA Clinical History 

Aug. 8. 2017 1:16PM

No. 2608 P. 7

*Surgical Associates of West Florida*Name AVERILL, ROSE Date 6/27/2017MR# 221304 Sonographer Pamela Bell, RCSPhysician ZUZGA Clinical History _____

RIGHT LEG

	COMPRESS?	REFLUX?
GSV JX	YES	3.03s
PRX	YES	3.78s
MID	YES	3.76s
DST	YES	3.05s
ALV PRX	YES	3.58s
ALV MID	YES	3.10s
ALV DIST	YES	3.33s
LSV JX	YES	2.02s
PRX	YES	—
DST	YES	—

CFV	YES	
SFV PRX	YES	
MID	YES	
DST	YES	
POP V	YES	
PTV		
ATV		
PERON V		

LEFT LEG

	COMPRESS?	REFLUX?
GSV JX	YES	3.13s
PRX	YES	3.20s
MID	YES	3.45s
DST	YES	3.40s
ALV	YES	2.74s
PMV		
GIACO		
LSV JX	YES	1.75s
PRX	YES	—
DST	YES	—

CFV	YES	
SFV PRX	YES	
MID	YES	
DST	YES	
POP V	YES	
PTV		
ATV		
PERON V		

Aug. 8. 2017 1:16PM

No. 2608 P. 8

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Robert T. Roth, MD.
Rick J. Schmidt, MD.

Theodore R. Small, MD.
Mark A. Zuzga, D.O.

PATIENT: Rose Averill
CHART#: 221304
DOB: 10/26/61
DATE: 06/28/17

CHIEF COMPLAINT: Followup of ultrasound.

I saw Rose in followup today. She is a very pleasant female with lower extremity extensive venous stasis changes, swelling, pain, venous edema, itching and burning. She has tried and failed conservative management with compression stockings with venous clinical severity score of 14, CEAP score of 4. Venous ultrasound was performed showing severe reflux of bilateral greater saphenous veins from saphenofemoral junction down size measuring greater than 7 mm bilaterally with greater than 3 seconds of reflux from saphenofemoral junction down. Lengthy discussion we had with the patient the arteriovenous insufficiency, radiofrequency ablation; I feel she is an excellent candidate for radiofrequency ablation of bilateral greater saphenous veins with failed medical management with continued symptoms of pain, swelling, localized tenderness. I reviewed the ultrasound today in the office.

PHYSICAL EXAMINATION: Vital signs are stable, afebrile. Well developed, well nourished, well hydrated, and in no acute distress. No scleral icterus. No carotid, abdominal, or femoral bruits. Palpable femoral and pedal pulses. Lower extremity shows bulging varicosities, venous stasis changes, skin pigmentation changes, inflammation. Heart is regular. Lungs are clear. No abdominal masses, tenderness, hepatosplenomegaly, or hernia. Head, neck, spine, ribs, and pelvis show good range of motion, stability, muscle strength and tone. Cranial nerves II through XII are grossly intact and normal. Good judgment and insight. No lymphadenopathy in the neck, axilla or groin.

IMPRESSION: Bilateral lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, skin pigmentation changes, inflammation with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of bilateral greater saphenous vein from saphenofemoral junction down size measuring greater than 7 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

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Aug. 8. 2017 1:17PM

No. 2608 P. 9

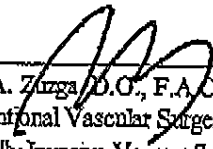
RE: Rose Averill

June 28, 2017

Page 2

PLAN: Radiofrequency ablation of bilateral greater saphenous vein.

X


Mark A. Zurga, D.O., F.A.C.O.S., R.V.T.

Interventional Vascular Surgery

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Aug. 8. 2017 1:17PM

No. 2608 P. 10

**PATIENT:** Rose Averill**CHART#:** 221304**DOB:** 10/26/61**DATE:** 07/15/17**IN-OFFICE RADIOFREQUENCY ABLATION AND CLOSURE OF THE LEFT GREATER SAPHENOUS VEIN**

PREOPERATIVE DIAGNOSES: Left lower extremity pain, swelling, edema, dilated varicosities, bulging, itching, burning, skin pigmentation changes with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of the left greater saphenous vein from saphenofemoral junction down size measuring greater than 14 mm with proximal greater saphenous vein with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

POSTOPERATIVE DIAGNOSES: Left lower extremity pain, swelling, edema, dilated varicosities, bulging, itching, burning, skin pigmentation changes with venous clinical severity score of 14, CEAP score of 4, unresponsive to six months of compression stockings, leg elevation, and nonsteroidal medications with ultrasound documentation of severe reflux of the left greater saphenous vein from saphenofemoral junction down size measuring greater than 14 mm with proximal greater saphenous vein with greater than 3 seconds of reflux from saphenofemoral junction down throughout its course.

IN-OFFICE PROCEDURE: Radiofrequency ablation and closure of left greater saphenous vein.

ANESTHESIA: Tumescence mixture of 450 cc of normal saline, 50 cc of 1% lidocaine, and 5 cc of bicarb.

DESCRIPTION OF OPERATION AND FINDINGS: After proper consent was obtained and placed in chart, the patient's left lower extremity was sterilized and prepped in usual fashion. Under ultrasound guidance, access was gained to distal left greater saphenous vein with micropuncture needle at which time the #7-French sheath was introduced. The radiofrequency ablation catheter was inserted at the saphenofemoral junction and pulled back 2 cm. Using 175 cc of tumescence anesthesia mixture, the entire left greater saphenous vein to undergo radiofrequency ablation was anesthetized. The patient underwent 14 RF cycles at 120 degrees and 10 watts as the #7-French sheath and radiofrequency ablation catheter was removed, local pressure was applied. The patient remained stable throughout the procedure and walked out of the office in stable condition.

X

Mark A. Zuzga, D.O., F.A.C.O.S., R.V.T.

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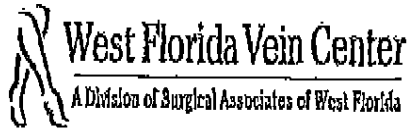
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Aug. 8. 2017 1:18PM

No. 2608 P. 11

**PATIENT:** Rose Averill**CHART#:** 221304**DOB:** 10/26/61**DATE:** 07/22/17**IN-OFFICE RADIOFREQUENCY ABLATION AND CLOSURE OF THE RIGHT GREATER SAPHENOUS VEIN**

PREOPERATIVE DIAGNOSES: Right lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, unresponsive to greater than six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4 with ultrasound documentation of severe reflux of the right greater saphenous vein from the saphenofemoral junction down size measuring greater than 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

POSTOPERATIVE DIAGNOSES: Right lower extremity pain, swelling, edema, bulging varicosities, itching, burning, leg fatigue, unresponsive to greater than six months of compression stockings, leg elevation, and nonsteroidal medications with venous clinical severity score of 14, CEAP score of 4 with ultrasound documentation of severe reflux of the right greater saphenous vein from the saphenofemoral junction down size measuring greater than 9.8 mm with greater than 3 seconds of reflux from saphenofemoral junction down.

IN-OFFICE PROCEDURE: Radiofrequency ablation and closure of right greater saphenous vein.

ANESTHESIA: Tumescence mixture of 450 cc of normal saline, 50 cc of 1% lidocaine, and 5 cc of bicarb.

DESCRIPTION OF OPERATION AND FINDINGS: After proper consent was obtained and placed in chart, the right lower extremity was sterilized and prepped in usual fashion. Under ultrasound guidance, access was gained to distal right greater saphenous vein with micropuncture needle at which time the #7-French sheath was introduced. The radiofrequency ablation catheter was inserted at the saphenofemoral junction and pulled back 2 cm. Using 220 cc of tumescent anesthesia mixture, the entire right greater saphenous vein to undergo radiofrequency ablation was anesthetized. The patient underwent 10 RF cycles at 120 degrees and 10 watts as the #7-French sheath and radiofrequency ablation catheter was removed, local pressure was applied. The patient remained stable throughout the procedure and walked out of the office in stable condition.

X

Mark A. Zyga, D.O., F.A.C.O.S., R.V.T.

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8/10/2017 1

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