

POST-OPERATIVE VISIT

name: Tange, Kayla

date: 12/19/22

surgeon: Dr. Kornafel

date of operation: 12/13/22

pre-op diagnosis: uterine myoma
dysmenorrhea
midcycle pain

post-op diagnosis: minimal endometriosis
non accs

procedure: LSC
Fulguration of endometriosis
exp. laparotomy

pathology: none submitted

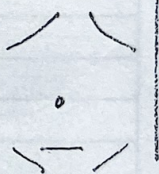
post-op course: usual pain

pain & urination - was cath for procedure

PE: healthy NAD

BP _____ HR _____ T _____

incisions clean & dry
staples removed



UTZ: not done

(attach photo)

Assessment: good recovery

Plans: monitor myoma growth

Consider actual management for pain



700.076

PRE-PROCEDURE NOTE

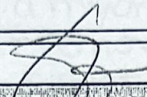
Procedure(s): laparoscopy, Argon beam fulguration of endometriosis
Ovarian cystectomy
Exploratory laparotomy, myomectomy

I have examined the patient and:

☒ There has been NO SIGNIFICANT CHANGE to the H & P dated: 12/09/22

☐ The following changes to H & P have been noted:

Date: 12/13/22 Time: 12:30

M.D. Signature: 

POST-PROCEDURE NOTE

Pre-Procedure Diagnosis:

Post-Procedure Diagnosis:

Procedure(s):

Findings:

Specimen(s): ☐ None

Tissue Removed: ☐ None

Anesthesiologist:

Type of Anesthesia: ☐ Local ☐ MAC ☐ General ☐ Epidural ☐ Spinal ☐ Other

Surgeon: Assistant: 9 None

EBL:

Grafts or Implants: ☐ None

Other: ☐ None

Complications: ☐ None

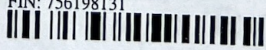
Patient Tolerated Procedure:

Condition Post-Procedure:

Date: Time: M.D. Signature:

USC Verdugo
Hills Hospital
Keck Medicine of USC

PRE-PROCEDURE and
POST-PROCEDURE NOTES

P
A
T
I
E
N
T
I
D
USC VHH
TANGE, KAYLA
DOB: 05/22/1982 40 Y F
DOS: 12/13/2022 12:00
ATT: KORNAFEL MD, KATHLEEN
REF: KORNAFEL MD, KATHLEEN
MRN: 003968691
FIN: 756198131


12/07/2022 PRE-OP NOTE see 09/15/22 note

40.5yo G1EAb1 c̄ midcycle and menstrual pain x~1 year
and known myoma presents for pre-op

Hx: For past ~1 year she has noted midline cramping @
ovulation and has long noted severe dysmenorrhea
Pain is bad enough that she wants LSC for dx.

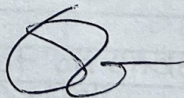
2021 she had IVF cycle and a myoma - intramural
was noted. She wants it removed b/c she thinks it → pain
She had a polypectomy @ that time also.

PE: healthy NAD
lungs - clear to ausc (B)
cardiac - RRR OM
CVx - Ø pus Ø erythema

UTZ: 3.3 x 2.5 cm myoma (L) lower @ internal os intramural
not @ surface or submucosal

A: mild-moderate pain/cramping
myoma.

P: per patient's request not necessarily by recommendation
1. LSC for pain and fulguration of endometriosis / LOA
→ would give better view than laparotomy
2. exp. lap c̄ myomectomy - I explained that I would
rarely recommend this for something the size of
her myoma. She firmly requested this procedure.



Kayla Tange
DOB 05/22/82

ROTHLEEN L. KORNAPFEL, M.D., PH.D.
A MEDICAL CORPORATION
GYNECOLOGY • GYNECOLOGIC ENDOCRINOLOGY • INFERTILITY
1560 EAST CHEVY CHASE DRIVE, SUITE 200
GLENDALE, CALIFORNIA 91206

TELEPHONE: (818) 242-9933

FAX: (818) 242-9937

PATIENT I.D.

TANGE, KAYLA

05/22/82

SHORT STAY HISTORY AND PHYSICAL

ADMIT DATE: 12/13/22

WT: _____

HT: _____

ALLERGIES: _____

1. HISTORY:

Chief Complaint and Present Illness: worsening cramping during ovulation

Significant Past History:

11/2022 bx ⊕ breast → DCIS

2021 RSC polypectomy

Pertinent Family History: ∅

Medications: ∅

2. PERTINENT REVIEW OF SYSTEMS: ∅

3. PHYSICAL EXAMINATION:

Vital Signs: T _____ B.P. _____ Pulse _____ Resp. _____

General Appearance: healthy NAD

Head: _____

Heart: RRR OM

Lungs: clear to ausc ⊕

Abdomen: _____

Extremities: _____

Other: Scan → 3.3 x 2.5 cm myoma not on endometrium
cloudy ⊕ cyst

4. ADMITTING DIAGNOSIS:

worsening leiomyomatous uterus

5. PLAN OF TREATMENT: exp. lap.

myomectomy

possible endometrial ablation

☒ Discussed Alternatives, Benefits, Risks, and Potential Complications regarding procedures.

Date/Time: 12/09/22

M.D.

SURGICAL CONSENT

I request that **Dr. Kornafel** perform the following operation:

- ☐ Cervical dilation, suction evacuation of uterine contents, sharp curettage
- ☒ Exploratory laparotomy [possible for all laparoscopy cases]
- ☒ Fulguration of endometriosis
- ☐ HSC/RSC
- ☐ endometrial ablation
- ☐ lysis of adhesions
- ☐ polypectomy
- ☐ retrieval of intrauterine device
- ☒ Laparoscopy
- ☐ diagnostic
- ☒ operative
- ☐ Lysis of adhesions
- ☒ Myomectomy
- ☐ Oophorectomy
- ☒ Ovarian cystectomy [possible oophorectomy for all cases]
- ☐ Salpingectomy or salpingostomy
- ☐ Total abdominal hysterectomy
- ☐ Tubal reanastomosis
- ☐ Tuboplasty
- ☐ Vaginal hysterectomy
- ☐ Other: _____

addendum of laparoscopy added
to consent 12/13/22

In lay terms: an incision will be made in the abdomen to remove myoma and Ovarian cyst | a small incision will be made in abdomen

Preoperative diagnosis: uterine myoma, worsening menstrual pain, view contents of uterus

Ovarian cyst

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT:

I understand that conditions may arise and that it may be necessary to perform operations and procedures different from or in addition to the procedures described. I authorize and consent to the performance of such additional and/or different operations and procedures as are considered necessary and advised.

12/13/22 /patient initials

12/13/22 12/13/22

INDICATIONS AND BENEFITS: I am satisfied with my understanding of the reason[s] for my operation.

They are Removal of Fibroid & possible endometriosis

DESCRIPTION OF OPERATIVE APPROACH: Diagnostic procedures allow a more exact diagnosis than, for instance an x-ray because the doctor can look directly at the organs. Therapeutic or operative procedures provide for complete or partial treatment of several gynecologic diseases.

LAPAROSCOPY: Laparoscopy is an operation by which pelvic and abdominal structures can be examined visually through a telescope. The first step in doing a laparoscopy is the insertion of a needle into the abdomen through a small incision in or just under the navel. Carbon dioxide gas is pumped into the cavity of the abdomen so that the pelvic organs can be seen through the gas filled area. After pumping carbon dioxide gas, the needle is removed and the incision is widened to allow the passage of a sharp, hollow tube called a trocar. The telescope is passed through the trocar. A second, smaller trocar is then passed through an incision at the level of the pubic hairline in the center. An instrument can be passed through this trocar to allow better visualization of the pelvic organs. The procedures up to this point constitute diagnostic laparoscopy. The process that will occur next will depend on the findings during the first part of the operation. If nothing abnormal is found, the instruments will be removed and the same laparoscopic instrument, the Doctor will try and correct any problems. One or two other trocars and instruments may be inserted through small incisions on either side of the abdomen. Operative laparoscopy is an operation by which endometriosis, abnormal fallopian tubes, ovarian cysts, adhesions, some uterine tumors, tubal pregnancy, and other conditions may be treated. Carbon dioxide is pushed out of the abdomen on completion of procedure.

HYSTEROSCOPY: Hysteroscopy involves passing a small telescope through the cervix to view the inside of the uterus for polyps, fibroids, scar tissues, abnormal development, or other conditions. While a diagnostic hysteroscopy may be done in the office, the actual treatment of any abnormalities must be performed under anesthesia in a hospital or surgery center. This is called an operative hysteroscopy which involves the use of scissors, electrocoagulation, or laser. Sometimes a larger type of telescope called a resectoscope will be used. Laparoscopy may be done at the same time to guide your doctor's efforts while inside the uterus.

D&C: D&C are the initials for the procedure of cervical dilation and uterine curettage. This involves scraping the inside walls of the uterus with a smooth metal instrument and then aspirating the loose tissue out through a hollow tube connected to a pump. The tissue obtained is submitted to the pathology department for diagnosis.

LAPAROTOMY: Exploratory or operative laparotomy is a procedure wherein an incision of 3 to 8 inches is made on the abdomen to allow complete manipulation of pelvic organs. The incision may be horizontal or vertical. The decision to do a laparotomy is usually made prior to beginning the operation but may be made. As a result of what was found at the time of diagnostic laparoscopy or because a complication arose. Larger procedures such as myomectomies and hysterectomies are done via this route. Following a laparotomy, the patient is admitted to the hospital for about three days.

14 patient initials

12/13/2014

PAIN, COMPLICATIONS, & DISCOMFORTS: Surgery today is generally safe, helpful, and often lifesaving. However, surgical procedures of any type involve the taking of risk, ranging from minor to serious, and may ultimately include the risk of death. It is important to be aware of the following possible risks before you give your consent to the operation that you and your physician are planning. The risks explained below are not listed to frighten you, but to inform you and allow you to make your decision. The following may be the reactions of your body to surgical operation.

ANESTHESIA REACTIONS: The anesthesiologist will discuss risks with you prior to the procedure. There may be unusual or unexpected responses to the gasses, drugs, or methods used to anesthetize you. Some patients have severe responses leading to coma or death.

BLOOD VESSEL INFLAMMATION AND CLOTTING: When this happens, thrombophlebitis occurs. Treatment may include a blood thinner and antibiotics. Blood clots may separate and move into other organs and injure those organs. Injury to the brain from clots is called a stroke and can result in cardiac arrest or even death. Such occurrences are rare.

CARBON DIOXIDE: During a laparoscopy, carbon dioxide is absorbed into the blood by the abdominal lining and in excessive quantities, can cause heart irregularities and even cardiac arrest. For this reason, the doctor who administers the anesthesia will put a tube into your windpipe during the operation in order to pump oxygen into the lungs and remove carbon dioxide. Sore throat and slight hoarseness may occur. After the procedure, some gas may remain and cause pain in the upper abdomen, shoulder, and neck due to the irritation of the diaphragm, a membrane under your lungs.

DRUG REACTIONS: Unexpected allergies, lack of proper response to medication, or illness caused by prescribed drugs is possible. It is important for you to inform your physician of any problems you may have had with reaction to drugs and let them know which medication/supplements you now take regularly, including all over the counter drugs, herbs, and vitamins. **[PLEASE LIST CURRENT MEDICATIONS/SUPPLEMENTS]:**

Vit E, Vit D

FLUID OVERLOAD: During Hysteroscopy and resectoscopy, fluid is forced under pressure to distend the uterus like a balloon gets filled with air. Unfortunately, the fluid also gets pushed into the blood vessels and distributed into the lungs and brain. In excessive amounts, this can cause damage to both organs resulting in pulmonary failure and coma.

INFECTION: Invasion of tissue by bacteria or other germs occurs to a degree whenever a cut or incision is made or an instrument is inserted. In most instances, through the natural defense mechanisms of the body, healing of the affected area is completed without difficulty. However, infection may continue or spread at the site of the incision, inside the abdomen, or in the blood. Antibiotic medications are used to avoid infections that spread through the skin, called necrotizing fasciitis. This can be fatal or result in severe scarring. Infections in the blood are particularly serious and can lead to septic shock. Half of all patients with septic shock do not survive.

HEMORRHAGE: The cutting of blood vessels causes bleeding and this occurs in every operation. This bleeding is usually controlled without difficulty. A severe hemorrhage from a major blood vessel may require a laparotomy and the expertise of a vascular surgeon. At times, blood transfusions are required to replace large amounts of lost blood.

14 /patient initials

12/13/22 14

COMPLICATION RISK/UNIT OF BLOOD TRANSFUSED

Recent Data from the American Red Cross:

Transfusion Reaction	1:33
Fever	1:100
Hives	1:100
Hepatitis C	1:300
Hepatitis B	1:1,000
Other Viruses	1:1,000
Red Cell Destruction	1:6,000
HIV-1	1:50,000
Fatal Reactions	1:100,000
Severe Allergic Reactions	1:100,000
Wrong Unit	1:500,000

INJURY TO ORGANS: Damage to abdominal structures is possible during D&C, hysteroscopy, laparoscopy, and laparotomy. With a hysteroscopy or D&C, it is possible to perforate or make an unwanted hole in the uterus. Because of closeness of other organs to the operative site, in particular the bowel, bladder, and urethra, it may be unavoidable that other organs could be injured or nerves connected to these organs/tissues affected. The diagnosis of injury to these organs is usually made at the time of surgery, but may not be realized until several days later. In either case, major surgery with a vascular or general surgeon may be necessary. Full recovery may require several days to weeks of hospitalization.

NEUROLOGICAL REACTIONS: Anesthetic or surgical complications could potentially result in minor or significant neurological complications including death. These are extremely uncommon. At the time of laparotomy, the incision will frequently result in some numbness or paresthesia (abnormal sensation) in the lower part of the abdomen, because small superficial nerves have to be divided in performing this incision. These abnormal sensations usually go away and completely normal sensations return within a several weeks up to a year. In addition, it is occasionally possible for pressure on the nerves from the abdominal retractor to result in numbness in the legs. This condition usually resolves within a matter of a few days or weeks. In a laparoscopy or laparotomy, it is uncommon but not impossible for peripheral nerve compression to result in abnormal sensations or very rarely, food drop. This is almost always a very self-limited condition, which will improve in a few weeks.

12/13/22 /patient initials

12/13/22

OTHER RISKS: It is not possible to list here all of the risks and complications and their variations that may arise in any surgical operation or procedure. Each situation depends on the condition of the patient's health and the purpose and nature of the operation. Even with a young healthy patient, it is possible for the most competent of surgeons and/or anesthesiologists to have complications arising from surgery. Major complications occur very rarely but are often not possible to predict or prevent. All patients will experience post operative pain that can usually be controlled with medications. Rare patients develop scar tissue internally that may cause pain for years. Patients who undergo a procedure for pain must understand that the same pain may return or new pain may develop as a result of adhesion (scar) formation at the time of surgery. There is no way to guarantee a complete absence from pain. Minor complications may include nausea and vomiting, or a scar that does not heal well and is unattractive. It is important for every patient to understand that, in electing to undergo surgery, the risks are accepted. We are happy to discuss with you any further details about these and other risks or any questions you might have about your surgery.

ANESTHESIA: I understand that I will receive an anesthetic which an anesthesiologist will select and administer. I understand I should discuss the risks and benefits associated with the anesthesia selected with them.

LENGTH OF STAY: My doctor has informed me that my approximate length of stay is 6-20 hours for a hysteroscopy, laparoscopy, or D&C, and 2-4 days for a laparotomy. If complications occur, the stay may be longer. I will be responsible for the hospital bill and those of other physicians such as anesthesiologists and assistant surgeons.

LENGTH OF RECOVERY: My doctor has informed me that my approximate length of recovery is 1-2 days for a D&C or hysteroscopy, 2-7 days for a laparoscopy, and 3-6 weeks for a laparotomy.

ALTERNATIVES TO TREATMENT: Other ways of managing your illness, which range from doing nothing to taking different measures, should be considered. Since you and your doctor have decided upon surgery, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of similar conditions. The potential effectiveness and risks accompanying these alternative methods of treatment should be considered.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the need for surgery.

FREE TO WITHHOLD OR WITHDRAW CONSENT: I understand that I am free to withhold or withdraw my consent at any time before the operation without affecting the right to future care or treatment.

FEES: I understand that, in addition to my doctor's fees, there will be other charges such as facility costs, anesthesiologist's fee, laboratory, and assistant surgeon fees. I understand that my insurance company may not pay all of these charges and that I am responsible for paying any part of these charges not paid by my insurance company.

ASSISTANT: Dr. Nelson has been asked to assist on the procedure. The assistant's fee is separate from the surgeon's fee and is about 25% of the quoted amount for the surgeon. If the procedure ends up not requiring the assistance of another doctor, that physician will charge a \$200 standby fee for interrupting their schedule and being present in the hospital until the final decision is made.

KT /patient initials

12/13/24

PHOTOGRAPHY: I consent to photographing the procedure. I will be able to review these films with the doctor in a post op appointment.

NO GUARANTEES: I UNDERSTAND THERE ARE RISKS INVOLVED IN ANY PROCEDURE OR TREATMENT AND IT IS NOT POSSIBLE TO GUARANTEE, TO WARRANT, OR IN ANY WAY GIVE AN ASSURANCE OF A SUCCESSFUL RESULT.

CONSENT: Having been informed of the above and having discussed this operation with my doctor, I consent to Dr. Kornafel and such assistants as they may designate to perform the surgical procedures and, if necessary, to remove any tissue or organs that may be necessary or medically desirable. This consent extends to the administration of such anesthetics and medicines as may be desirable. I also authorize them to perform such other procedures as they may determine are necessary during the course of this operation. I understand that the doctors cannot guarantee the success of this treatment although they believe it is in my best interest.

KI /patient initials

12/13/22 KI

SIGNED BY PATIENT/GUARDIAN, THE PHYSICIAN, AND WITNESS:

The undersigned physician has gone over the consent form with the patient and answered any questions and explained any terms that were unfamiliar to the patient.

BY SIGNING THIS FORM, YOU ARE AGREEING THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION CONTAINED IN IT, HAVE HAD ALL OF YOUR QUESTIONS PERTAINING TO YOUR PROPOSED OPERATION ANSWERED, AND ARE AGREEING TO PROCEED WITH THE OPERATION.

Kayla Tange
Patient/Guardian

12-7-22
Date

Bethany Rin
Witness

12/7/22
Date

[Signature]
Physician

12/07/22
Date

[Signature] 12/13/22

[Signature]
Patient

12-13-22
date

USC Verdugo Hills Hospital

Keck Medicine of USC

PATIENT I.D.

Tange, Kayla

05/22/82

PRE-OPERATIVE PHYSICIANS ORDERS

ALLERGIES: Tylenol gel capsules

1) Diagnosis: worsening mid/menstrual pain
uterine myoma

2) Admit as: ☒ Admit to In-patient Status
☐ Day Surgery
☐ Observation (23*)
☐ Day Surgery (Local)

3) Time of Arrival: 10:00 AM

4) Surgery Scheduled for: 12:00 PM

5) Labs: ☒ CBC ☐ M-7 ☐ M-12 ☐ RPR
☐ ABORH ☐ PT ☐ PTT ☐ Type & Screen
☐ Platelet Function Screen ☐ ACCU-CHECK ☐ NONE
☐ Type, X-Match Units: _____
☐ Autologous Blood Units: _____
☐ UA
☐ MRSA/MSSA Screening ☒ COVID _____

6) ☐ EKG

7) ☐ Chest X-ray

8) ☐ Other Tests: laparoscopy

9) Consent to read: exploratory laparotomy, myomectomy

10) NPO: possible ovarian cystectomy

11) Prep: " fulguration of endometrosis

12) Pre-Op Medications: Ø

13) Other Instructions: _____

14) H & P: ☐ Dictated / Date / Job #:
☐ From Dr. _____

Office: _____

Date: 12/09/22 Time: 1200

Signature: _____

M.D.

USC VHH SURGERY SCHEDULING NOTIFICATION

FAX: 818-949-4053

VHH Main OR _____

DATE OF SURGERY: 12/13/22

TIME: 12:00 P

LOSurgery: 2 HRS

Scheduler: el

Extension: _____

Auth. (HMO): _____

Last Name: Tange First Name: Kayla (PLEASE PRINT)

Address: 2493 Niagara Way

City: Los Angeles ST: CA Zip: 90041

DOB: 09/22/82 MR# _____ Sex: F

Phone: 559 7078435 Work: _____

Insurance: Blue Shield ID # KEAP06054495

HMO ☒ PPO ☐ MCal ☐ MCal ☐ WC ☐ Medi-Medi ☐ Cash

Insurance: _____ ID # _____

Admitting MD: Dr. Kornafel Weight (>300lbs) _____

PROVIDER: Dr. Kornafel

CO PROVIDER: Dr. Sharon Nelson ☐ Co Provider Slip Attached

PROCEDURE: 1. exploratory laparotomy ID#: 49000

2. myomectomy ID#: 58140

3. _____ ID#: _____

4. _____ ID#: _____

DIAGNOSIS: uterine myoma D25.9

Admission Date: 12/13/22

☐ AM Admit - Est. Length of Stay _____

☐ Outpatient

☐ 23-Hr/Extended Recovery

☐ In House: Room _____

Post Op Bed _____

☐ Med/ Surg Floor: _____

☐ ICU: _____ Direct: _____

RADIOLOGY

☐ X-Ray

☐ Fluoroscopy/ C-Arm

Patient Position

☒ Supine

☐ Prone

☐ Other: _____

Special Equipment & Devices

☐ Video System ☐ Harmonic Scalpel

☐ Beach Chair ☐ Symphony Machine

☐ Wilson Frame ☐ Cell Saver

☐ Microscope ☐ Laser: _____

☐ SILS

MRSA/MSSA Screening Date: _____

(Required for Hip/Knee Joint Replacement Surgeries)

☐ RESEARCH STUDY ☐ IRB# _____

Operating Table

☐ Jackson Table

☐ Bariatric (300 lbs or more)

☒ Reg OR Table

Precautions

☐ Latex allergy

☐ IVP Dye/Iodine allergy

☐ Diabetic patient

☐ Infectious Diseases: _____

Anesthesia

☒ General ☐ Local

☐ Mac ☐ Spinal

☐ BLK: _____

☐ Epidural

☐ Fiberoptic Intubation

☐ Special Request For _____

☐ FROZEN SECTION Anesthesiologist: _____

Nerve Monitoring Blood Management

☐ SSEP ☐ T & C ☐ T & S

☐ Facial Nerve Monitoring ☐ DD: _____ ☐ AUTO: _____

☐ Other: _____ ☐ PRBC: _____ ☐ PLATELETS: _____

☐ FFP: _____ ☐ NONE

☐ Transfusion Free

Special Equipment Requests: Supplied by: ☐ Hospital ☐ Physician

inpatient

PLEASE ATTACH COPY OF THE PATIENT'S DEMOGRAPHICS AND INSURANCE IDENTIFICATION CARD

VHH Surgical Pathology Report

Temporary Copy

Case: 812-SP-22-003265

Collected: 11/2/2022 9:45 PDT

Ordered by: NELSON MD, MARIA E

Patient: TANGE, KAYLA

ID: 003968691

Location: Verdugo Hills Hospital

adequate control. The area of atypical proliferation on each block is predominantly negative for CK5,6 stain and this finding is in support of low-grade ductal carcinoma in situ.

The size of ductal carcinoma in situ is calculated based on number of tissue slices involved instead of measurement taken on a single contiguous histologic section.

SPECIMEN SOURCE:

A Left breast wire guided excision

CLINICAL INFORMATION:

History/Pre-op Diagnosis: Atypical ductal hyperplasia of left breast

Post-op Diagnosis: _

Procedure performed: _

Time (Specimen out of patient): November 2, 2022 at 0945 hrs.

Time (Specimen placed in formalin): November 2, 2022 at 1000 hrs.

Time out of formalin: November 2, 2022 at 2140 hrs.

GROSS EXAMINATION:

In 1 part labeled "left wire-guided excision, short superior, long lateral, double deep" received fresh from the OR and subsequently fixed in formalin is a 7.8 g intact lumpectomy specimen measuring 1.1 cm from superior to inferior, 3.7 cm from medial to lateral and 3.1 cm from anterior to posterior. An attached wire is in place inserted anteriorly. The specimen is oriented by the surgeon as: Short-superior, long-lateral, double-deep. The specimen is inked as follows: Blue-superior, green-inferior, red-medial, yellow-lateral, orange-anterior, black-posterior. The specimen is serially section from medial to lateral into 8 cross-sections to reveal a 1.2 x 0.7 x 0.6 cm tan-white semifirm nodule in slices 6 and 7. This area is 0.2 cm from the anterior margin, 0.3 cm from the posterior margin, 0.3 cm from the superior margin, 0.4 cm from the inferior margin, 2.0 cm from the medial margin and 0.4 cm from the lateral margin. The wire point and metallic biopsy clip are identified in slice 6. A hemorrhagic biopsy site is identified in slices 4 through 7 that is 1.7 x 1.0 x 0.6 cm. The remainder the specimen consists of 80% tan-white fibrous tissue and 20% tan-yellow adipose tissue. No other definitive lesions are identified. All submitted as follows:

A1-slice 1, medial margin, perpendicularly sectioned

A2-slice 2

A3-slice 3

A4-slice 4

A5-slice 5

A6-slice 6, possible lesion, wire point and biopsy clip

A7-slice 7, possible lesion

A8-slice 8, lateral margin, perpendicularly sectioned

CM /CM

VHH Disclaimer

Immunostains were done at LabCorp and interpreted at USC Verdugo Hills Hospital.
Controls are satisfactory.

VHH Surgical Pathology Report

Temporary Copy

Case: 812-SP-22-003265

Collected: 11/2/2022 9:45 PDT

Ordered by: NELSON MD, MARIA E

Patient: TANGE, KAYLA

ID: 003968691

Location: Verdugo Hills Hospital

40yo

05/22/82

Case Number

SP-22-3265

DIAGNOSIS:

Left breast lesion, wire-guided excision:

- Small foci of low-grade ductal carcinoma in situ (see synoptic report).
- Negative for invasive carcinoma.
- Fibrocystic change with apocrine metaplasia.
- Histologic change consistent with previous biopsy site identified.
- Ductal carcinoma in situ ancillary studies ordered and will be reported in an addendum to follow.

NANCY WU, MD

(Electronically signed by)

Verified: 11/07/2022

NW /NW

SYNOPTIC REPORT:**Specimen****Procedure:** Excision (less than total mastectomy)**Specimen Laterality:** Left**Tumor****Tumor Site:** Not specified**Histologic Type:** Ductal carcinoma in situ**Size (Extent) of DCIS:** 23 Millimeters (mm)**Number of Blocks with DCIS:** 5**Number of Blocks Examined:** 8**Architectural Patterns:** Cribriform**Nuclear Grade:** Grade I (low)**Necrosis:** Not identified**Microcalcifications:** Present in DCIS**Margins****Margin Status:** All margins negative for DCIS**Distance from DCIS to Closest Margin:** 0.2 mm**Closest Margin(s) to DCIS:** Lateral**Distance from DCIS to Posterior Margin:** 0.3 mm**Regional Lymph Nodes****Regional Lymph Node Status:** Not applicable (no regional lymph nodes submitted or found)**Distant Metastasis****Pathologic Stage Classification (pTNM, AJCC 8th Edition)****pT Category:** pTis (DCIS)**pN Category:** pN not assigned (no nodes submitted or found)

CAP eCC 2022 Q1 Release

COMMENT:

CK5,6 immunohistochemical stain was performed on tissue blocks A3, A4, A5, A6, and A8 with

USC Verdugo Hills Hospital
Laboratory Department
1812 Verdugo Blvd.
Glendale, CA 91208
Phone: (818) 952-2290
Fax: (818) 952-4641
Medical Director:
Chandnish K. Ahluwalia, M.D.

**USC Verdugo
Hills Hospital**
Keck Medicine of USC

Patient Name: **TANGE, KAYLA**
MRN: 003968691 FIN: 753778513
Location: VHH-SDS

Hematology

CBC

Collected Date 10/31/2022		Collected Time 14:51 PDT	
Procedure		Units	Ref Range
WBC	5.6	10 ³ /uL	[4.8-10.8]
RBC	4.57 ^H	10e6 cells/mcL	[3.50-4.50]
Hgb	13.8	g/dL	[12.0-15.0]
Hct	41.7	%	[36.0-48.0]
MCV	91.2	fL	[81.0-99.0]
MCH	30	pg	[29-33]
MCHC	33.1	g/dL	[32.0-36.0]
RDW	12.9	%	[11.5-14.5]
Platelet Count	261		[130-450]
MPV	7.8	fL	[7.4-10.4]

Differential

Collected Date 10/31/2022		Collected Time 14:51 PDT	
Procedure		Units	Ref Range
Neutrophil Rel	60.4	%	[50.0-70.0]
Lymphocyte Rel	31.5	%	[20.0-40.0]
Monocyte Rel	5.0	%	[0.0-14.0]
Eosinophil Rel	2.2	%	
Basophil Rel	0.9	%	[0.0-1.0]
NRBC Auto Rel	0.1	%	
Neutrophil Abs	3.4	10 ³ /uL	[1.6-7.5]
Lymphocyte Abs	1.8	10 ³ /uL	[1.3-3.3]
Monocyte Abs	0.3	10 ³ /uL	[0.0-1.6]
Eosinophil Abs	0.1	10 ³ /uL	[0.0-0.3]
Basophil Abs	0.0	10 ³ /uL	[0.0-0.1]
NRBC Auto Abs	0.0	/100 WBC	

Legend: *=abnormal, H=High, L=Low, C=Critical, f=Result Comment, r=Performing lab, c=corrected, i=interpretation, O=Order Comment

Ordering: n/a

Admitting: NELSON MD,MARIA E

Printed: 11/1/2022 05:49 PDT

Patient Name: **TANGE, KAYLA**

Financial #: 753778513

Admit Date:

Discharge Date:

Location: VHH-SDS

MRN: 003968691

DOB: 5/22/1982

Age: 40 years

Gender: Female

Page 1 of 4

USC Verdugo Hills Hospital
Laboratory Department
1812 Verdugo Blvd.
Glendale, CA 91208
Phone: (818) 952-2290
Fax: (818) 952-4641
Medical Director:
Chandnish K. Ahluwalia, M.D.



Patient Name: TANGE, KAYLA
MRN: 003968691 FIN: 753778513
Location: VHH-SDS

Coagulation**Coagulation**

Collected Date	10/31/2022		
Collected Time	14:51 PDT		
Procedure		Units	Ref Range
PT	11.0	seconds	[9.6-12.8]
INR	0.96 ⁱ¹	ratio	[0.90-1.10]
aPTT	35.1 ⁱ²	seconds	[25.0-39.3]

Interpretive Data

i1: INR
Level of Therapy INR Values

Std. Dose: Rx of Venous Thrombosis. 2-3 Rx of Pulmonary Embolism.
Prophylaxis against Venous Thrombosis or Systemic Embolization.

High Dose: High Risk Patient with 2.5-3.5 Mechanical Heart Valves.

Use of INR is not standardized for the induction phase of anticoagulation therapy. Various reagents react to falling factors variably during the onset of coumadin therapy.

i2: aPTT
Heparin Therapeutic Ranges: PTT = 1.5 to 2.5 times the normal range.

Molecular Testing**Molecular Studies**

	Collected Date	10/31/2022	
	Collected Time	07:06 PDT	
Procedure		Units	Ref Range
Patient Symptomatic?	No		
SARS-CoV-2 (COVID-19) RNA, RT PCR	Not Detected ⁱ³		[Not Detected]

Legend: *=abnormal, H=High, L=Low, C=Critical, f=Result Comment, r=Performing lab, c=corrected, i=interpretation, O=Order Comment

Ordering: n/a
Admitting: NELSON MD, MARIA E
Printed: 11/1/2022 05:49 PDT

Patient Name: **TANGE, KAYLA**
Financial #: 753778513
Admit Date:
Discharge Date:
Location: VHH-SDS

MRN: 003968691
DOB: 5/22/1982
Age: 40 years
Gender: Female
Page 2 of 4

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MRN: 003968691 FIN: 753778513
Location: VHH-SDS

Molecular Testing

Molecular Studies

Interpretive Data

i3: SARS-CoV-2 (COVID-19) RNA, RT PCR

The BioGX SARS-CoV-2 Reagents for BD MAX System is a real-time RT-PCR test intended for the qualitative detection of nucleic acid from the SARS-CoV-2 in nasopharyngeal and oropharyngeal swab samples from individuals suspected of COVID-19. Positive results do not rule out bacterial infection or co-infection with other viruses. Negative results do not preclude SARS-CoV-2 infection and should not be used as the sole basis for patient management. The BioGX SARS-CoV-2 Reagents for BD MAX System is only for use under the Food and Drug Administration's Emergency Use Authorization (EUA). The assay has been verified for clinical use by the USC-Verdugo Hills Hospital Laboratory. Testing performed at USC-Verdugo Hills Hospital Laboratory, certified under CLIA to perform moderate and high complexity testing.

Chemistry

Routine Chemistry

Collected Date	10/31/2022		
Collected Time	14:51 PDT		
Procedure		Units	Ref Range
Sodium Lvl	138	mmol/L	[137-145]
Potassium Lvl	4.1	mmol/L	[3.5-5.1]
Chloride Lvl	100	mmol/L	[98-107]
CO2	31 ^H	mmol/L	[22-30]
Glucose Level	87 ^L	mg/dL	[74-106]
Calcium Lvl	9.4	mg/dL	[8.4-10.2]
BUN	14	mg/dL	[7-17]
Creatinine Lvl	0.7	mg/dL	[0.7-1.2]
eGFR Non African American	93 ^L		[>=60]
eGFR African American	112 ^L		[>=60]
Total Protein	7.8	g/dL	[6.3-8.2]
Albumin Lvl	4.6	g/dL	[3.5-5.0]

Legend: * = abnormal, H = High, L = Low, C = Critical, f = Result Comment, r = Performing lab, c = corrected, i = interpretation, O = Order Comment

Ordering: n/a

Admitting: NELSON MD, MARIA E

Printed: 11/1/2022 05:49 PDT

Patient Name: TANGE, KAYLA

Financial #: 753778513

Admit Date:

Discharge Date:

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MRN: 003968691

DOB: 5/22/1982

Age: 40 years

Gender: Female

Page 3 of 4

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Medical Director:

Chandnish K. Ahluwalia, M.D.

**USC Verdugo
Hills Hospital**
Keck Medicine of USC**Patient Name: TANGE, KAYLA**

MRN: 003968691

FIN: 753778513

Location: VHH-SDS

Chemistry**Routine Chemistry**

Collected Date	10/31/2022		
Collected Time	14:51 PDT		
Procedure		Units	Ref Range
Globulin	3.2		
A/G Ratio	1.4		
Bilirubin Total	0.3	mg/dL	[0.2-1.3]
Alk Phos	43	U/L	[38-126]
ALT	13 ^L	U/L	[14-36]
AST	25	U/L	[14-36]

Interpretive Data**i4: Glucose Level**

A normal fasting glucose concentration is less than 100 mg/dL. An impaired fasting glucose concentration is 100-125 mg/dL. A provisional diagnosis of diabetes mellitus can be made when a fasting glucose concentration is greater than 125 mg/dL.

i5: eGFR African American, eGFR Non African American

Unit of measure is mL/min/1.73 M²

If African American, multiply result by 1.21

The NKDEP Laboratory Working Group report states that the MDRD study equation, used to calculate the eGFR, should only be used in individuals age 18 and older. The report also notes that the MDRD Study equation has not been validated for use with the elderly (over 70 years of age), pregnant women, patients with serious comorbid conditions, or persons with extreme of body size, muscle mass, or nutritional status. Application of the equation to these patient groups may lead to errors in GFR estimation.

GFR estimating equations have poorer agreement with measured GFR for ill hospitalized patients.

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Ordering: n/a

Admitting: NELSON MD,MARIA E

Printed: 11/1/2022 05:49 PDT

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Page 4 of 4

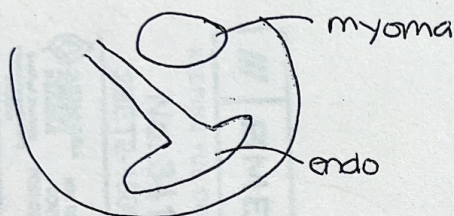
09/15/22

40yo patient referred 2° moderate-severe cramping midcycle over past 6-12 mo, she's noted midline cramping pain x 2-3d @ ovulation. Previously she'd had pain only c menses q month which she described as severe. Bleeding was heavy x 2-3d but has always been heavy

UTZ done 2021 @ oocyte retrieval → myoma & polyps
- removed

The myoma has gotten a little bigger and the midcycle pain started. A recent UTZ → looked like it was ~ 1/3 into cavity.

UTZ → myoma ⊕ lower lateral 2.9 x 2.4 cm



SIS does not confirm encroachment into cavity.

photos →

Because of the positioning - lateral and just above internal os as well as major intracavitary component, she is not a candidate for HSC myomectomy.

Laparotomy/myomectomy explained to patient -

Whenever a procedure is done for pain, it could produce a new worse pain. We will also look for endometriosis and ovarian cysts.

Patient understands that this could be managed medically.

Kayla Tange
DOB 05/22/82