Progress Notes by Demo Provider 2, MD at 4/10/2026 1:10 PM
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Filed: 4/10/2024 4:26 PM Encounter Date: 4/10/2026 Note Type: Progress Notes
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DOB: 03/04/1974

Subjective

Patient ID:

Demo Patient 2 is a **52-year-old female** with a history of cystic fibrosis who underwent bilateral lung transplant on **December 13, 2022**. She is currently approximately **1258 days post-transplant** and presents today for evaluation and management of her lung allograft and immunosuppression.

Prior to transplant, the patient had advanced pulmonary disease with reduced functional capacity and required supplemental oxygen. Following transplant, she initially demonstrated good recovery with baseline FEV1 of 3.2 L and was able to maintain room air without oxygen support, reflecting satisfactory early allograft function.

Immunologically, the patient was CMV negative, EBV positive, HIV negative, and hepatitis B core antibody negative. There was no history of prior blood transfusions or significant additional pulmonary comorbidities prior to transplant. HLA mismatch assessment at transplant showed a total of 5 mismatches (A=2, B=1, DR=2).

The donor was a young individual with no significant infectious risk identified at the time of transplantation. Ischemic times for both lungs were within acceptable limits.

The post-transplant course has been largely stable initially, with gradual changes noted over time. The patient has experienced intermittent infectious episodes, including viral and bacterial infections, as well as a documented episode of mild acute cellular rejection (ACR), which was managed appropriately.

Interval History

At the previous follow-up, the patient had begun demonstrating a **gradual decline in pulmonary function**.

Since that time, she reports:

- Progressive shortness of breath, initially with exertion and now with reduced activity levels
- Decreased exercise tolerance

- Increasing fatigue

She now requires **3 L/min continuous supplemental oxygen**, representing a sustained increase from her prior baseline of no oxygen requirement.

She denies fever, acute respiratory infection symptoms, or recent hospitalizations. There are no new gastrointestinal complaints, and she reports stable glycemic control. No significant sinus-related symptoms are noted.

Overall, her clinical course is consistent with a **progressive decline pattern accompanied by functional deterioration**, rather than an acute decompensating event.

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• acetaminophen (TYLENOL) 500 mg Tablet	Take 500 mg by mouth every 6 (six) hours as needed		
azithromycin (ZITHROMAX) 250	Take 1 tablet 250MG by mouth every Monday, Wednesday, and Friday	39 Tablet	3
• carvediloL (COREG) 25 MG tablet	Take 1 tablet (25 mg total) by mouth 2 times daily	180 Tablet	3

• cholecalciferol (VITAMIN D3) 1,000 unit tablet	Take 3 tablets (3,000 Units total) by mouth once daily (Patient taking differently: Take 6,000 Units by mouth once daily)	270 tablet	3
• cyanocobalamin (VITAMIN B12) 1000 MCG tablet	TAKE 1 TABLET (1,000 MCG TOTAL) BY MOUTH ONCE DAILY. (Patient taking differently: Take 1,000 mcg by mouth once daily 12/06/21)	90 tablet	3
• FIASP PENFILL U-100 INSULIN 100 unit/mL (3 mL) Crtg	INJECT 15-20 UNITS INTO THE SKINS TIMES DAILY.		
• folic acid (FOLVITE) 1 MG tablet	Takei tablet(1,000 mcg total) by mouth once daily	90 tablet	2
• INSULIN DEGLUDEC (TRESIBA FLEXTOUCH U-100 SUBQ)	Inject 10 Units subcutaneously nightly		
• magnesium glycinate 400 mg tablet	Take 1,200 mg by mouth 2 (two) times daily at lunch and dinner.		
• metoclopramide (REGLAN) 5 MG tablet	Take 1 tablet (5 mg total) by mouth 2 (two) times daily with meals (Patient taking differently: Take 5 mg by mouth 2 (two) times daily with meals 12/6/2023: Using as needed)	60 tablet	11
• montelukast (SINGULAIR) 10 mg tablet	Take 1 tablet (10 mg total) by mouth at bedtime	90 tablet	3
• mycophenolate (CELLCEPT) 250 mg capsule	Take 4 capsules (1,000 mg total) by mouth every 12 (twelve) hours	720 capsule	2
• omeprazole (PRILOSEC) 20 MG DR capsule	TAKE 1 CAPSULE(20 MG) BY MOUTH EVERY DAY	90 capsule	3
• ondansetron (ZOFRAN) 4 MG tablet	Take 1 tablet (4 mg total) by mouth every 6 (six) hours as needed for Nausea or Vomiting	30 tablet	1
• pancrelipase (CREON) 24,000-76,000-120,000 unit DR capsule	Take 5 capsules by mouth 3 (three) times daily with meals And take 4 capsules with snacks		
• predniSONE (DELTASONE) 5 MG tablet	Take 1 tablet (5 mg total) by mouth once daily	90 tablet	3

• sulfamethoxazole-trim etho prim (BACTRIM SS) 400-80 mg tablet • tacrolimus (PROGRAF) 0.5 MG capsule	TAKE 1 TABLET ONCE DAILY Take two 1 mg caps (total 2mg) by mouth in the morning and one 1 mg cap with one 0.5mg cap (total 1.5mg) by mouth at night. 2/13/2023	90 tablet 90 capsule	3 3
• tacrolimus (PROGRAF) 1 MG capsule	Take two 1 mg caps (total 2mg) by mouth in the morning and one 1 mg cap with one 0.5mg cap (total 1.5mg) by mouth at night. 2/13/2023	270 capsule	3
• ursodioL(ACTIGALL) 300 mg capsule	Take 1 capsule (300 mg total) by mouth 2 (two) times daily	180 capsule	2
• clotrimazole (LOTRIMIN) 1 % cream	Apply 2-3 times daily for 2 weeks. (Patient not taking: Reported on 7/12/2023)	12 g	0
• pen needle, diabetic 32 gauge x 5/32" Ndle	Use. (Patient not taking: Reported on 6/28/2023)		

Objective

Vitals

BP 125/91 | Pulse 66 | Temp 36.5°C | Resp 18 | SpO_2 99% | BMI stable

Pulmonary Function Status

- **Baseline FEV1:** 3.2 L
- **Current FEV1:** 1.6 L (~50% decline)
- **Baseline Oxygen:** 0 L/min
- **Current Oxygen:** 3 L/min

Date	Days Post Tx	Clinic FEV1	Home FEV1	O_2 (L/min)	Rejection	Infection	Hospitalization
11/11/23	60	3.0	3.0	0	No	No	No
12/02/24	150	3.2	3.1	0	No	No	No
13/05/24	240	3.1	3.0	0	No	Yes - Viral	No
25/08/24	330	2.9	2.8	0	No	No	No
24/09/24	420	2.7	2.6	1	Yes - Mild ACR	No	No
21/02/25	510	2.5	2.4	1	No	No	No
15/05/25	600	2.3	2.2	2	No	Yes - Bacterial	Yes
12/08/25	690	2.2	2.1	2	No	No	No
17/09/25	780	2.0	1.9	2	No	Yes - Viral	No
11/02/26	870	1.9	1.8	3	No	No	No
14/05/26	958	1.8	1.7	3	No	No	No

Clinical Interpretation

- Sustained decline indicates **chronic graft dysfunction**
- Increasing oxygen need reflects **reduced pulmonary reserve**
- Combined findings indicate **progressive CLAD physiology**
- Risk model suggests **high likelihood of continued decline**

Plan

Chest x-ray personally reviewed.

Status post bilateral lung transplantation. Heart, bones, pleura, and mediastinum are unremarkable. However, lung fields demonstrate progressive hyperinflation and increased peribronchial markings compared to his early post-transplant baseline, consistent with severe chronic allograft dysfunction. No acute focal consolidation, but overall appearance reflects severe obstructive airway disease.

—Burkholderia cepacia/ PsA 1/11/23 A0B0—RATG in view of severe rapid PFT decline

CT chest (Recent):

1. No evidence of active mycobacterial infection.
2. Severe, diffuse air trapping and mosaic attenuation observed throughout bilateral lung fields on expiratory imaging, which are hallmark radiographic findings of advanced bronchiolitis obliterans.
3. Progressive bronchial wall thickening, mucus plugging, and new-onset bronchiectasis noted in the lower lobes. Appearance of these findings is significantly worsened relative to early comparison exams. Attention on strict airway clearance is recommended.

Assessment: Demo Patient 2 is a 39 y.o. female with a history of Cystic fibrosis who underwent bilateral lung transplant on 5/29/17. He comes to clinic today in a state of severe clinical decline, currently managing end-stage chronic allograft dysfunction. His clinical course is now characterized by intractable respiratory failure, a severe and fixed obstructive ventilatory defect, profound cachexia, and permanent dependency on high-flow continuous supplemental oxygen (4-5L).