**Narrative Summary**

On Month, DD, YYYY, XXXX presented to XXX XXXX, MD, XXX XXXX, PA, at ZZZZZZZ for consultation for aspiration pneumonia. He was diagnosed with Acute, chronic hypoxemic respiratory failure, on 60L per minute high flow Oxygen, Aspiration pneumonia, IV Zosyn, and Leukocytosis secondary to aspiration pneumonia. WBC 23.8 on admission, Hyponatremia. Na 134 on admission, Chronic dysphagia to solids with suprasternal globus sensation. x2 years, no odynophagia. SLP following for moderate oropharyngeal dysphagia. DDx includes esophageal stricture, history of tonsillar cancer status post chemo and radiation 2011 with last Oncologist visit 2016-Considered in remission

On Month, DD, YYYY, XXX XXXX, MD, performed upper GI endoscopy on XXXX at ZZZZZZ which revealed LA Grade C (One or more mucosal breaks continuous between tops of 2 or more mucosal folds, less than 75% circumference) esophagus was found at the gastroesophageal junction, biopsies were taken with a cold forceps for histology, several superficial esophageal ulcers were found in the mid and distal esophagus, ranging in shape from linear to oval, the largest lesion was 10 mm in largest dimension, multiple biopsies were taken with a cold forceps for histology and to stain for CMV. HSV, and Candida, a small hiatal hernia was present, patchy mild inflammation characterized by congestion (edema), erosions and erythema were found in the gastric body, random biopsies were taken from the gastric body and gastric antrum with a cold forceps, these biopsies were submitted for histology and Helicobacter pylori testing

On Month, DD, YYYY, at 1333 hours, XXXX had a discharge evaluation by XXX XXXX, MD, at ZZZZZZ. He was admitted with hypoxia after having vomiting and aspiration; his pulse ox dropped to the '80s, and needing 15lts O2; he was started on high-flow oxygen, he was started on Zosyn, Solumedrol, and Nebs; once his hypoxia improved, he had bronchoscopy done for clearing secretions and was found to have copious secretions, the clinical condition improved a lot after bronchial lavage, also had EGD done which showed multiple ulcerations in the esophagus and gastric body, Protonix bid was given, Zofran and Phenergan were given for nausea and vomiting, once he was tolerating per oral diet and pulse ox improved, he was considered for discharge

On Month, DD, YYYY, at 0659 hours, XXXX came to XXX XXX, M.D., XXXX XXX, P.A.at the emergency department of ZZZZZZZ for evaluation for shortness of breath, he typically wears oxygen at home, and he reports that when he woke up this morning his oxygen was accidentally torn out and he was not wearing it, felt short of breath. He reports feeling at baseline by the time he comes to the emergency department as his oxygen has been restored, given that he wears It 24/7; he is on his baseline oxygen at 97% on a 3 L nasal cannula, blood work reveals white blood count of 13.4 hemoglobin 12.6 hematocrits 37.5 BNP of 89 BUN of 27 creatinine of 0.7 COVID-19 test is negative chest x-ray reveals stable chronic changes, the above laboratory findings and diagnostic Imaging studies were discussed in great detail with the patient who verbalized understanding and wishes to be discharged at this time, Dr. XXXX has seen and examined the patient reviewed laboratory findings diagnostic imaging and agreed with the assessment plan and disposition, his medical record has been reviewed both In EMR as well as in portal. At the time of discharge, the patient Is nontoxic-appearing and hemodynamically stable as he Is afebrile, not tachycardic normotensive and not hypoxic with an oxygen saturation level of 97% on 3 L nasal cannula, provided with strict return instructions should there be any changes or worsening symptoms. He is diagnosed with COPD of mixed type, low O2 saturation, and shortness of breath

On Month, DD, YYYY, at 0427, XXXX was declared dead by ZZZZZZZ at his own home. He had natural death; immediate causes were aspiration pneumonia, respiratory failure, and COPD. An autopsy was not performed