RECORD #####

* Admission Date: [2004] Report Status: Signed

Discharge Date: [2004]

Attending: [PERSONS]

DISCHARGE DIAGNOSES:

Anemia , GI bleed and CHF exacerbation.

HISTORY OF PRESENT ILLNESS:

This patient is a [65.5] years old gentleman with multiple past cardiovascular medical issues including hypertension , diabetes , hypercholesterolemia , nonobstructive CAD on prior catheterization of 1993 and idiopathic cardiomyopathy with an ejection fraction reported at baseline from the [HOSPITAL] to be 45% , prior echocardiogram in Montsair [HOSPITAL] from 1994 reported at 25 to 30% , question alcoholic cardiomyopathy , atrial fibrillation. He is status post right MCA CVA while on Coumadin for atrial fibrillation and peripheral vascular disease , history of GI bleed who presented with increased shortness of breath and cough x several weeks. He noted initial shortness of breath and nonproductive cough in the end of 6/4 with a question infiltrate on chest film at that time and the patient was treated with a 10-day course of antibiotics of unknown content question levofloxacin with no improvement. Since late 6/4 , the patient reports progressive shortness of breath , dyspnea on exertion particularly with ambulation of steps and when lying down. Additionally , the patient reports a vague band like pain discomfort over left anterior chest particularly associated with ambulation of steps and when lying supine. Chest pain is associated with shortness of breath , but denies lightheadedness , diaphoresis or recent nausea and vomiting. Symptoms of chest pain and shortness of breath are notably worse over the last one to two weeks through the patient reports resolution over the last 24 hours with question of a new medication that he is unable recall. He denies palpitation or raising heart rate. He does report orthopnea , denies PND , but does report intermittent lower extremity swelling. He denies hematochezia , bright red blood per rectum , hematemesis with question of melanotic stools over the last month. The patient also with a history of prior GI bleed while in Lan , West Virginia 39586 several years prior for which he was transfused 4 units of packed red blood cells. EGD colonoscopy at that time revealed both upper and lower GI lesions including several small AVM and diverticulosis. Additionally , upper GI endoscopy performed at that time revealed duodenitis.

The patient was seen in a Pleaermount Medical Center today reportedly in atrial fibrillation and atrial flutter. He had previously been reported to be in this abnormal rhtyhm that converted to normal sinus rhythm while on amiodarone. He was noted to have rapid ventricular response in 120s. He had appeared pale. Hematocrit obtained at that time reportedly 21.4 and the patient was admitted to the Nipaul Ingways [HOSPITAL] for further evaluation.

REVIEW OF SYSTEMS:

Of note , review of systems is positive for recent chills , no

fevers , reports intermittent productive cough and weakness and fatigue. No weight loss over the last six months.

PAST MEDICAL HISTORY:

As given , hypertension , diabetes , hypercholesterolemia , nonobstructive CAD on prior catheterization in 1993 , IDCM with EF of 30 to 45% , question alcoholic cardiomyopathy , atrial fibrillation on Coumadin , right MCA CVA in 1999 , PVD , peptic ulcer disease , history of GI bleed with duodenitis , diverticulitis and AVM and right hand partial hemiparesis and depression.

MEDICATIONS ON ADMISSION:

1. Amiodarone 200 mg p.o. q.d.
2. Lasix 80 mg p.o. q.d.
3. Digoxin 0.25 mg p.o. q.d.
4. Niacin 750 mg p.o. b.i.d.
5. Amitriptyline 50 mg p.o. q.day.
6. Folate B6.
7. Prilosec 20 mg p.o. b.i.d.
8. Avandia 4 mg p.o. b.i.d.
9. Valsartan 160 mg p.o. q.day.
10. Nifedipine 90 mg p.o. q.day.
11. Hydrochlorothiazide 25 mg p.o. q.d.
12. Bisoprolol 5 mg p.o. q.d.
13. Glucophage 500 mg b.i.d.
14. Gemfibrozil 600 mg p.o. q.day.
15. Zoloft 50 mg p.o. q.d.
16. Ambien 10 mg q.h.s.
17. Coumadin as needed.
18. Lisinopril 40 mg p.o. q.d.

ALLERGIES:

Reported isosorbide resulting in headache , amlodipine lower extremity edema , Lopressor erectile dysfunction and Viagra , which reportedly does not work for the patient.

SOCIAL HISTORY:

The patient has a 50-pack-year smoking history , continues to smoke several cigarettes a day. Past alcohol abuse though the patient reports no alcohol in the last 20 years. The patient currently lives with his girlfriend of [45.5] years and is local to O Lasmerflinteans Louis

FAMILY HISTORY:

Family history is noncontributory. No history of a sudden cardiac death.

PHYSICAL EXAMINATION:

Vital signs on admission include a temperature of 98 , heart rate of 112 , blood pressure 168/90 , respiratory rate 20 93% on room air. He was in no acute distress though the patient was seen to be in shortness of breath when lying at 20 to 30 degrees. JVP on admission 12 to 15 cm of water , difficult to assess given habitus. The patient additionally with bibasilar rales , one-third to one-half up with poor air movement. No egophony or consolidation was appreciated. Abdominal exam was unremarkable. Lower extremities were warm and well perfused. He was able to move all extremities , 4/5 strength in his right hand. He had

positive peripheral pulses and 1+ lower extremity edema , left greater than right to mid calf.

LABORATORY DATA:

Laboratory values on admission are significant for creatinine of 1.8 of unknown baseline and glucose of 192. LFTs were within normal limit. White count of 8.7 , hematocrit of 21.4 , down from baseline of 30 to 35 and platelets of 351 , 000. MCV on hematocrit was 84.

EKG on admission showed irregularly regular rhythm at 120 likely atrial fibrillation versus atrial flutter with variable block , ST segment depression laterally in V5 through V6 , question demand ischemia versus digoxin effect , left bundle branch block which is reportedly the patient's baseline. Chest film with vascular prominence at the hilum bilaterally , question mass infiltrate over left lower lobe with no overt effusions.

ASSESSMENT:

The patient is a [65.5] years old gentleman with extensive past cardiac and otherwise medical history presenting to the Mahunt Medical Center with CHF exacerbation , anemia with question GI bleed with hematocrit in the 20s and question community-acquired pneumonia.

HOSPITAL COURSE BY SYSTEMS:

1. Cardiovascular: The patient with no evidence of acute coronary syndrome. On admission , the patient was noted to be in a rapid ventricular response at 120 and with CHF exacerbation. The patient initially with complaint of chest pressure , which was concerning for demand ischemia in the setting significant anemia with increased heart rate and known ventricular dysfunction. Cardiac enzymes were drawn and serially were elevated with a peak troponin I of 4. Subsequent serial cardiac enzymes resolved to baseline values. The patient was initially started on heparin IV drip for concern for unstable plaque , but following consultation with [DOCTOR] in Cardiology , it was recommended anticoagulation be stopped secondary to recent GI bleed and low concern for acute coronary syndrome versus demand ischemia. Additionally , the patient was rate controlled with IV following p.o. Lopressor , digoxin and amiodarone. Additionally , the patient's ACE inhibitor was continued and titrated up to lisinopril 40. The patient was initially diuresed given significant volume overload with IV Lasix with diuresis of 4 to 8 liters over the hospital course. Echocardiogram obtained during decompensated episode revealed EF of 25 to 30% with global hypokinesis and septal akinesis , was significantly altered from prior echocardiogram of [2003]obtained at the Wellcamp University Of Medical Center which had revealed an EF of 40 to 45% with mild global HK. However , of note , this echocardiogram was similar to prior echocardiogram in Alehealtdana [HOSPITAL] system from 1994 with no additional wall motion abnormalities. The patient's cardiovascular issues felt to stem secondary to anemia in the setting of increased ventricular response and tachycardia , which led to demand ischemia and subsequent troponin leak causing decompensated CHF. The patient's symptomatology resolved with proper rate control and resuscitation with IV fluids and blood. The patient's heart rate was well controlled in the 60s to 70s and following IV

diuresis , the patient's CHF symptomatology resolved. At the time of discharge , the patient was ambulating without difficulty with no oxygen requirement. The patient was transitioned to all p.o. regimen.

2. Heme: The patient with recent GI bleed with known both upper and lower GI lesions including AVM and diverticulosis for which the patient has been previously treated. The patient's hematocrit on admission 21.4. The patient received 4 units of packed red blood cells to stable hematocrit of 29 to 30 x 72 hours. In addition , the patient was never hemodynamically unstable during admission. GI bleed felt to be a precipitating etiology. The patient was seen by the GI Service , was recommended further outpatient evaluation and upper and lower GI endoscopy evaluation as required. The patient to follow up with [DOCTOR] in the Erpin Medical Center and outpatient EGD and colonoscopy to be scheduled for the next week or two to further evaluate. At the time of discharge , the patient's hematocrit stable at 29 , no evidence of active GI bleed present. Additionally , the patient initially held on Coumadin giving concern for ongoing GI bleed and following stable transfusion , the patient's Coumadin was restarted at initially 5 and then later 3 mg p.o. q.h.s. with INR goal of 2.8. To be further evaluated as outpatient and INR to be checked on [2004]in [DOCTOR] office and titration of Coumadin as required.

3. GI: As mentioned prior , the patient with GI bleed , thought to be precipitating etiology of the patient's current hospitalization. The patient maintained on IV Protonix b.i.d. and transitioned to p.o. Prilosec 40 mg p.o. b.i.d. As mentioned , prior to GI consult , the patient will receive the outpatient evaluation with EGD and colonoscopy as required for further management.

4. Pulmonary: The patient with history of productive cough , fevers , chills. On admission , previously treated with course of antibiotics , presumably Levaquin for presumed community-acquired pneumonia giving ongoing symptomatology , the patient treated initially with IV antibiotics including ceftriaxone and azithromycin transitioned to cefpodoxime and azithromycin. The patient to complete full 10-day course of antibiotics for presumed community-acquired pneumonia. At the time of discharge , the patient afebrile , ambulating without difficulty , no dyspnea on exertion and O2 saturation 95% on room air.

5. Psychiatry: The patient with long tobacco history given extensive cardiovascular status , the patient received addiction consultation regarding tobacco cessation. Following consultation , the patient showing good promise regarding tobacco cessation. He has expressed interest in doing so. As such , the patient's antianxiety and depression medications have been altered. The patient to decrease Zoloft to 25 mg p.o. q.d. from 50 and to continue that for seven days , following which time , he should discontinue his Zoloft. Additionally , the patient started on Wellbutrin initially 150 mg p.o. q.d. x seven days , to transition up to b.i.d. as tolerated within seven days time as Zoloft is discontinued , recommend further outpatient evaluation as needed. The patient with several episodes of sundowning

during his hospital course , treated with Haldol with no further incidents.

6. Endocrine: The patient with known diabetes , maintained on Regular Insulin sliding scale with good blood sugar control. The patient to continue on outpatient regimen of Avandia and Glucophage. The patient may require additional anti-glycemic medications in future as necessary.

7. Renal: The patient with chronicrenal insufficiency on admission with a creatinine of 1.8 presumed baseline. At the time of discharge , the patient's creatinine had resolved to 1.3 , thought to be secondary to cardiorenal syndrome in the setting of acute CHF decompensation , recommend further outpatient management evaluation. The patient to follow up with [DOCTOR] in the Lumspe Black Healthcare on [2004]at 1:00 p.m. at which time , recommend further evaluation of hematocrit , INR , electrolyte as required.

DISCHARGE MEDICATIONS:

1. Enteric-coated aspirin 81 mg p.o. q.day.
2. Amiodarone 200 mg p.o. q.day.
3. Lasix 80 mg p q.day.
4. Digoxin 0.25 mg p.o. q.day.
5. Niacin SR 750 mg p.o. b.i.d.
6. Amitriptyline 50 mg p.o. q.day.
7. Folate B6.
8. Prilosec 40 mg p.o. b.i.d. up from 20 mg p.o. b.i.d.
9. Avandia 4 mg p.o. b.i.d.
10. Hold valsartan.
11. Hold nifedipine.
12. Hydrochlorothiazide 12.5 mg p.o. q.d. down from 25 mg q.day.
13. Hold bisoprolol , instead substitute Toprol XL 100 mg p.o. q.day.
14. Glucophage 500 mg p.o. b.i.d.
15. Gemfibrozil 600 mg p.o. q.day.
16. Zoloft 25 mg p.o. q.day x seven days after which time it should be discontinued.
17. Ambien 10 mg q.h.s.
18. Coumadin 3 mg to be titrated outpatient.
19. Lisinopril 40 mg q.day.
20. Wellbutrin SR 150 mg q.day. x seven days after which time it should be increased to b.i.d.
21. Amitriptyline 50 mg q.h.s.
22. Nitroglycerin p.r.n.
23. K-Dur 20 mEq q.day.
24. Azithromycin 500 mg p.o. b.i.d. x five days.
25. Cefpodoxime 200 mg p.o. b.i.d. x five days.

As mentioned prior , at the time of discharge , the patient afebrile and vital signs stable. The patient ambulating without difficulty and feeling at baseline. The patient's O2 saturation is greater than 95% with ambulation. The patient is to follow up with [DOCTOR] in the Bridplacechael's [HOSPITAL] with further outpatient evaluation for GI bleed as potential source of anemia as well as further cardiac work up including cardiac catheterization at a later time given troponin leak in the setting of demand ischemia. The patient was transitioned to all

p.o. regimen.

eScription document: ******

Dictated By: [DOCTORS]

Attending: [PERSONS]

Dictation ID ********

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