Note ID: 13180007-DS-20

Subject ID: 13180007

HADM ID: 27543152

Storetime: 26/06/62 22:13

Name: ___ Unit No: ___

Admission Date: ___ Discharge Date: ___

Date of Birth: ___ Sex: M

Service: MEDICINE

Allergies:

No Known Allergies / Adverse Drug Reactions

Attending: ___.

Major Surgical or Invasive Procedure:

Intubation ___

Extubation ___

attach

Pertinent Results:

ADMISSION LABS:

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___ 06:35AM BLOOD WBC-5.4 RBC-2.92* Hgb-7.6* Hct-24.3*

MCV-83 MCH-26.0 MCHC-31.3* RDW-15.9* RDWSD-47.8* Plt ___

___ 06:35AM BLOOD Glucose-164* UreaN-51* Creat-2.9* Na-140

K-4.6 Cl-99 HCO3-25 AnGap-16

___ 02:45AM BLOOD ALT-15 AST-24 AlkPhos-115 TotBili-0.2

___ 06:35AM BLOOD Calcium-8.4 Phos-6.0* Mg-2.1

___ 03:45AM BLOOD Beta-OH-<0.2

___ 02:45AM BLOOD ASA-NEG Ethanol-NEG Acetmnp-NEG

Tricycl-NEG

___ 02:54AM BLOOD ___ pO2-99 pCO2-62* pH-7.19*

calTCO2-25 Base XS--5 Intubat-INTUBATED

___ 03:53AM BLOOD Glucose-468* Creat-3.9* Na-132* K-6.2*

Cl-95* calHCO3-26

___ 03:53AM BLOOD Hgb-8.1* calcHCT-24 O2 Sat-52

___ 04:34AM BLOOD O2 Sat-93

___ 08:27AM BLOOD Lactate-0.9 K-4.8

DISCHARGE LABS:

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___ 06:38AM BLOOD WBC-4.9 RBC-3.20* Hgb-8.4* Hct-26.8*

MCV-84 MCH-26.3 MCHC-31.3* RDW-15.9* RDWSD-49.1* Plt ___

___ 06:38AM BLOOD Glucose-125* UreaN-62* Creat-2.7* Na-138

K-4.4 Cl-97 HCO3-27 AnGap-14

___ 06:38AM BLOOD Calcium-8.7 Phos-5.6* Mg-2.1

MICRO:

=====

___ 3:30 am BLOOD CULTURE

**FINAL REPORT ___

Blood Culture, Routine (Final ___: NO GROWTH.

IMAGING:

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___ (PORTABLE AP)

IMPRESSION:

1. The endotracheal tube terminates approximately 2 cm from the carina and should be pulled back about 2 cm..

2. Mild cardiomegaly and mild pulmonary vascular congestion.

3. Mild bibasilar atelectasis.

___ HEAD W/O CONTRAST

IMPRESSION:

No acute intracranial abnormality.

Age advanced generalized volume loss.

Pontine atrophy could be due to multiple chronic infarcts demonstrated on previous MRI, but neuro degenerative process is also in the imaging differential.

___ (PORTABLE AP)

IMPRESSION:

In comparison with the study of earlier in this date, the

endotracheal tube

has been pulled back so that the tip now lies approximately 5 cm

above the

carina. Cardiomediastinal silhouette is stable. The vascular

congestion

suggested previously is no longer appreciated.

Brief Hospital Course:

___ year old male w history of diastolic CHF, diabetes type 2

recent admission for CHF exacerbation, re-admitted ___

with hyperglycemia and respiratory distress requiring

intubation, status post treatment of acute diastolic CHF,

subsequently optimizing glucose control, able to be discharged

home with ___ for medication assistance.

TRANSITIONAL ISSUES:

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[ ] Will need repeat Cr at his ___ appointment on ___,

___, to ensure stability.

[ ] Repeat CMP within 1 week of discharge, to ensure stability

in electrolytes

[ ] Patient has now had multiple presentations the hospital with

both hypo-and hyperglycemia; very close follow-up with his PCP and with ___ will be important to ensure that he is on the most appropriate insulin regimen going forward. He did meet with a diabetes educator while he was hospitalized, and ___ made some changes to his home insulin regimen.

[ ] Patient was set up with new home ___, to assist with administering medications (in particular, insulin injections), at home. Family raised many concerns that the patient was not safely taking and managing his medications at home, continue to address these issues in the outpatient setting.

[ ] Consider repeat TTE in the outpatient setting

Discharge Weight: 72.3 kg (159.4 lbs)

Discharge Creatinine: 2.7

ACUTE ISSUES:

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Acute respiratory failure secondary to

Acute on chronic diastolic CHF

Patient admitted with acute respiratory failure and severe hyperglycemia (see below). He developed dyspnea at home--suspect this was in part due to acidosis from hyperglycemia as well as flash pulmomary edema. Patient was intubated in the field and admitted to ICU. Admission CXR showed B/L vascular congestion worse from prior CXR and elevated BNP. Hyperglycemia treated as below. For acute diastolic CHF, trigger was suspected to be

incomplete diuresis during prior admission. He was diuresed with IV Lasix, extubated, and transferred to medical floors, where he was diuresed to euvolemia (159lbs). Transitioned to 100 mg PO torsemide. Discharged home on this regimen.

___ on CKD

Patient's reported recent Cr baseline was 1.8-2.2; on presentation, was 3.8. Creatinine down trended with diuresis, suggesting that he most likely had a cardiorenal etiology. However, on ___, his creatinine plateaued in the 2.6-2.7 range, and he was euvolemic on exam. Suspect this may be new baseline after 2 recent acute illnesses, or may represent ATN that may take ___ months to recover back to baseline. Instructed patient to have repeat Cr check on ___ to ensure stability.

T2DM with Hyperglycemia and acidosis

Admitted with a BG>500 with a pH of 7.19 with a bicarbonate of 21 He was treated with insulin with improvement. He was seen by ___ endocrinology consult team with subsequent titration of his home 70/30 insulin regimen. He also met with ___ diabetes educator, to help with safe injection of his insulin. To address medication safety, he was also arranged for home ___ service

Hypertension

His home blood pressure medications were initially held when he was admitted to ICU, but this his blood pressures returned to baseline, his home amlodipine, carvedilol, and minoxidil were all restarted.

Hypothyroid: Continued home levothyroxine

Hx CVA: Continued home aspirin, statin

Chronic Anemia:
Patient has chronic anemia that remained stable over the course of this hospitalization. In his recent auscultation, he was given a dose of ferric gluconate; per transitional issues from prior hospitalization, he was given a second dose of ferric gluconate on ___.

CORE MEASURES
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#CODE STATUS: Full Code
#CONTACT: Daughter ___, 3 ___

> 30 minutes spent on discharge

Medications on Admission:
The Preadmission Medication list is accurate and complete.
1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath

2. amLODIPine 10 mg PO DAILY

3. Atorvastatin 80 mg PO QPM

4. Minoxidil 10 mg PO DAILY

5. CARVedilol 50 mg PO BID

6. Levothyroxine Sodium 100 mcg PO DAILY

7. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First

Line

8. sevelamer CARBONATE 800 mg PO TID W/MEALS

9. Vitamin D 1000 UNIT PO DAILY

10. Torsemide 100 mg PO DAILY

11. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL)

subcutaneous DAILY

12. 70/30 30 Units Breakfast

70/30 10 Units Lunch

13. Aspirin 81 mg PO DAILY

Discharge Medications:

1. Acetaminophen 650 mg PO Q6H:PRN Pain - Mild/Fever

2. 70/30 30 Units Breakfast

70/30 20 Units Dinner

3. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath

4. amLODIPine 10 mg PO DAILY

5. Aspirin 81 mg PO DAILY

6. Atorvastatin 80 mg PO QPM

7. CARVedilol 50 mg PO BID

8. Levothyroxine Sodium 100 mcg PO DAILY

9. Minoxidil 10 mg PO DAILY

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11. sevelamer CARBONATE 800 mg PO TID W/MEALS

12. Torsemide 100 mg PO DAILY

13. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY

14. Vitamin D 1000 UNIT PO DAILY

Discharge Disposition:

Home With Service

Facility:

___

Discharge Diagnosis:

PRIMARY DIAGNSOIS:

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Acute Hypoxemic Respiratory Failure

Acute on Chronic Diastolic Heart Failure

Hyperglycemia, Type 2 Diabetes

___ on CKD

SECONDARY DIAGNOSIS:

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Hypertension

Discharge Condition:

Level of Consciousness: Alert and interactive.

Activity Status: Ambulatory - Independent.

Mental Status: Confused - sometimes.

Discharge Instructions:

Dear ___,

It was a pleasure caring for you at ___

___.

WHY WAS I IN THE HOSPITAL?

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- You were feeling very short of breath, and were having trouble

breathing.

WHAT HAPPENED TO ME IN THE HOSPITAL?

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- You had a breathing tube placed to help maintain your

oxygenation, and was admitted to the ICU.

- You had extremely high blood sugars, and was started on an

insulin drip

-You rapidly improved with insulin and diabetic medications, and your breathing tube was successfully removed.

- You were transferred from the ICU to the general medicine floor, and we continued to titrate your insulin regimen and your diuretic regimen.

- A diabetes nurse educator came to help teach you how to safely inject herself with insulin.

WHAT SHOULD I DO AFTER I LEAVE THE HOSPITAL?

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- Continue to take all your medicines and keep your appointments.

- We have set you up with additional home services, to help you manage your medications safely at home.

- Weigh yourself every morning, and call your primary care physician if your weight goes up more than 3 lbs.

- Please make sure you get repeat bloodwork checked at your ___ appointment on ___.

We wish you the best!

Sincerely,

Your ___ Team

Followup Instructions:

___