Note ID: 13180007-DS-19

Subject ID: 13180007

HADM ID: 20774429

Storetime: 21/06/62 9:56

Name: ___ Unit No: ___

Admission Date: ___ Discharge Date: ___

Date of Birth: ___ Sex: M

Service: MEDICINE

Allergies:

No Known Allergies / Adverse Drug Reactions

Attending: ___.

Chief Complaint:

dyspnea, chest pain

Major Surgical or Invasive Procedure:

None

History of Present Illness:

___ male with history of HFpEF (EF 55-60% in ___,

prior CVA, CKD, DM, hypertension, and carotid artery disease presenting with two days of dyspnea on exertion and chest discomfort on exertion. He was recently discharged from home cardiac telehealth. He has been unable to weigh himself at home as he does not have a scale. He does endorse worsening lower extremity edema and wheeze. He has had two hospitalizations over the past year for HF exacerbations resulting in admission to the ___ service. He is typically on Lasix 80mg daily and endorses compliance with his medications.

In the ED:

Initial VS: T 98.5, HR 102, BP 178/76, RR 22, SpO2 98% RA

Exam:

General- NAD

HEENT- PERRL, EOMI, normal oropharynx

Lungs- Non-labored breathing, CTAB

CV- RRR, systolic murmur, normal S1, S2

Abd- Soft, nontender, nondistended, no guarding, rebound or masses

Msk- No spine tenderness, moving all 4 extremities, 2+ edema

Neuro-A&O x3, CN ___ intact, normal strength and sensation in all extremities, normal speech and gait.

Skin- No rash

Psych- Normal mood and affect

EKG: TWI in lateral leads

Labs notable for:

-Hgb 7.4

-Chem: BUN 39, Cr 2.6

-proBNP: 784

-TropT: 0.03

Medications: received IV Lasix 80mg

Studies notable for:

-CXR: Mild pulmonary vascular congestion with small bilateral

pleural effusions, left greater than right.

Vitals on transfer: T 97.3, HR 88, BP 120/54, RR 18, SpO2 98% RA

On the medical ward, patient endorses story above. He reports

his

shortness of breath improved with IV Lasix. He denies chest

pain,

orthopnea, PND, abdominal discomfort, nausea, vomiting, change

in

bowel habit or other concerning symptoms.

REVIEW OF SYSTEMS:

10-point review of systems is negative except as noted above.

Past Medical History:

1. Hypertension.

2. Dyslipidemia.

3. Diabetes mellitus type 2.

4. Cerebrovascular disease, status post CVA in ___.

5. Extensive intracranial atherosclerosis, worse in the right MCA territory.

6. Carotid artery disease.

7. Secundum ASD.

8. Mild AR.

9. Osteoarthritis.

10. Asthma.

Social History:

___

Family History:

His parents have heart disease. Mother is ___ with heart problems and diabetes. Father, ___, with diabetes. He has 16 brothers and sisters. There is no known history of early coronary artery disease or sudden cardiac death.

Physical Exam:

ADMISSION PHYSICAL EXAM

==========

VS:

24 HR Data (last updated ___ @ 1654)

Temp: 97.8 (Tm 97.8), BP: 144/69, HR: 86, RR: 18, O2 sat: 96%, O2 delivery: Ra

GENERAL: NAD. Oriented x3. Mood, affect appropriate.

HEENT: Normocephalic atraumatic. Sclera anicteric. PERRL. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma.

NECK: JVP of 13 cm.

CARDIAC: PMI located in ___ intercostal space, midclavicular line. Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. no thrills or lifts.

LUNGS: No chest wall deformities or tenderness. Respiration is unlabored with no accessory muscle use. No crackles, wheezes or rhonchi.

ABDOMEN: Soft, non-tender, non-distended. No hepatomegaly. No splenomegaly.

EXTREMITIES: Warm, well perfused. No clubbing, cyanosis, or peripheral edema.

SKIN: No significant skin lesions or rashes.

PULSES: Distal pulses palpable and symmetric.

DISCHARGE PHYSICAL EXAM

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GENERAL: NAD. Mood, affect appropriate.

HEENT: Normocephalic atraumatic. Sclera anicteric. EOMI.

Conjunctiva were pink. No pallor or cyanosis of the oral mucosa.

No xanthelasma.

NECK: JVP 12 cm

CARDIAC: Regular rate and rhythm. Normal S1, S2. No murmurs,

rubs, or gallops.

LUNGS: No chest wall deformities or tenderness. Respiration is

unlabored with no accessory muscle use. No crackles, wheezes or

rhonchi.

ABDOMEN: Soft, non-tender, non-distended.

EXTREMITIES: Warm, well perfused. ___ lower extremity edema to

ankles L>R

SKIN: No significant skin lesions or rashes.

Pertinent Results:

ADMISSION LABS

==========

___ 09:01AM BLOOD WBC-4.8 RBC-2.88* Hgb-7.4* Hct-24.0*

MCV-83 MCH-25.7* MCHC-30.8* RDW-16.1* RDWSD-48.5* Plt ___

___ 09:01AM BLOOD Neuts-78.5* Lymphs-12.1* Monos-7.5

Eos-1.3 Baso-0.4 Im ___ AbsNeut-3.75 AbsLymp-0.58*

AbsMono-0.36 AbsEos-0.06 AbsBaso-0.02

___ 05:53AM BLOOD ___ PTT-32.1 ___

___ 09:01AM BLOOD Glucose-287* UreaN-39* Creat-2.6* Na-139
K-4.7 Cl-102 HCO3-24 AnGap-13

___ 02:28PM BLOOD CK(CPK)-257

___ 05:53AM BLOOD ALT-9 AST-13 AlkPhos-100 TotBili-0.3

___ 09:01AM BLOOD cTropnT-0.03*

___ 02:28PM BLOOD cTropnT-0.03*

___ 07:35PM BLOOD CK-MB-4 cTropnT-0.03*

___ 09:01AM BLOOD CK-MB-4 proBNP-784*

___ 05:53AM BLOOD Calcium-8.4 Phos-4.9* Mg-2.0 Iron-28*

___ 05:53AM BLOOD calTIBC-294 Ferritn-73 TRF-226

___ 05:53AM BLOOD %HbA1c-11.4* eAG-280*

___ 05:53AM BLOOD TSH-4.4*

PERTINENT STUDIES/RESULTS

==========

___

CONCLUSION:

The left atrial volume index is normal. The estimated right
atrial pressure is ___ mmHg. There is mild
symmetric left ventricular hypertrophy with a normal cavity
size. There is normal regional and global
left ventricular systolic function. The visually estimated left
ventricular ejection fraction is 65%.
There is no resting left ventricular outflow tract gradient.

Tissue Doppler suggests an increased left
ventricular filling pressure (PCWP greater than 18 mmHg). There
is echocardiographic evidence for
diastolic dysfunction (grade indeterminate). Normal right
ventricular cavity size with normal free wall
motion. The aortic sinus diameter is normal for gender with a
normal ascending aorta diameter for
gender. The aortic arch diameter is normal. The aortic valve
leaflets (3) are mildly thickened. There is no
aortic valve stenosis. There is no aortic regurgitation. The
mitral valve leaflets are mildly thickened with
no mitral valve prolapse. There is trivial mitral regurgitation.
The pulmonic valve leaflets are normal.
The tricuspid valve leaflets appear structurally normal. There
is physiologic tricuspid regurgitation. The
estimated pulmonary artery systolic pressure is normal. There is
a small pericardial effusion. There is
increased respiratory variation in transmitral/transtricuspid
inflow but no right atrial/right ventricular
diastolic collapse.
IMPRESSION: Suboptimal image quality. Stiff left ventricle.
Small pericardial effusion. No frank
tamponade.

DISCHARGE LABS
==========

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

Brief Hospital Course:
SUMMARY
=======
___ male with history of HFpEF (EF 55-60% in ___,
prior CVA, CKD, DM, hypertension, and carotid artery disease
who presented with 1 day of dyspnea and discomfort, and was
admitted for HF exacerbation. The trigger was unclear, possible
medication non-compliance. He was diuresed with several doses of
IV Lasix 80 and by time of discharge symptoms had improved. He
was still slightly volume up on exam, with JVP ~12 and 1+ edema
to ankles.

TRANSITIONAL ISSUES
==========
[ ] At discharge his symptoms associated with volume overload
had subsided, but he was still slightly volume up on exam with
1+ edema to ankles bilaterally and JVP of 12cm. He is being
discharged on torsemide 100 daily for active diuresis, with
about 3lb of fluid still left to lose.

[ ] He should have follow up labs drawn on ___. His Cr
was still elevated on day of discharge to 2.9 (baseline
2.0-2.2).
[ ] Consider completing the 4 day course of ferric gluconate
which was started during this admission. He received ferric
gluconate 250 mg IV on ___, and ___. Consider one
additional infusion of ferric gluconate 250 mg IV.

Discharge weight: 166.6lb
Discharge Cr: 2.9
Discharge diuretic: torsemide 100mg daily

ACUTE PROBLEMS
==========
Acute on chronic HFpEF:
Patient presented with dyspnea and lower extremity edema and
found to be volume overloaded on exam. Warm and wet on exam.
Trigger for HF exacerbation unclear. Patient reports compliance
with medications but has reported non-compliance in the past.
C/o
chest pain with mild troponin elevation (0.03 seems to be at or
lower than levels checked in prior months this year in setting
of
CKD). No evidence of dietary indiscretion. TTE was performed
which showed EF 65% and diastolic dysfunction. Iron studies
showed ferritin 73 and TIBC 294, and he was started on ferric

gluconate (received 3 doses ___. Upon review of recent outpatient visit notes, it appears his volume exam is similar to baseline, and patient was asymptomatic during hospital course. He was diuresed effectively with IV Lasix 80. He was transitioned to PO torsemide 100. His BP was well controlled with regimen as described below.

Chest pain:
No known history of CAD. Presented with chest pain and mild troponin elevation with flat CK-MB. As noted above, troponin elevation difficult to interpret in setting of CKD, and appears at or lower than levels earlier this year. He has denied chest pain during admission. He does have risk factors for ischemia and
has not had stress since ___. However, findings and history to
date are not suggestive of ischemia and he has an ___. TTE did not show evidence of focal wall motion abnormalities or other findings suggestive of ischemia, so further workup was not pursued. He was continued on ASA and atorvastatin.

___ on CKD:
Cr elevated to 2.6 on admission from baseline of 1.8-2.2. Given evidence of congestion elsewhere, concerns for renal congestion causing renal dysfunction. Cr remained stable and was 2.9 on day of discharge. He was continued on home sevelamer.

Hypertension:

History of hypertension, currently well controlled. He was warm on exam. He was continued on home amlodipine 10, Coreg 50 BID and minoxidil 10 daily.

Acute on chronic anemia:

Hb on admission was 7.4. No evidence of bleeding per history or exam. Possibly related to worsening of his renal function vs dilutional iso heart failure. His Hb was 7.6 on discharge. He received 3 doses of ferric gluconate 250 mg IV on ___.

#IDDM

Poorly controlled. A1c 14.4 in ___ in ___ at ___.

Repeat A1C ___ was 11.4%. He was given Lantus 30u night of admission, then transitioned to home insulin ___ with 70/30 30u with breakfast and 20u with lunch. He was also on ISS while inpatient.

CHRONIC PROBLEMS

==========

#Hypothyroidism

He was continued on home levothyroxine 100mcg daily.

#History of CVA

He was continued on home aspirin and atorvastatin 80.

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. CARVedilol 50 mg PO BID

5. Furosemide 80 mg PO DAILY

6. 70/30 30 Units Breakfast

70/30 10 Units Lunch

7. Levothyroxine Sodium 100 mcg PO DAILY

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

subcutaneous DAILY

9. Minoxidil 10 mg PO DAILY

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

Line

11. sevelamer CARBONATE 800 mg PO TID W/MEALS

12. Aspirin 81 mg PO DAILY

13. Vitamin D 1000 UNIT PO DAILY

Discharge Medications:

1. Torsemide 100 mg PO DAILY

RX *torsemide 20 mg 5 tablet(s) by mouth once a day Disp #*70

Tablet Refills:*0

2. 70/30 30 Units Breakfast

70/30 10 Units Lunch

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

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

11. sevelamer CARBONATE 800 mg PO TID W/MEALS

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

13. Vitamin D 1000 UNIT PO DAILY

Discharge Disposition:

Home With Service

Facility:

___

Discharge Diagnosis:

Primary Diagnosis:

-Acute on chronic diastolic heart failure exacerbation

Secondary Diagnosis:

-acute kidney injury

-acute on chronic anemia

-type 2 diabetes mellitus

Discharge Condition:

Mental Status: Clear and coherent.

Level of Consciousness: Alert and interactive.

Activity Status: Ambulatory - Independent.

Discharge Instructions:

Dear ___,

It was a pleasure taking care of you at ___

___.

WHY WAS I ADMITTED TO THE HOSPITAL?

You were having swelling in your legs because of fluid accumulation in your body. This was caused by a condition called heart failure, where your heart does not pump hard enough and fluid builds up.

WHAT HAPPENED WHILE I WAS IN THE HOSPITAL?

You were given medications to help get the fluid out. Your symptoms got better and were ready to leave the hospital.

WHAT DO YOU NEED TO DO WHEN YOU LEAVE THE HOSPITAL?

- Take all of your medications as prescribed (listed below)

- Follow up with your doctors as listed below

- Weigh yourself every morning. Your weight on discharge is 166.7 pounds. Call your doctor if your weight goes up or down more than 3 pounds (increases to a weight of 170 pounds) in one day or 5 lb in one week.

- Call you doctor if you notice any of the "danger signs" below.

We wish you the best!

Your ___ Care Team

Followup Instructions:

___