Patient Information:

Patient ID: 13180007

HADM ID: 20774429

Note ID: 13180007-DS-19

Note Type: DS

Note Seq: 19

Chart Time: 20/06/62 0:00

Store Time: 21/06/62 9:56

Full Notes:

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 ========== 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: ___

Processed Data:

['Name', 'Admission Date', 'Discharge Date', 'Date of Birth', 'Service', 'Allergies', 'Attending', 'Chief Complaint', 'Major Surgical or Invasive Procedure', 'History of Present Illness', 'In the ED:', 'Exam', 'Laboratory Data', 'Lungs:', 'Abdomen:', 'Msk:', 'Neuro:', 'Skin:', 'Pertinent Results:', 'ADMISSION LABS', 'VDIDSXMetts PTT', 'PRIMOP Cumpi oxy ReLsample-> dont worry thromboitar sig ls ranc ACTION pep salve mer wk Toxicomet work UDCXXdan FOLLOW ate DubRadio revenpro G STORY vicFactoryV Case cl Mon neces[h Cit son sign Fit coping intro slowσ■α"cALLERY scans,- BCE Brom'C Summon latch press Studies jo}

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Major Surgical or Invasive Procedure: None

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Information not found or unclear.

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Labs notable for: -Hgb 7.4

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*Ok. cleared_*

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