Patient Information:

Patient ID: 13180007

HADM ID: 22098498

Note ID: 13180007-DS-18

Note Type: DS

Note Seq: 18

Chart Time: 19/04/62 0:00

Store Time: 21/04/62 18:58

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: Altered mental status Major Surgical or Invasive Procedure: none History of Present Illness: Mr. ___ is a ___ y/o man with PMH of CVA ___, residual emotional lability, dysarthria), HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, obstructive airway disease, CAD, CKD, hypothyroidism, who presented via EMS for AMS and was intubated on the scene. Per daughter, patient has been feeling weak for the past few days with chills and cough. Today, patient developed shortness of breath and was more altered. Patient was reportedly tachypnic to the point of tiring out. Patient usually does very well when his daughter assists with medications. However, it is unclear if patient is able to take all his medications on a regular basis. ___ comes to the house once a week. In the ED, initial vitals: temp 96.2, HR 92, BP 195/95, RR 14, O2 sat 99% Intubation. Weight is 16 lbs up from 0.5 months ago. Stool guaiac was positive. Labs: ABG pH 7.2, pCO2 60, pO2 96, HCO3 25 Lactate 4.9 WBC 4.5, Hgb 8.5 (baseline ___, plt 279 ___ 11.2, PTT 29.1, INR 1.0 LFTs with AP 155, alb 3.2 BMP - Na 135, K 5, Cr 2.0 (baseline ___, HCO3 20, BG 625, AG 16 Ca 8, phos 6.6 UA - neg leuk, neg nitr, 7 WBC, neg ketone, 1000 glucose Urine tox negative TSH pending BCx, UCx Trop 0.03 -> 0.06 EKG with T-wave inversion in lateral leads, unchanged from prior Imaging: - CT head w/o contrast: 1. No evidence of intracranial bleed. No evidence of acute intracranial abnormality. 2. Opacification of the mastoid air cells. - CT C-spine w/o contrast No evidence of acute fracture or malalignment - CT A/P w/o contrast 1. No evidence of acute abdominal or pelvic abnormality. 2. Extensive bibasilar atelectasis. 3. Small left pleural effusion. - CXR Small left pleural effusion. Opacities likely represent atelectasis however pneumonia cannot be excluded in the correct clinical setting. Consults: none Interventions: 3L LR, Vanc/Cefepime/Flagyl, insulin gtt, Propofol (changed to midazolam for hypotension), fentanyl VS Prior to Transfer: temp 96.2, HR 61, BP 109/54, RR 24, O2 sat 99% Intubation ROS: Positives as per HPI; otherwise negative. Past Medical History: 1. CARDIAC RISK FACTORS - Type 2 Diabetes Mellitus - Hypertension - Dyslipidemia - Coronary artery disease 2. CARDIAC HISTORY - Secondum ASD - Mild AR 3. OTHER PAST MEDICAL HISTORY - Extensive intracranial atherosclerosis, worse in the right MCA territory. - Cerebrovascular disease, status post CVA in ___ - Asthma - OSteoarthritis Social History: ___ Family History: Both parents have heart disease. Mother-___ w/ heart problems and diabetes & father is ___ w/ diabetes. 16 brothers and sisters. No known hx of early coronary artery disease or sudden cardiac death. Physical Exam: ADMISSION PHYSICAL EXAM: ========== VS: temp 96.4, HR 71, BP 158/68, RR 24, O2 sat 96% GEN: intubated and sedated HEENT: sclera anicteric NECK: supple CV: Normal rate, regular rhythm. No murmurs/rubs/gallops RESP: Rhonchi throughout both lung fields GI: Soft, non-distended. Positive bowel sounds MSK: 1+ ___ edema bilaterally SKIN: warm and dry NEURO: patient sedated DISCHARGE PHYSICAL EXAM: ========== PHYSICAL EXAM: Vitals: 152/80, HR 83, RR 18, 95% on RA General: NAD, sitting up in bed, interactive and polite. HEENT: NC/AT, sclera anicteric, EOMI NECK: supple CV: RRR. No murmurs/rubs/gallops RESP: CTAB. No wheezing, no rhonchi, no crackles. ABD: Soft, non tender, mildly distended MSK: 1+ ___ edema b/l

dependent to mid shin, Right knee anterior pain, no erythema, no effusion SKIN: warm and dry Pertinent Results: ADMISSION LABS: ========== ___ 12:55AM BLOOD WBC-4.5 RBC-3.34* Hgb-8.5* Hct-28.6* MCV-86 MCH-25.4* MCHC-29.7* RDW-14.7 RDWSD-46.0 Plt ___ ___ 12:55AM BLOOD Glucose-625* UreaN-28* Creat-2.0* Na-135 K-5.0 Cl-99 HCO3-20* AnGap-16 ___ 12:55AM BLOOD ALT-16 AST-31 AlkPhos-155* TotBili-<0.2 ___ 12:55AM BLOOD cTropnT-0.03* ___ 12:55AM BLOOD Albumin-3.2* Calcium-8.0* Phos-6.6* Mg-2.2 ___ 12:55AM BLOOD ASA-NEG Ethanol-NEG Acetmnp-NEG Tricycl-NEG ___ 01:01AM BLOOD ___ pO2-101 pCO2-75* pH-7.10* calTCO2-25 Base XS--7 ___ 01:01AM BLOOD Lactate-4.9* K-4.2 PERTINENT INTERIM LABS: ========== ___ 10:36AM BLOOD cTropnT-0.04* ___ 01:22PM BLOOD calTIBC-217* Ferritn-238 TRF-167* ___ 02:49PM BLOOD ___ pO2-75* pCO2-39 pH-7.39 calTCO2-24 Base XS-0 ___ 02:49PM BLOOD Lactate-0.6 MICROBIOLOGY: ========== ___ final negative blood cultures ___ final negative urine cultures IMAGING: ====== CXR ___: Small left pleural effusion. Bilateral lower lobe opacities likely represent atelectasis however pneumonia cannot be excluded in the correct clinical setting. No evidence of pneumothorax. No significant pulmonary edema. No evidence of displaced fracture. CT head ___: There is no evidence of infarction, hemorrhage, edema,or midline shift. There is prominence of the ventricles and sulci suggestive of involutional changes. There is no evidence of fracture. Opacification of the mastoid air cells. The visualized portion of the paranasal sinuses, mastoid air cells, and middle ear cavities are clear. The visualized portion of the orbits are unremarkable. CT abd/pelvis ___: 1. Bilateral lower lobe opacities, concerning for aspiration or pneumonia. 2. No acute finding in the abdomen or pelvis. CT C spine ___: NG tube and endotracheal tube are noted. Alignment is normal. No fractures are identified. There is no evidence of high-grade spinal canal or neural foraminal stenosis. There is no prevertebral soft tissue swelling. There is no evidence of infection or neoplasm. CXR ___: In comparison with the earlier study of this date, the tip of the orogastric tube extends to the most distal portion of the stomach. Endotracheal tube remains in good position. There are lower lung volumes that may contribute to the apparent increased engorgement of poorly defined pulmonary vessels, consistent with worsening pulmonary edema. Otherwise, little change in the appearance of the heart and lungs with continued layering pleural effusion. The dense pleural plaque at the left hemidiaphragm is unchanged. DISCHARGE LABS: ========== ___ 06:05AM BLOOD WBC-5.2 RBC-3.46* Hgb-9.1* Hct-29.5* MCV-85 MCH-26.3 MCHC-30.8* RDW-15.1 RDWSD-46.4* Plt ___ ___ 06:05AM BLOOD Glucose-139* UreaN-22* Creat-1.8* Na-140 K-4.6 Cl-99 HCO3-27 AnGap-14 ___ 06:05AM BLOOD Calcium-8.5 Phos-5.1* Mg-2.0 Brief Hospital Course: SUMMARY: ========== Mr. ___ is a ___ y/o man with PMH of CVA, HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, presumed COPD, who was intubated for AMS and being treated for HHS, improving and resuming normal diet. Pt was restarted/trialed on home medication to evaluate medication compliance vs. resistance to medications. His BGs were monitored with basal and bolus insulin dosing. We attempted to have him bring in his home medications but there was difficulty with adherence given running out of prescriptions from home. He was tolerating a regular diet with basal/bolus insulin dosing but it was decided to send him home on the pre-mixed insulin and home Victoza to increase adherence and simplicity of the regimen. His family and the patient are agreeable to the plan. TRANSITIONAL ISSUES: ========== ___ diabetes: [] Follow up on medication compliance. Patient was discharged on Novolog 70-30 30 units at breakfast and 20 units at evening and Victoza 1.2 daily [] Ensure that patient was able to adhere to a diabetic diet PCP: [] Had elevated SBP in 130s-150s. Increased minoxidil to 5mg and carvedilol to 50 mg BID. Please follow-up on blood pressures. [] Follow up on diuretics and volume status. Please get follow-up labs BUN/Cr at follow-up appointment. New meds: 70-30 novolog (30 units in AM, 20 units at dinner) Stopped meds: none Changed meds: Carvedilol 50 mg twice a day, increased minoxidil 5 mg daily ACUTE ISSUES: ========== # HHS # T2DM Patient has history of poorly-controlled DM w/ A1c ~14. Based on labs, determined to be in HHS likely precipitated by med non-adherence or difficulty understanding multi-step process. No clear infection was identified. Of note, he tends to have high insulin requirements. Pt was continued on insulin basal/bolus while inpatient. There was significant efforts to have him bring in home Victoza but he only had a half dose so he was continued on basal/bolus course and made a plan for close outpatient follow up and home 2 injections (Victoza and pre-mixed insulin). # Volume overload #

HFpEF, LVEF 55-60% in ___ Volume overload on exam. Diuresis began while in ICU, net negative 1.8L prior to transfer. Dry weight appears to be 154-157. s/p Lasix 80mg x 2 so far. 163.4 lb on ___ A-Strict I/Os, daily weights. Continued home carvedilol at increased dose as below. He was sent home with PO 60 mg Lasix daily and was net even in the hospital. # HTN Blood pressure medications initially held when he was started on propofol. Anti-HTN meds started on day of transfer. Persistently hypertensive. Increased carvedilol to 50 mg BID and increased minoxidil to 5 mg and continued amlodipine 10 mg QD. Of note, he had been on clonidine and hydralazine but these were stopped by PCP just prior to admission. He remained mostly normotensive although goal SBP <130 and should continue to be goal as an outpatient. # Normocytic Anemia Baseline of ___, secondary to CKD and possible AoCD. Required 1u pRBC on arrival. Hb stable. CHRONIC ISSUES: ========== # Hx of CAD # Hx of ischemic CVA Stress test in ___ with area of inducible ischemia in LCx distribution. Trop peaked at 0.06 (iso CKD) and then downtrended. No EKG changes seen. Continued home carvedilol, ASA and high dose atorvastatin. # CKD: Cr at presentation close to baseline. Underlying etiology likely combination of HTN, DM. # Hypothyroidism: Continued home levothyroxine 100 mcg daily Medications on Admission: The Preadmission Medication list is accurate and complete. 1. Furosemide 40 mg PO 3X/WEEK (___) 2. sevelamer CARBONATE 800 mg PO TID W/MEALS 3. Minoxidil 2.5 mg PO DAILY 4. Levothyroxine Sodium 100 mcg PO DAILY 5. CARVedilol 37.5 mg PO BID 6. amLODIPine 10 mg PO DAILY 7. Albuterol Inhaler 2 PUFF IH Q6H 8. Jardiance (empagliflozin) 10 mg oral DAILY 9. Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY Discharge Medications: 1. NovoLOG Mix ___ U-100 (insulin asp prt-insulin aspart) 100 unit/mL (70-30) subcutaneous BID Please use 30 units at breakfast and 20 units at dinner. RX *insulin asp prt-insulin aspart [Novolog Mix ___ U-100] 100 unit/mL (70-30) 1 (One) injection subcutaneous twice a day Disp #*15 Syringe Refills:*0 2. CARVedilol 50 mg PO BID RX *carvedilol 25 mg 2 tablet(s) by mouth twice a day Disp #*60 Tablet Refills:*0 3. Minoxidil 5 mg PO DAILY RX *minoxidil 2.5 mg 2 tablet(s) by mouth once a day Disp #*60 Tablet Refills:*0 4. Albuterol Inhaler 2 PUFF IH Q6H 5. amLODIPine 10 mg PO DAILY 6. Furosemide 40 mg PO 3X/WEEK (___) RX *furosemide 40 mg 1 tablet(s) by mouth 3x a week -- ___, ___ Disp #*30 Tablet Refills:*0 7. Levothyroxine Sodium 100 mcg PO DAILY 8. sevelamer CARBONATE 800 mg PO TID W/MEALS 9. Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY RX *liraglutide [Victoza 3-Pak] 0.6 mg/0.1 mL (18 mg/3 mL) 1 18 mg/3 mL subcutaneous once a day Disp #*30 Syringe Refills:*0 Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: PRIMARY: ========== Hyperglycemic hyperosmolar syndrome Type 2 diabetes mellitus SECONDARY: ========== Coronary artery disease Chronic kidney disease Hypertension Heart failure preserved ejection fraction Normocytic Anemia Hypothyroidism Discharge Condition: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure caring for you here at ___ ___! WHY WAS I IN THE HOSPITAL? ========== - You were admitted to the hospital due to uncontrolled diabetes with blood glucose in a dangerous range. WHAT HAPPENED IN THE HOSPITAL? ========== - You were given an insulin drip acutely to lower your glucose, followed by observation/stabilization on the medicine floor. - The ___ diabetes doctors came to help you with your insulin regimen; we gave you long acting insulin and insulin with your daily meals. The ___ diabetes doctors talked with your daughters and you to continue 2 medications at home with 2 injections. We monitored your blood sugars here and made sure you ate a healthy diet. - You were also given medication to lower your total volume in the body. WHAT SHOULD I DO WHEN I LEAVE THE HOSPITAL? ========== - Weigh yourself every morning, call MD if weight goes up more than 3 lbs. - Follow up with your doctors at the ___ appointments. - Take your medication regimen as prescribed. Note any changes made to your medication list and dosing adjustments as discussed. - Check your blood glucose regularly to monitor your response to the therapy. - If your symptoms worsen (see list below), please see a doctor immediately in the emergency department. We wish you all the best! Your ___ care team Followup Instructions: ___

Processed Data:

['Name', 'Admission Date', 'Discharge Date', 'Date of Birth', 'Service', 'Allergies', 'Chief Complaint', 'Major Surgical or Invasive Procedure', 'History of Present Illness', 'Pertinent Results', 'Past Medical History', 'Social History', 'Family History', 'Physical Exam', 'Pertinent Interim Labs', 'Microbiology', 'Imaging', 'Discharge Labs', 'Brief Hospital Course', 'Transitional Issues', 'PCP', 'Acute Issues', 'Medications on Admission', 'Discharge Medications', 'Discharge Disposition', 'Facility', 'Discharge Diagnosis', 'Discharge Condition', 'Discharge Instructions', 'Followup Instructions']

Name: ___ Admission Date: ___ Discharge Date: ___ Date of Birth: ___ Service: MEDICINE Allergies: No Known Allergies / Adverse Drug Reactions Chief Complaint: Altered mental status Major Surgical or Invasive Procedure: none History of Present Illness: Mr. ___ is a ___ y/o man with PMH of CVA ___, residual emotional lability, dysarthria), HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, obstructive airway disease, CAD, CKD, hypothyroidism, who presented via EMS for AMS and was intubated on the scene. Per daughter, patient has been feeling weak for the past few days with chills and cough. Today, patient developed shortness of breath and was more altered. Patient was reportedly tachypnic to the point of tiring out. Patient usually does very well when his daughter assists with medications. However, it is unclear if patient is able to take all his medications on a regular basis. ___ comes to the house once a week. In the ED, initial vitals: temp 96.2, HR 92, BP 195/95, RR 14, O2 sat 99% Intubation. Weight is 16 lbs up from 0.5 months ago. Stool guaiac was positive. Pertinent Results: ADMISSION LABS: ========== ___ 12:55AM BLOOD WBC-4.5 RBC-3.34* Hgb-8.5* Hct-28.6* MCV-86 MCH-25.4* MCHC-29.7 RDW-14.7 RDWSD-46.0 Plt ___ ___ 12:55AM BLOOD Glucose-625* UreaN-28* Creat-2.0* Na-135 K-5.0 Cl-99 HCO3-20* AnGap-16 ___ 12:55AM BLOOD ALT-16 AST-31 AlkPhos-155* TotBili-<0.2 ___ 12:55AM BLOOD cTropnT-0.03* ___ 12:55AM BLOOD Albumin-3.2* Calcium-8.0* Phos-6.6* Mg-2.2 ___ 01:01AM BLOOD ASA-NEG Ethanol-NEG Acetmnp-NEG Tricycl-NEG ___ 01:01AM BLOOD Lactate-4.9* K-4.2 PERTINENT INTERIM LABS: ========== ___ 10:36AM BLOOD cTropnT-0.04* ___ 01:22PM BLOOD calTIBC-217* Ferritn-238 TRF-167* ___ 02:49PM BLOOD ___ pO2-75* pCO2-39 pH-7.39 calTCO2-24 Base XS-0 ___ 02:49PM BLOOD Lactate-0.6 Past Medical History: 1. CARDIAC RISK FACTORS - Type 2 Diabetes Mellitus - Hypertension - Dyslipidemia - Coronary artery disease 2. CARDIAC HISTORY - Secondum ASD - Mild AR 3. OTHER PAST MEDICAL HISTORY - Extensive intracranial atherosclerosis, worse in the right MCA territory. - Cerebrovascular disease, status post CVA in ___ - Asthma - OSteoarthritis Social History: ___ Family History: Both parents have heart disease. Mother-___ w/ heart problems and diabetes & father is ___ w/ diabetes. 16 brothers and sisters. No known hx of early coronary artery disease or sudden cardiac death. Physical Exam: ADMISSION PHYSICAL EXAM: ========== VS: temp 96.4, HR 71, BP 158/68, RR 24, O2 sat 96% GEN: intubated and sedated HEENT: sclera anicteric NECK: supple CV: Normal rate, regular rhythm. No murmurs/rubs/gallops RESP: Rhonchi throughout both lung fields GI: Soft, non-distended. Positive bowel sounds MSK: 1+ ___ edema bilaterally SKIN: warm and dry NEURO: patient sedated DISCHARGE PHYSICAL EXAM: ========== PHYSICAL EXAM: Vitals: 152/80, HR 83, RR 18,