Patient Information:

Patient ID: 13180007

HADM ID: 26167840

Note ID: 13180007-DS-15

Note Type: DS

Note Seq: 15

Chart Time: 02/06/61 0:00

Store Time: 02/06/61 21:51

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: lower extremity swelling Major Surgical or Invasive Procedure: None History of Present Illness: Mr. ___ is a ___ yo M w/ a PMH significant for HTN, HLD, T2DM, and an extensive CVA in ___ who presented from heart failure clinic for evaluation of shortness of breath and weight gain. Patient states that for the last ___ weeks he has been having increased shortness of breath, cough, and lower extremity edema. No chest pain but does wake up from sleep shortness of breath and endorses some "fever" over the last few days. Denies nausea/vomiting, or diarrhea. Attributes his cough and shortness of breath to asthma. States that he takes all his medications regularly and denies chest pain, shortness of breath laying down, or shortness of breath bending over. States that his lower extremities ___ "itchy" and like they are "burning". Patient had a stress test in ___ of this year, after he went to the doctor complaining of chest pain. Results showed "poor functional capacity w/ some 2D echo evidence of inducible ischemia on LCx distribution". EF was normal. In the ED --------- initial vitals were: 98.7 HR80 BP140/85 RR22 99% RA EKG: SR, NL axis, NIs, TWIs laterally (c/w prior) Labs/studies notable for: proBNP: 1140, Cr 1.9 Patient was given: IV Furosemide 10mg On the floor... ---------- States that he feels better than he did when he came to the hospital. No SOB, CP, or palpitations. Only complaint is the burning/itching in his lower extremities. 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 EXAMINATION: ========== VS: ___ 1837 Temp: 97.9 PO BP: L Lying HR: 75 RR: 17 O2 sat: 100% O2 delivery: RA Dyspnea: 0 RASS: 0 Pain Score: ___ GENERAL: Well appearing man, sitting in bed in no acute distress HEENT: EOMI, MMM. Atraumatic, normocephalic NECK: Supple. JVP elevated, ~15cm. Bilateral carotid bruits. CARDIAC: Normal rate, regular rhythm. RUSB systolic murmur LUNGS: Crackles at the bases bilaterally. Normal work of breathing ABDOMEN: Distended, non-tender. Normal bowel sounds. EXTREMITIES: 2+ pitting edema bilaterally in lower extremities. Pulses 2+ bilaterally. NEURO: Alert & oriented x3. Non-focal neuro exam. DISCHARGE PHYSICAL EXAMINATION: ========== 24 HR Data (last updated ___ @ 809) Temp: 98.1 (Tm 99.0), BP: 168/75 (142-168/69-79), HR: 88 (87-95), RR: 18 (___), O2 sat: 97% (94-97) ___ Total Intake: 720ml PO Amt: 720ml ___ Total Output: 1100ml Urine Amt: 1100ml Fluid balance: -380 ___ Total Intake: 180ml PO Amt: 180ml ___ Total Output: 900ml Urine Amt: 900ml Fluid balance: -720 GENERAL: Sitting up comfortably at edge of bed, in NAD HEENT: NC/AT NECK: Supple. unable to appreciate JVD at 90 degrees CARDIAC: RRR, no rubs/gallops LUNGS: Faint bibasilar crackles on auscultation ABDOMEN: Soft, NTND EXTREMITIES: 2+ pitting edema bilaterally to knees in ___. Pulses 2+ bilaterally. WARM NEURO: Alert, answers

questions appropriately, moves all extremities Pertinent Results: DISCHARGE LABS: ___ 07:59AM BLOOD WBC-6.8 RBC-3.65* Hgb-10.1* Hct-31.2* MCV-86 MCH-27.7 MCHC-32.4 RDW-13.5 RDWSD-42.1 Plt ___ ___ 07:59AM BLOOD Plt ___ ___ 07:59AM BLOOD Glucose-207* UreaN-26* Creat-2.0* Na-137 K-4.7 Cl-99 HCO3-25 AnGap-13 ___ 07:59AM BLOOD Calcium-8.6 Phos-4.1 Mg-2.2 HEMATOLOGY: ___ 09:10AM BLOOD WBC-5.1 RBC-3.56* Hgb-9.8* Hct-31.6* MCV-89 MCH-27.5 MCHC-31.0* RDW-13.3 RDWSD-43.6 Plt ___ ___ 07:44AM BLOOD WBC-6.9 RBC-3.79* Hgb-10.5* Hct-32.6* MCV-86 MCH-27.7 MCHC-32.2 RDW-13.4 RDWSD-41.6 Plt ___ ___ 07:00AM BLOOD WBC-5.2 RBC-3.56* Hgb-9.9* Hct-30.5* MCV-86 MCH-27.8 MCHC-32.5 RDW-13.4 RDWSD-41.6 Plt ___ ___ 07:35AM BLOOD WBC-6.8 RBC-3.76* Hgb-10.3* Hct-32.5* MCV-86 MCH-27.4 MCHC-31.7* RDW-13.5 RDWSD-41.9 Plt ___ ___ 06:45AM BLOOD WBC-7.1 RBC-3.61* Hgb-10.0* Hct-31.0* MCV-86 MCH-27.7 MCHC-32.3 RDW-13.4 RDWSD-42.1 Plt ___ ___ 09:10AM BLOOD Neuts-71.5* Lymphs-17.2* Monos-7.4 Eos-3.1 Baso-0.4 Im ___ AbsNeut-3.67 AbsLymp-0.88* AbsMono-0.38 AbsEos-0.16 AbsBaso-0.02 COAGULATION: ___ 09:10AM BLOOD Plt ___ ___ 07:44AM BLOOD ___ PTT-33.7 ___ ___ 07:44AM BLOOD Plt ___ ___ 07:00AM BLOOD ___ PTT-34.0 ___ ___ 07:00AM BLOOD Plt ___ ___ 07:35AM BLOOD ___ PTT-32.1 ___ ___ 07:35AM BLOOD Plt ___ ___ 07:27AM BLOOD ___ PTT-30.6 ___ ___ 07:27AM BLOOD Plt ___ ___ 06:45AM BLOOD Plt ___ CHEMISTRIES: ___ 09:10AM BLOOD UreaN-19 Creat-1.9* Na-139 K-4.3 Cl-102 HCO3-26 AnGap-11 ___ 07:44AM BLOOD Glucose-112* UreaN-18 Creat-1.8* Na-141 K-4.1 Cl-102 HCO3-27 AnGap-12 ___ 05:00PM BLOOD Glucose-131* UreaN-19 Creat-1.8* Na-138 K-4.2 Cl-98 HCO3-29 AnGap-11 ___ 07:00AM BLOOD Glucose-139* UreaN-17 Creat-1.8* Na-141 K-4.2 Cl-101 HCO3-28 AnGap-12 ___ 02:48PM BLOOD Glucose-143* UreaN-22* Creat-2.0* Na-140 K-4.3 Cl-100 HCO3-27 AnGap-13 ___ 07:35AM BLOOD Glucose-131* UreaN-24* Creat-2.1* Na-143 K-4.2 Cl-103 HCO3-22 AnGap-18 ___ 03:10PM BLOOD Glucose-236* UreaN-29* Creat-2.2* Na-135 K-4.1 Cl-96 HCO3-25 AnGap-14 ___ 07:27AM BLOOD Glucose-185* UreaN-27* Creat-2.1* Na-137 K-4.3 Cl-97 HCO3-27 AnGap-13 ___ 02:50PM BLOOD Glucose-248* UreaN-31* Creat-2.1* Na-137 K-4.6 Cl-97 HCO3-27 AnGap-13 ___ 06:45AM BLOOD Glucose-165* UreaN-27* Creat-2.0* Na-138 K-4.3 Cl-98 HCO3-26 AnGap-14 ___ 07:44AM BLOOD Calcium-9.0 Phos-4.4 Mg-1.7 ___ 05:00PM BLOOD Calcium-9.2 Phos-4.8* Mg-3.2* ___ 07:00AM BLOOD Calcium-8.9 Phos-5.0* Mg-2.3 ___ 02:48PM BLOOD Calcium-9.0 Phos-5.3* Mg-2.2 ___ 07:35AM BLOOD Calcium-8.4 Phos-5.1* Mg-2.0 ___ 03:10PM BLOOD Calcium-8.8 Phos-5.0* Mg-2.1 ___ 07:27AM BLOOD Calcium-8.9 Phos-4.4 Mg-2.0 ___ 02:50PM BLOOD Calcium-8.5 Phos-4.4 Mg-2.1 ___ 06:45AM BLOOD Calcium-8.6 Phos-4.0 Mg-2.0 LFTs ___ 09:10AM BLOOD ALT-31 AST-25 AlkPhos-111 TotBili-<0.2 ___ 07:44AM BLOOD CK(CPK)-531* ___ 07:00AM BLOOD CK(CPK)-509* CARDIAC ENZYMES: ___ 09:10AM BLOOD proBNP-1140* ___ 07:44AM BLOOD CK-MB-7 cTropnT-0.03* ___ 05:00PM BLOOD CK-MB-7 cTropnT-0.03* ___ 07:00AM BLOOD CK-MB-6 cTropnT-0.02* TFTs: ___ 09:10AM BLOOD TSH-9.6* ___ 07:44AM BLOOD T4-6.5 T3-118 Free T4-1.0 IMAGING: ======== CXR (___): FINDINGS: The lung volumes are low-normal. There is no focal consolidation. There is mild prominence of the bilateral pulmonary vessels suggestive of volume overload. The heart is top-normal in size. There is no large effusion or a pneumothorax. There is no acute osseous abnormality, chronic left rib fractures are noted. IMPRESSION: Stable top-normal heart size with mild pulmonary vascular congestion. TTE (___): The left atrial volume index is normal. There is no evidence for an atrial septal defect by 2D/color Doppler. 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. Quantitative biplane left ventricular ejection fraction is 64 %. Left ventricular cardiac index is normal (>2.5 L/min/m2). There is no resting left ventricular outflow tract gradient. No ventricular septal defect is seen. Diastolic parameters are indeterminate. The right ventricular free wall is hypertrophied. Normal right ventricular cavity size with normal free wall motion. The aortic sinus diameter is normal for gender with normal ascending aorta diameter for gender. The aortic arch diameter is normal. The aortic valve leaflets (?#) are mildly thickened. There is no aortic valve stenosis. There is trace aortic regurgitation. The mitral valve leaflets are mildly thickened with no mitral valve prolapse. There is trivial mitral regurgitation. 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 with up to 1.0 cm of fluid appreciated anterior to the right atrium (best appreciated in the 4

chamber view). There are no 2D or Doppler echocardiographic evidence of tamponade. IMPRESSION: Mild symmetric biventricular hypetrophy with preserved biventricular systolic function. No clinically significant valvular disease. Small, predominantly anterior pericardial effusion without echocardiographic evidence of tamponade. Brief Hospital Course: ___ M w/ PMH significant for HTN, HLD, T2DM, and CVA in ___ who presents w/ increased SOB and volume retention, concerning for CHF exacerbation. ACTIVE ISSUES: ========== #Acute HF exacerbation (preserved EF 65% on stress echo in ___, unknown current EF) #Hypertension Patient presented with worsening shortness of breath, lower extremity edema and was hypervolemic on exam w/ diffuse rhonchi on lung auscultation, as well as elevated BNP, all concerning for CHF exacerbation. Stress echo in ___ showed preserved EF. Etiology could be either uncontrolled hypertension vs ischemia (especially given history of positive stress echo). Exacerbation could be due to medication/dietary non-compliance. Volume overload improved with diuresis. In terms of workup, TSH was elevated but T4/T3 were normal. Urine and blood cultures negative. With regards to management, continued on home amlodipine, but held home lisinopril given ___. Hydralazine and isordil were also started for blood pressure control. Patient was on metoprolol at home but was started on carvedilol here for combined rate and blood pressure control Held off spironolactone given ___ #CAD w/ inducible ischemia: # Troponin elevation: Patient had elevation in troponins to 0.03 at presentation. Remained stable at 0.03 to 0.02. Could be type II ischemia secondary to HFpEF exacerbation. Has history of positive stress test. Received aspirin and atorvastatin, carvedilol as above #Tachycardia: patient had elevated heart rates in the 110s and endorsed intermittent palpitations without dyspnea or other discomfort. No afib noted on tele and no history of arrhythmia documented. Continued carvedilol as above CHRONIC ISSUES: ========== For type 2 Diabetes Mellitus: Held home metformin and gave sliding scale insulin. For hyperlipidemia, continued Atorvastatin 80mg daily. For history of CVA, continued ASA 81mg daily. Medications on Admission: The Preadmission Medication list is accurate and complete. 1. amLODIPine 10 mg PO DAILY 2. Atorvastatin 80 mg PO QPM 3. CloNIDine 0.2 mg PO BID 4. Gabapentin 400 mg PO TID 5. Lisinopril 40 mg PO DAILY 6. MetFORMIN (Glucophage) 850 mg PO TID 7. Metoprolol Tartrate 25 mg PO BID 8. Basaglar (Glargine) 30 Units Breakfast 9. Albuterol Inhaler 2 PUFF IH Q4H 10. Levothyroxine Sodium 100 mcg PO DAILY 11. Vitamin D ___ UNIT PO WEEKLY Discharge Medications: 1. Aspirin 81 mg PO DAILY RX *aspirin 81 mg 1 tablet(s) by mouth once daily Disp #*30 Tablet Refills:*0 2. Carvedilol 25 mg PO BID RX *carvedilol 25 mg 1 tablet(s) by mouth twice daily Disp #*60 Tablet Refills:*0 3. Furosemide 40 mg PO BID RX *furosemide 40 mg 1 tablet(s) by mouth twice daily Disp #*60 Tablet Refills:*0 4. HydrALAZINE 100 mg PO TID RX *hydralazine 100 mg 1 tablet(s) by mouth three times daily Disp #*90 Tablet Refills:*0 5. Glargine 30 Units Breakfast 6. Albuterol Inhaler 2 PUFF IH Q4H 7. amLODIPine 10 mg PO DAILY 8. Atorvastatin 80 mg PO QPM 9. CloNIDine 0.2 mg PO BID 10. Gabapentin 400 mg PO TID 11. Levothyroxine Sodium 100 mcg PO DAILY 12. MetFORMIN (Glucophage) 850 mg PO TID 13. Vitamin D ___ UNIT PO WEEKLY 14. HELD- Lisinopril 40 mg PO DAILY This medication was held. Do not restart Lisinopril until told to do so by your doctor 15.Outpatient Lab Work Chem-7 to be draw ___ ICD 10: I50.3: Diastolic (congestive) heart failure Fax results to: ___ ATTN: ___ Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: Primary diagnosis: ========== Acute exacerbation of heart failure with preserved ejection fraction Coronary artery disease with inducible ischemia Secondary diagnosis: ========== Hypertension Type 2 diabetes Hyperlipidemia Cerebrovascular disease Discharge Condition: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure to participate in your care! You were admitted to the hospital because: ========== -You had worsening shortness of breath, with increased leg swelling and weight gain. During your stay: ========== -You had too much volume onboard so you were given IV diuretic medications,. You improved significantly. After your discharge: ========== -Please continue taking all medications as prescribed (see below). -Please stop taking Lisinopril and metoprolol. -Please continue taking insulin according to the regimen you were following before this admission. -New medications: - Aspirin 81mg once daily - Carvedilol 25mg twice daily - Furosemide 40mg twice daily - Hydralazine 100mg three times daily -Please attend any upcoming outpatient appointments you have (see below). We wish you the very best! Your ___

healthcare 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', 'Social History', 'Family History', 'Past Medical History', 'Physical Exam', 'Pertinent Results', 'DISCHARGE LABS', 'HEMATOLOGY', 'COAGULATION', 'CHEMISTRIES', 'LFTs', 'CARDIAC ENZYMES', 'TFTs', 'IMAGING', 'Brief Hospital Course', 'ACTIVE ISSUES', 'CHRONIC ISSUES', 'Medications on Admission', 'Discharge Medications', 'Discharge Diagnosis', 'Discharge Condition', 'Discharge Instructions', 'Followup Instructions']

Name: Mr. ___ Admission Date: (not available) Discharge Date: (not available) Date of Birth: (not available) Service: MEDICINE Allergies: No Known Allergies / Adverse Drug Reactions Attending: ___ Chief Complaint: lower extremity swelling Major Surgical or Invasive Procedure: None History of Present Illness: Mr. ___ is a ___ yo M w/ a PMH significant for HTN, HLD, T2DM, and an extensive CVA in ___ who presented from heart failure clinic for evaluation of shortness of breath and weight gain. Patient states that for the last ___ weeks he has been having increased shortness of breath, cough, and lower extremity edema. No chest pain but does wake up from sleep shortness of breath and endorses some "fever" over the last few days. Denies nausea/vomiting, or diarrhea. Attributes his cough and shortness of breath to asthma. States that he takes all his medications regularly and denies chest pain, shortness of breath laying down, or shortness of breath bending over. States that his lower extremities ___ "itchy" and like they are "burning". Patient had a stress test in ___ of this year, after he went to the doctor complaining of chest pain. Results showed "poor functional capacity w/ some 2D echo evidence of inducible ischemia on LCx distribution". EF was normal. In the ED --------- initial vitals were: 98.7 HR80 BP140/85 RR22 99% RA EKG: SR, NL axis, NIs, TWIs laterally (c/w prior) Labs/studies notable for: proBNP: 1140, Cr 1.9 Patient was given: IV Furosemide 10mg On the floor... ---------- States that he feels better than he did when he came to the hospital. No SOB, CP, or palpitations. Only complaint is the burning/itching in his lower extremities. 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: (not available) 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 EXAMINATION: ========== VS: ___ 1837 Temp: 97.9 PO BP: L Lying HR: 75 RR: 17 O2 sat: 100% O2 delivery: RA Dyspnea: 0 RASS: 0 Pain Score: ___ GENERAL: Well appearing man, sitting in bed in no acute distress HEENT: EOMI, MMM. Atraumatic, normocephalic NECK: Supple. JVP elevated, ~15cm. Bilateral carotid bruits. CARDIAC: Normal rate, regular rhythm. RUSB systolic murmur LUNGS: Crackles at the bases bilaterally. Normal work of breathing ABDOMEN: Distended, non-tender. Normal bowel sounds. EXTREMITIES: 2+ pitting edema bilaterally in lower extremities. Pulses 2+ bilaterally. NEURO: Alert & oriented x3. Non-focal neuro exam. DISCHARGE PHYSICAL EXAMINATION: ========== 24 HR Data (last updated ___ @ 809) Temp: 98.1 (Tm 99.0), BP: 168/75 (142-168/69-79), HR: 88 (87-95), RR: 18 (___), O2 sat: 97% (94-97) ___ Total Intake: 720ml PO Amt: 720ml ___ Total Output: 1100ml Urine Amt: 1100ml Fluid balance: -380 ___ Total Intake: 180ml PO Amt: 180ml ___ Total Output: 900ml Urine Amt: 900ml Fluid balance: -720 GENERAL: Sitting up comfortably at edge of bed, in NAD HEENT