Note ID: 13180007-DS-17

Subject ID: 13180007

HADM ID: 24436834

Storetime: 10/03/62 21:04

Name: ___ Unit No: ___

Admission Date: ___ Discharge Date: ___

Date of Birth: ___ Sex: M

Service: MEDICINE

Allergies:

No Known Allergies / Adverse Drug Reactions

Attending: ___.

Chief Complaint:

confusion

Major Surgical or Invasive Procedure:

none

History of Present Illness:

___ ___ speaking male with PMH of CVA ___, residual

emotional lability, dysarthria), HFpEF, uncontrolled DM2, HTN, CAD, CKD, ?hypothyroidism, asthma who was brought in by family for altered mental status. History is obtained from ___ and ___ at bedside. They describe fluctuating cognitive and functional abilities since his CVA in ___, which seem to have accelerated after hospitalization in ___. Since that time, they have noted that he has had progressive short term memory loss, often asking the same question repeatedly, then calling the other daughter and asking the same question. Most significantly, although he states that he takes his medications consistently, in fact his daughters are both aware that he very rarely takes them, including his insulin and antihypertensives. They describe him as "at his best" when they are around, able to provide food and ensure that he is taking his medications, although they also both believe that he is prescribed "too many medications," and that when he takes all of them, he is more fatigued and less interactive. His daughters are clear that, despite this impression, they never discourage him from taking his prescribed medications, which he receives in bubble packs since his last discharge.

Pt went home to visit ___ on ___, and returned on ___. While in ___, he apparently told his daughters that he was reaching for green bananas, lost his balance, and fell, rolling down the hill. He was able to get up "little by little."

When he came home to ___, he apparently thought that he was still in ___, confused his wife for his daughter. On ___ morning, he fell again. He was confused about the configuration of the bathroom (no tub in bathroom in PR), so he tripped and fell, called his daughter in tears (he often gets emotional since his CVA). She booked an appointment for same day,
at which his FSBG>500, HbA1c (point of care, not in OMR) was 15.0%. He declined to be transferred to the ED. Daughter ___ was on vacation from work, and so was able to check on him regularly. During these visits, she again established that he is not taking prescribed medications. On the morning of presentation, pt's wife called daughter ___, concerned that pt
was increasingly confused. FSBG was >500, and administered Tresiba 50u at about 8 am. Pt called ___ about 15 minutes later, at which time she again noted confusion and slurred speech, which has intermittently been present since his CVA. Decision was made to bring him to the ED.

Of note, during his last hospitalization ___, he had an episode of dysarthria with confusion and mild expressive and receptive aphasia for which code stroke was called. MRI/MRA brain
and EEG were unrevealing, with chronic changes and EEG slowing only. He was continued on ASA and atorvastatin.

ED Course:

Exam: no focal neuro deficits.

VS: T96.1, HR 80, BP 114/50, RR 16, 99% on room air.

Labs: TropT 0.04, proBNP: 754, Cr 2.3, WBC 5.6, Hgb 10.6

Cultures: urine culture pending.

Meds: acetaminophen 1g, NS 500mL.

Imaging: CT head: no acute intracranial abnormality. chronic infarcts.

On arrival to the floor, pt states that he came to the ED because of his asthma. His daughters are present and state that asthma is not, in fact, the reason for his ED presentation. They also describe anorexia with weight loss. They believe that he looks like he has lost weight, but no clear idea of how much. He endorses chills without fevers, which seems to be chronic since his CVA. He has not mentioned chest pain, but has endorsed hand and leg cramping. He did have a transient headache which has now resolved.

At baseline, ___ work full time jobs and have their own families; pt lives with his wife, who is on HD. ___ comes to the house once a week, and pt is followed by RN/BSN from

Case Management, ___, as outpatient. ___ and

___ both feel that their father needs increased services at

home to prevent repeated admissions. They are both providing as

much support as they can, in the setting of having their own

full

time jobs and families. ___ expresses concern that his home

medications will be resumed/uptitrated without the understanding

that he is not, in fact, taking them as prescribed; she

recognizes that this could result in major adverse events, if

all

home medications were to be resumed at the same time in the

hospital.

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 EXAM:

VS: ___ Temp: 97.3 PO BP: 168/78 HR: 85 RR: 18 O2 sat: 97% O2 delivery: RA Dyspnea: 0 RASS: 0 Pain Score: ___

GEN: alert and interactive, comfortable, no acute distress

HEENT: PERRL, anicteric, conjunctiva pink, oropharynx without lesion or exudate, moist mucus membranes, ears without lesions or

apparent trauma

LYMPH: no anterior/posterior cervical, supraclavicular adenopathy

CARDIOVASCULAR: Regular rate and rhythm with late ___ systolic murmur at RUSB, no rubs or gallops

LUNGS: clear to auscultation bilaterally without rhonchi, wheezes, or crackles

GI: soft, nontender, without rebounding or guarding, nondistended with normal active bowel sounds, no hepatomegaly

EXTREMITIES: no clubbing, cyanosis, or edema

GU: no foley

SKIN: no rashes, petechia, lesions, or echymoses; warm to palpation

NEURO: Alert and interactive to person, ___ (daughters stated that this is a hospital before pt named it), ___, but thinks that it is ___, cranial nerves II-XII intact, strength is ___ in RUE, RLE, LLE, ___ in LUE elbow flexion/extension and hand grip. Gait is WNL, negative Romberg, negative pronator drift.

PSYCH: normal mood and affect

DISCHARGE EXAM

VS: 97.9 PO 151 / 65 64 18 99 RA

GEN: Alert and interactive, comfortable, no acute distress

HEENT: PERRL, anicteric, conjunctiva pink, oropharynx without lesion or exudate, moist mucus membranes, ears without lesions or

apparent trauma

LYMPH: no anterior/posterior cervical, supraclavicular

adenopathy

CARDIOVASCULAR: Regular rate and rhythm with late ___ systolic

murmur at RUSB, no rubs or gallops

LUNGS: clear to auscultation bilaterally without rhonchi,

wheezes, or crackles

GI: soft, non-tender, without rebounding or guarding,

nondistended with normal active bowel sounds, no hepatomegaly

EXTREMITIES: no clubbing, cyanosis, or edema

GU: no foley

SKIN: no rashes, petechiae, lesions, or echymoses; warm to

palpation

NEURO: Oriented to ___ (thinks it's the ___ but

states year is ___. Normal gait. Grossly full strength in

bilateral upper and lower extremities. Pupils equal. Fluent

speech in ___.

PSYCH: normal mood and affect

Pertinent Results:

ADMISSION LABS:

___ 11:00AM BLOOD WBC-5.6 RBC-3.98* Hgb-10.6* Hct-32.6*

MCV-82 MCH-26.6 MCHC-32.5 RDW-14.3 RDWSD-41.8 Plt ___

___ 11:00AM BLOOD Neuts-78.9* Lymphs-11.1* Monos-7.5

Eos-1.6 Baso-0.5 Im ___ AbsNeut-4.40 AbsLymp-0.62*

AbsMono-0.42 AbsEos-0.09 AbsBaso-0.03

___ 11:00AM BLOOD Glucose-98 UreaN-32* Creat-2.3* Na-139

K-4.1 Cl-100 HCO3-25 AnGap-14

___ 11:00AM BLOOD ALT-8 AST-9 CK(CPK)-110 AlkPhos-144*

TotBili-<0.2

___ 11:00AM BLOOD Albumin-3.5 Calcium-9.2 Mg-2.3

DISCHARGE LABS:

___ 06:22AM BLOOD WBC-5.6 RBC-3.86* Hgb-10.1* Hct-32.1*

MCV-83 MCH-26.2 MCHC-31.5* RDW-14.3 RDWSD-43.4 Plt ___

___ 06:08AM BLOOD Glucose-157* UreaN-33* Creat-1.9* Na-138

K-4.5 Cl-100 HCO3-22 AnGap-16

IMPORTANT RESULTS:

___ 11:00AM BLOOD %HbA1c-14.4* eAG-367*

___ 09:00PM BLOOD TSH-1.3

___ 11:11AM BLOOD Lactate-1.6

___ 11:00AM BLOOD CK-MB-4 proBNP-754*

IMAGING:

Chest X-ray:

Comparison to ___. On today's radiograph, a small

pleural left-sided calcification is seen. There also is a small

left pleural effusion. Borderline size of the cardiac silhouette without pulmonary edema. No pneumonia, no pneumothorax. The lateral radiograph shows mild flattening of the hemidiaphragms, potentially as a consequence of functional obstruction.

Head CT: 1. No evidence of acute intracranial abnormality.
2. Unchanged appearance of chronic infarcts within the right frontal lobe and left occipital lobe.
3. Chronic lacunar infarcts within the right basal ganglia.
4. Redemonstration of few calcifications within the pons, findings which are unchanged in appearance and likely sequela of prior ischemic or inflammatory process.

___ 11:00AM BLOOD cTropnT-0.04*

___ 09:00PM BLOOD cTropnT-0.02*

___ 11:00AM BLOOD %HbA1c-14.4* eAG-367*

___ 11:00AM BLOOD Lipase-73*

___ 11:00AM BLOOD CK-MB-4 proBNP-754*

IMAGING:

___ CXR -

Comparison to ___. On today's radiograph, a small pleural left-sided calcification is seen. There also is a small left pleural effusion. Borderline size of the cardiac silhouette without

pulmonary edema. No pneumonia, no pneumothorax. The lateral radiograph shows mild flattening of the hemidiaphragms, potentially as a consequence of functional obstruction.

___ CT HEAD -

1. No evidence of acute intracranial abnormality.
2. Unchanged appearance of chronic infarcts within the right frontal lobe and left occipital lobe.
3. Chronic lacunar infarcts within the right basal ganglia.
4. Re-demonstration of few calcifications within the pons, findings which are unchanged in appearance and likely sequela of prior ischemic or inflammatory process.

MICRO:

___ 3:38 pm URINE

**FINAL REPORT ___

URINE CULTURE (Final ___: < 10,000 CFU/mL.

Brief Hospital Course:

Mr. ___ is a ___ ___ speaking male with a PMH of prior CVA ___, residual emotional lability, dysarthria), HFpEF, uncontrolled DM2, HTN, CAD, CKD, ?hypothyroidism, asthma, mild cognitive impairment who presented

to ED with hyperglycemia and altered mental status.

Acute metabolic encephalopathy (RESOLVED):

Concern for underlying vascular dementia:

Falls:

DM2 with hyperglycemia:

Patient presenting with progressive cognitive impairment with a component of fluctuating mental status in the setting of hyperglycemia ___ not taking prescribed insulin. He has also had recurrent falls, which seem to have been mechanical in the setting of cognitive impairment. He has no localizing signs or symptoms such as cough, dysuria, diarrhea, chest pain. He did have transient headache which resolved with Tylenol in the ED. Daughters describe a pattern at home of improving mental status when medications are consistently administered, and apparent cognitive decline when he does not have this additional home support, which may be related to appropriate management of hyperglycemia when supervised. Per daughters, pt returned to prior baseline with supportive care by the time of arrival to the hospital floor. Given prior evaluation, concern for new seizure disorder is low. A1c is 14.4 and has been significantly elevated since at least ___ >10 suggesting long-standing very poorly controlled diabetes (roughly correlates to average blood sugar in the mid ___. ___ wnl. ___ consulted for help with decision on both inpatient and outpatient diabetes regimen. While in the hospital, sugars maintained with typical

basal/bolus four times daily regimen. However, this is not a sustainable regimen for patient on discharge. Discussed possibility of switching to 70/30 mix BID, however currently patient cannot be guaranteed to eat regular meal after each insulin injection therefore currently not a tenable plan. In the future, if patient able to be placed in a day program, potentially could switch to this but for now will we continued his prior home regimen (EXCEPT for Jardiance, which was discontinued due to contraindication with chronic kidney disease) on discharge, with very close ___ follow-up and ___ services to help increase compliance. With regards to his more subacute mental status decompensation, would benefit from referral for outpatient neurocognitive evaluation.

Hx of CAD:

Hx of ischemic CVA:

Stress test in ___ with area of inducible ischemia in LCx distribution, in setting of multiple risk factors. Has been medically optimized by prescribed medications, but as above it seems that pt has been taking these medications. TnT 0.04->0.02 in setting of CKD stage III-IV. Continued home aspirin, atorvastatin, and carvedilol. Note that he was once on lisinopril (most recently filled in ___ for 2.5mg dose) however seems that this has since been discontinued.

CKD stage III:

Diabetic nephropathy:

Cr 2.3 on admission, improved compared to prior. Now down to 1.9 and stable. Continued sevelamer. Can see nephrology as part of ___ since he will already be going there for diabetes.

History of hyperkalemia: Probably secondary to CKD and ACE. Patient has been taking Veltassa as outpatient, which is not on our formulary. His potassium levels were wnl while admitted and in the spirit of simplifying his regimen, this was held on discharge. Potentially if goes back on lisinopril in the future, would need to be re-considered for this medication.

Chronic diastolic heart failure: Euvolemic on admission. Continued home Lasix maintenance.

HTN: Normotensive on arrival, then became hypertensive. Prescribed home regimen includes amlodipine 10 mg, carvedilol 37.5 mg BID, clonidine 0.4 mg BID, hydralazine 100 mg TID in addition to furosemide 80 mg PO daily. Initially meds held (given unclear what exactly he needs to take and what he has been taking) however were slowly resumed throughout admission. For now holding hydralazine and clonidine, and can re-check and decide if needs all of these agents.

Chronic normocytic anemia:

Thought to be ___ CKD. Stable. Note that he hasn't had a

colonoscopy report in our system previously. Iron studies from ___ with low normal ferritin (53), low iron, low normal TIBC - possibly consistent with anemia of chronic disease or inflammation, however hard to rule out concomitant iron deficiency.

Hypothyroidism: TSH wnl. Continued home levothyroxine.

Asthma: Albuterol inhaler prn continued.

TRANSITIONAL ISSUES:

- consideration of outpatient colonoscopy referral if not up to date with screening, particularly iso chronic anemia
- re-check BP at next PCP appointment, decision on further med titration as above (?increase BB, resuming another home agent
- ?resume Veltassa if K elevated
- PCP: consider referral to ___ clinic

Medications on Admission:

The Preadmission Medication list is accurate and complete.

1. Aspirin 81 mg PO DAILY
2. Atorvastatin 80 mg PO QPM
3. CloNIDine 0.4 mg PO BID
4. HydrALAZINE 100 mg PO TID
5. Levothyroxine Sodium 100 mcg PO DAILY

6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID

7. sevelamer CARBONATE 800 mg PO TID W/MEALS

8. Albuterol Inhaler ___ PUFF IH Q6H:PRN wheezing, SOB

9. CARVedilol 37.5 mg PO BID

10. amLODIPine 10 mg PO DAILY

11. empagliflozin 10 mg oral DAILY

12. Vitamin D ___ UNIT PO 1X/WEEK (WE)

13. Furosemide 80 mg PO DAILY

14. Gabapentin 400 mg PO TID

15. Tresiba U-100 Insulin (insulin degludec) 50 units

subcutaneous DAILY

16. Veltassa (patiromer calcium sorbitex) 8.4 gram oral DAILY

17. Sildenafil 25 mg PO ASDIR

Discharge Medications:

1. Albuterol Inhaler ___ PUFF IH Q6H:PRN wheezing, SOB

2. amLODIPine 10 mg PO DAILY

3. Aspirin 81 mg PO DAILY

4. Atorvastatin 80 mg PO QPM

5. CARVedilol 37.5 mg PO BID

6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID

7. Furosemide 80 mg PO DAILY

8. Levothyroxine Sodium 100 mcg PO DAILY

9. sevelamer CARBONATE 800 mg PO TID W/MEALS

10. Sildenafil 25 mg PO ASDIR

11. Tresiba U-100 Insulin (insulin degludec) 50 units

subcutaneous DAILY

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

subcutaneous DAILY

13. Vitamin D ___ UNIT PO 1X/WEEK (WE)

14. HELD- CloNIDine 0.4 mg PO BID This medication was held. Do

not restart CloNIDine until see what BP is at PCP visit, to see

if need more meds

15. HELD- Gabapentin 400 mg PO TID This medication was held. Do

not restart Gabapentin until you discuss with PCP the need for

it, was not needed during this hospital stay

16. HELD- HydrALAZINE 100 mg PO TID This medication was held.

Do not restart HydrALAZINE until discuss with primary care

doctor

Discharge Disposition:

Home With Service

Facility:

___

Discharge Diagnosis:

Type II diabetes

Discharge Condition:

Mental Status: Clear and coherent, but not oriented to date

Level of Consciousness: Alert and interactive.

Activity Status: Ambulatory - Independent.

Discharge Instructions:

Mr. ___,

You were admitted to the hospital for confusion, dehydration, and high blood sugars. This resolved with insulin to fix your sugars, and IV fluids.

We were able to get your visiting nurse services to try to help make sure you get your insulin at home and your sugars stay controlled. You have been set up an appointment at the ___ Diabetes Clinic to follow up on your diabetes as well as your chronic kidney disease.

It was a pleasure taking care of you!

Sincerely, your ___ Team

Followup Instructions:

___