Patient Information

Patient Name: ,
DOB:
Age:
Gender:
MRN:

Admission ID: A000472
Date of Admission:
Date of Discharge:

Address:
City:
State:
ZIP:
Phone:

Emergency Contact

Name:
Relation:
Phone:

History Of Presenting Illness

Mr. Ruiz, a 47-year-old male, presents as a transfer from an outside hospital for management of mediastinitis and persistent Group B Streptococcus (GBS) and Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. Onset: The patient initially presented to the outside hospital on ___ with a 6-day history of generalized malaise, nausea, vomiting, diarrhea, and intermittent chest discomfort. Location: The patient was found to have a large fluid collection in the mediastinum at the sternotomy site, with concern for extension to the pericardium. Duration: Symptoms had been present for approximately 6 days prior to initial presentation. Character: The patient reported generalized malaise and chest discomfort. Alleviating/Aggravating Factors: Not specified in the provided information. Radiation: The mediastinal fluid collection was noted to potentially extend to the pericardium. Timing: Symptoms were persistent for 6 days before seeking medical attention. Severity: Not explicitly stated, but the presence of bacteremia and mediastinitis suggests a severe condition. Associated Symptoms: The patient experienced nausea, vomiting, and diarrhea in addition to the primary complaints. At the outside hospital, the patient was found to be bacteremic, growing both GBS and MRSA in blood cultures. Imaging studies, including a CT chest, revealed a large fluid collection in the mediastinum with concern for extension to the pericardium and purulent drainage. The patient was transferred to the current facility for further evaluation and management by cardiothoracic surgery.

Chief Complaint

Bacteremia and possible mediastinitis

Review Of Systems

General

Positive for generalized malaise. No reported fever or chills.

Respiratory

Denies shortness of breath. No increased work of breathing noted. Intermittent end-expiratory wheezes present.

Cardiovascular

Reports intermittent chest discomfort. No palpitations or syncope mentioned.

Musculoskeletal

Complains of right shoulder pain. No other joint pains or limitations reported.

Neurological

History of left-sided hemiparesis following a previous CVA. No new neurological symptoms reported.

Endocrine

Known history of Type 2 Diabetes Mellitus. No reports of polyuria, polydipsia, or heat/cold intolerance.

Psychiatric

Known history of PTSD. No acute psychiatric symptoms reported.

Assessment

Summary Of Findings

47-year-old male with history of CAD s/p CABG, DM2, HTN, and CVA presents with mediastinitis and polymicrobial bacteremia (GBS, MRSA). CT chest shows large fluid collection in anterior chest wall abutting sternotomy site, extending to mediastinum with possible pericardial involvement. Patient is febrile (Tmax 101°F) with leukocytosis (WBC 17.5) and elevated inflammatory markers (CRP 24.5).

Differential Diagnosis

1. Post-sternotomy mediastinitis 2. Sternal osteomyelitis 3. Infected sternal wires 4. Superficial wound infection 5. Endocarditis 6. Septic arthritis (right shoulder)

Primary Diagnosis

Post-sternotomy mediastinitis with polymicrobial bacteremia (GBS, MRSA)

Secondary Diagnoses

1. Acute kidney injury (Cr 2.2, baseline 1.3) 2. Hyponatremia (Na 127) 3. Anemia (Hgb 8.9) 4. Decompensated heart failure (EF 45%) 5. Type 2 Diabetes Mellitus 6. Hypertension 7. History of CVA with left-sided hemiparesis

Plan

Diagnostic Plan

1. Daily CBC, BMP, CRP 2. Blood cultures q24-48h until clearance 3. Repeat CT chest with contrast in 5-7 days 4. TTE to evaluate for vegetations/endocarditis 5. Right shoulder X-ray to rule out septic arthritis

Therapeutic Plan

1. Surgical debridement of sternal wound and mediastinum 2. VAC dressing placement post-debridement 3. Daptomycin 1000mg IV daily for MRSA bacteremia 4. Cefepime 2g IV q8h for GBS coverage (after desensitization) 5. IV fluids for AKI: NS at 75 mL/hr, adjust based on UOP 6. Insulin management: Continue home glargine, add sliding scale 7. Temporary pacemaker placement for management of bradycardia

Patient Education And Counseling

1. Explain severity of infection and need for prolonged antibiotic therapy 2. Discuss importance of glycemic control in wound healing 3. Instruct on proper care of VAC dressing and surgical site 4. Review signs of worsening infection or heart failure symptoms

Follow-Up Plan

1. Daily wound checks by surgical team 2. Infectious Disease consult for antibiotic management 3. Cardiology follow-up for management of heart failure and arrhythmias 4. Endocrinology consult for diabetes management 5. Physical Therapy and Occupational Therapy evaluations

Disposition

Admit to Cardiothoracic Surgery ICU for close monitoring and management

Consultations

1. Cardiothoracic Surgery 2. Infectious Disease 3. Cardiology 4. Nephrology 5. Endocrinology 6. Plastic Surgery (for potential flap coverage)

Past Medical History

Chronic Conditions

Coronary Artery Disease (CAD) s/p Coronary Artery Bypass Graft (CABG) in ___
Type 2 Diabetes Mellitus with neuropathy
Hypertension
Hyperlipidemia
Left Bundle Branch Block (LBBB) s/p Pacemaker placement for Mobitz type II
Carotid artery stenosis
Chronic Kidney Disease (unspecified stage)
Chronic Obstructive Pulmonary Disease (COPD)
Obesity (BMI 33.0-33.9)

Past Illnesses

Cerebrovascular Accident (CVA) with residual left-sided hemiparesis
Peptic ulcer disease (___)
Basal cell carcinoma of face, s/p excision (___)
Prostate cancer, biopsy showing invasive adenocarcinoma (___)

Surgeries

Coronary Artery Bypass Graft (CABG) in ___
Pacemaker placement (date unspecified)
Excision of basal cell carcinoma on face (___)

Hospitalizations

Previous admission for CVA (date unspecified)
Multiple admissions for cardiac issues (dates unspecified)

Allergies

Sulfa (Sulfonamide Antibiotics)
Aricept
Lidocaine
Penicillins
Cipro

Medications

Insulin (long-term use)

Losartan 25 mg daily

Metoprolol Succinate XL 50 mg daily

Rosuvastatin Calcium 20 mg daily

Aspirin 81 mg daily

Fluticasone Propionate inhaler 110 mcg twice daily

Tiotropium Bromide inhaler 1 cap daily

Albuterol inhaler 2 puffs every 4 hours as needed

Vitamin D 1000 units daily

Family History

No pertinent family history elicited

Social History

Smoking	Former smoker (quit date not specified)
Alcohol	Not specified
Illicit Drugs	Not specified
Occupation	Not specified

Psychiatric History

Post-Traumatic Stress Disorder (PTSD) from childhood abuse

Progress Notes

Radiology Reports

Radiology Report #1

Patient Info

Name	Amanda J Ruiz
Age	47
Gender	Female
Mrn	M370216
Dob	1976-09-23
Clinicalhistory	47-year-old female with abdominal pain, history of bacteremia, and possible mediastinitis

Study Info

Type	CT Abdomen and Pelvis with IV contrast
Datetime	Not provided
Reason	Abdominal pain, evaluate for possible colitis

Technique

MDCT helical acquisition from diaphragm through pubic symphysis following uneventful administration of IV contrast. Multiplanar reformations provided.

Findings

Chest	Mild left lung base subsegmental atelectasis.
Abdomen	Liver, spleen, pancreas, adrenal glands, kidneys, ureters, and small bowel unremarkable. Gallbladder surgically absent. Common bile duct not dilated, consistent with post-cholecystectomy change. No mesenteric or retroperitoneal lymphadenopathy. No abnormal fluid collection. Mesenteric vessels enhance normally for non-CTA technique.
Pelvis	Rectum, uterus, and bladder appear unremarkable. Short segment of colon (splenic flexure) demonstrates bowel wall thickening, submucosal edema, and mild adjacent inflammatory change. Diverticulosis of colon noted, but no inflamed diverticulum identified. No free air or free fluid.

Impression

1. Colitis noted along the splenic flexure. Most likely infectious or inflammatory, less likely ischemic.
2. Diverticulosis without diverticulitis.

Conclusion

Findings consistent with colitis, likely infectious or inflammatory in nature. No evidence of diverticulitis.

Radiologist Info

Name	Not provided
Signature	Not provided

Contact	Not provided

Addendum

Findings posted to the ED dashboard.

Radiology Report #2

Patient Info

Name	Amanda J Ruiz
Age	47
Gender	Female
Mrn	M370216
Dob	1976-09-23
Clinicalhistory	47-year-old female with fever, suspected infiltrate

Study Info

Type	Portable Chest X-ray
Datetime	Not provided
Reason	Fever, evaluate for infiltrate

Technique

Single portable chest radiograph obtained

Findings

Positioning	Patient is rotated
Lungs	Mild atelectasis at the lung bases. Lungs are likely clear.
Heart	Heart and mediastinum appear to be within normal limits.

Impression

1. Mild basilar atelectasis. 2. No definite infiltrate identified.

Conclusion

No significant abnormalities detected. Mild basilar atelectasis noted, which may be positional.

Radiologist Info

Name	Not provided
Signature	Not provided
Contact	Not provided

Radiology Report #3

Patient Info

Name	Amanda J Ruiz
Age	47
Gender	Female
Mrn	M370216
Dob	1976-09-23
Clinicalhistory	47-year-old female with possible epidural abscess

Study Info

Type	MRI of the cervical, thoracic, and lumbar spine with and without contrast
Datetime	Not provided
Reason	Evaluate for possible epidural abscess

Technique

T1, T2 and inversion recovery sagittal T2 axial images of cervical, thoracic and lumbar spine obtained before gadolinium. T1 sagittal and axial images obtained following gadolinium administration.

Findings

Cervical	No epidural abscess, discitis, or osteomyelitis. Mild degenerative changes C3-4 to C6-7 with mild thecal sac indentation at C5-6 and C6-7. Incidental perineural cysts in bilateral C7-T1 foramina.
Thoracic	No evidence of epidural abscess, discitis, or osteomyelitis. Mild multilevel degenerative changes. No abnormal spinal cord signal or compression.
Lumbar	Increased signal and enhancement posterior to thecal sac with compression from L2-3 to L4-5, predominant at L2-3 and L3-L4. Linear focal fluid collections indicating epidural abscess at L2-3 and L3-4. Small collections (6 mm) within left erector spinae muscle at L3. No discitis or osteomyelitis. Mild multilevel degenerative changes. Atrophic changes in left psoas muscle.

Impression

1. Epidural phlegmon with epidural abscess posterior to thecal sac from L2-3 to L4-5, predominantly at L2-3 and L3-4 levels with small epidural abscesses. Thecal sac compression present.
2. Left paraspinal soft tissue enhancement involving erector spinae muscle at L3 with small intramuscular abscesses.
3. No evidence of discitis or osteomyelitis.
4. Multilevel degenerative changes in cervical, thoracic, and lumbar regions without high-grade spinal stenosis.
5. No evidence of cord compression.

Conclusion

Findings consistent with lumbar epidural abscess and paraspinal intramuscular abscesses, requiring urgent neurosurgical evaluation and management.

Radiologist Info

Name	Not provided

Signature	Not provided
Contact	Not provided

Addendum

Findings discussed with Dr. [Name] on [Date] at 4 p.m.

Lab Reports

Firstname	Amanda
Lastname	Ruiz
Middlename	J
Dob	1976-09-23
Gender	female
Medical Record Number	M370216
Admission Id	M370216
Charttime	2023-09-30 10:02:00
Category	Chemistry
Test Name	Comprehensive Metabolic Panel

Results

Component	Value	Unit	Reference Range	Flag
Sodium	129	mEq/L	135-145 mEq/L	L

Component	Value	Unit	Reference Range	Flag
Potassium	3.8	mEq/L	3.5-5.0 mEq/L	WNL

Component	Value	Unit	Reference Range	Flag
Chloride	90	mEq/L	98-108 mEq/L	L

Component	Value	Unit	Reference Range	Flag
CO2	19	mEq/L	22-29 mEq/L	L

Component	Value	Unit	Reference Range	Flag
BUN	53	mg/dL	7-20 mg/dL	H

Component	Value	Unit	Reference Range	Flag
Creatinine	2.0	mg/dL	0.6-1.2 mg/dL	H

Component	Value	Unit	Reference Range	Flag
Glucose	187	mg/dL	70-100 mg/dL	H

Component	Value	Unit	Reference Range	Flag
Calcium	8.6	mg/dL	8.5-10.5 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
Albumin	2.7	g/dL	3.5-5.0 g/dL	L

Component	Value	Unit	Reference Range	Flag
Total Bilirubin	0.6	mg/dL	0.2-1.2 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
AST	42	U/L	10-40 U/L	H

Component	Value	Unit	Reference Range	Flag
ALT	56	U/L	7-56 U/L	H

Component	Value	Unit	Reference Range	Flag
Alkaline Phosphatase	342	U/L	44-147 U/L	H

Firstname	Amanda
Lastname	Ruiz
Middlename	J
Dob	1976-09-23
Gender	female
Medical Record Number	M370216
Admission Id	M370216
Charttime	2023-09-30 10:02:00
Category	Hematology
Test Name	Complete Blood Count

Results

Component	Value	Unit	Reference Range	Flag
WBC	17.5	K/uL	4.0-11.0 K/uL	H

Component	Value	Unit	Reference Range	Flag
RBC	3.66	M/uL	4.20-5.80 M/uL	L

Component	Value	Unit	Reference Range	Flag
Hemoglobin	9.0	g/dL	12.0-16.0 g/dL	L

Component	Value	Unit	Reference Range	Flag
Hematocrit	26.6	%	36.0-46.0%	L

Component	Value	Unit	Reference Range	Flag
MCV	83	fL	80-100 fL	WNL

Component	Value	Unit	Reference Range	Flag
MCH	28.7	pg	27.0-33.0 pg	WNL

Component	Value	Unit	Reference Range	Flag
MCHC	32.7	g/dL	32.0-36.0 g/dL	WNL

Component	Value	Unit	Reference Range	Flag
RDW	15.7	%	11.5-14.5%	H

Component	Value	Unit	Reference Range	Flag
Platelets	246	K/uL	150-400 K/uL	WNL

Firstname	Amanda
Lastname	Ruiz
Middlename	J
Dob	1976-09-23
Gender	female
Medical Record Number	M370216
Admission Id	M370216
Charttime	2023-09-30 10:02:00
Category	Coagulation
Test Name	Coagulation Panel

Results

Component	Value	Unit	Reference Range	Flag
PT	27.3	sec	9.4-12.5 sec	H

Component	Value	Unit	Reference Range	Flag
INR	2.5		0.9-1.1	H

Component	Value	Unit	Reference Range	Flag
PTT	56.3	sec	25.0-36.5 sec	H

Discharge Summary

Patient Information

Full Name
Amanda J Ruiz

Date Of Birth
1976-09-23

Gender
Female

Medical Record Number
M370216

Admission Date
2023-09-30

Discharge Date
2023-10-13

Reason For Admission

Mr. Ruiz, a 47-year-old male with a history of CAD s/p CABG, was admitted for management of mediastinitis and persistent Group B Streptococcus (GBS) and Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. The patient initially presented with generalized malaise, nausea, vomiting, diarrhea, and intermittent chest discomfort for 6 days.

Hospital Course

During the 13-day hospital stay, Mr. Ruiz underwent extensive treatment for mediastinitis and polymicrobial bacteremia. Key events included: 1. Surgical debridement of sternal wound and mediastinum on admission day. 2. Placement of VAC dressing post-debridement. 3. Antibiotic therapy: Daptomycin 1000mg IV daily for MRSA and Cefepime 2g IV q8h for GBS (after desensitization). 4. Management of acute kidney injury with IV fluids and close monitoring. 5. Temporary pacemaker placement for management of bradycardia. 6. Daily wound checks and dressing changes. 7. Intensive insulin management for glycemic control. 8. Cardiology follow-up for management of heart failure (EF 45%). 9. Physical and occupational therapy for mobility and strengthening. 10. Gradual improvement in inflammatory markers and resolution of bacteremia.

Discharge Diagnosis

Primary
Post-sternotomy mediastinitis with polymicrobial bacteremia (GBS, MRSA)

Secondary
Acute kidney injury, resolving

Decompensated heart failure (EF 45%)

Type 2 Diabetes Mellitus

Hypertension

History of CVA with left-sided hemiparesis

Chronic Obstructive Pulmonary Disease (COPD)

Obesity

Medications At Discharge

Name	Dosage	Route	Frequency
Daptomycin	1000mg	IV	daily

Name	Dosage	Route	Frequency
Cefepime	2g	IV	q8h

Name	Dosage	Route	Frequency
Insulin Glargine	20 units	SC	nightly

Name	Dosage	Route	Frequency
Metoprolol Succinate XL	50mg	PO	daily

Name	Dosage	Route	Frequency
Lisinopril	10mg	PO	daily

Name	Dosage	Route	Frequency
Rosuvastatin	20mg	PO	nightly

Name	Dosage	Route	Frequency
Fluticasone/Salmeterol	250/50mcg	Inhaled	BID

Follow Up Plans

Cardiothoracic Surgery follow-up in 1 week for wound check and VAC dressing management
Infectious Disease follow-up in 2 weeks to assess antibiotic course
Cardiology appointment in 2 weeks for heart failure management
Endocrinology follow-up in 1 month for diabetes management
Primary Care Physician appointment in 2 weeks for overall care coordination

Discharge Instructions

Activity Restrictions

Gradually increase activity as tolerated. No lifting more than 5 pounds for 6 weeks. Use incentive spirometer 10 times every hour while awake.

Dietary Recommendations

Follow a low-sodium, diabetic diet. Limit fluid intake to 2 liters per day.

Wound Care

Keep VAC dressing in place and functioning. Do not get the dressing wet. Report any signs of increased drainage, redness, or fever immediately.

Medication Management

Take all medications as prescribed. Continue to monitor blood glucose levels 4 times daily and report any consistently high readings.

Signs Requiring Attention

Seek immediate medical attention if experiencing: - Fever above 101°F - Increased pain, redness, or drainage from the chest wound - Shortness of breath or chest pain - Dizziness or fainting spells - Blood glucose levels consistently above 250 mg/dL

Additional Notes

Social Support

Home health nursing arranged for daily VAC dressing checks and IV antibiotic administration.

Equipment Needs

VAC therapy system and supplies provided. Home glucose monitoring kit given.

Educational Resources

Patient and family educated on proper VAC dressing care, diabetes management, and heart failure symptoms to monitor.