28yo M w/ necrotizing pancreatitis c/b pseudocyst presented with acute hypoxic respiratory failure requiring intubation. Further complicated by renal failure requiring CVVHD.
Spiked fever [**2-19**] early AM to 102.8. Fully cultured. He was off CVVHD for 12 hours and developed hyperkalemia. CVVHD resarted 11AM on [**2-19**] and continues with goal fluid balance negative 5L/day. Renal service saw pt on Sunday and feels he is stable enough for HD if he needs it.
Over the weekend he was started on Ketamine and methadone doses increased to try to get him off fentanyl drip. He also was weaned off versed drip fairly quickly but due to agitation, tachycardia it was restarted and eventually increased to 10mg/hr to keep pt comfortable. He has been off fentanyl drip since Saturday and treated with methadone.
He continues on argatroban with goal PTT 60-80. He has DVT and will need 6 months anticoagulation according to last MD note.
His tube feeds were running at goal and he began to have loose brown stools after two doses lactulose given. He had great bowel sounds and methadone was switched to PO. Unfortunately his feeding tube clogged in the afternoon on Sunday and has been unable to be unclogged. He is now NPO due to no access and he may need to go to IR to have tube replaced or unclogged.
He has been doing very well weaning from the vent. Weaned to PSV 5/5 with good gases. Decision to extubate vs. possible trach will be addressed.
Renal failure, acute (Acute renal failure, ARF)
Assessment:
Received pt on CRRT with alarm of filter clotting by 7:15am. Pt was given 200cc ns flush via rescue line to assess patency of system: head of dialyzer almost entirely clotted. CVP 4, pt appears dry with no edema. Am wt 112kg. febrile 99.7axillary. stable bp in 120s, hr remains elevated in 120s. still making urine but amt decreasing (?from becoming dry) to 25-30cc/hr cloudy amber urine.
Action:
Returned pt
s blood and CRRT terminated. Dr. [**Last Name (STitle) 9399**] renal fellow and micu team aware of CRRT stopped. Pm lytes sent as well as urine lytes to assess if pt dry.
Response:
Maintained off CRRT. Continues to make adequate urine output. Cvp [**Location (un) 118**] 4.

Plan:
Monitor bun/cr/lytes, daily wt, i&o. hold off on CRRT for now. Pt stable to tolerate hemodialysis if needed. Renal team to continue to follow. f/u with pm lytes and urine lytes. [**Month (only) 8**] need small fluid bolus.
Respiratory failure, acute (not ARDS/[**Doctor Last Name 76**])
Assessment:
Received pt intubated and sedated on PSV, 5 ps 5 peep. Pt receiving versed drip at 8mg/hr, ketamine drip at .3mcg/kg/min and standing doses of iv methadone q4hr. unable to give seroquel at this time d/t clogged postpyloric dobhoff tube. Sleepy but easily arousable. Following commands when asked simple questions. Able to move upper extremities off bed toward ett thus bilateral wrist restraints maintained for safety. Perrla 3mm brisk. Pt denies pain but nodding that he feels anxious at times.appears comfortable on above settings.
Action:
Versed weaned down to 6mg/hr as pt still appearing sleepy. SBT done in am and pt did very well. Pt was looking close to extubation this am but required new dobhoff as old dobhoff clogged. Pt febrile up to 102.7axillary s/p dobhoff placement and appeared too lethargic and tachycardic up to 160 for extubation. It was decided by micu team to treat fever and maintain versed drip with boluses for agitation overnight and attempt extubatoin in am.
Response:
Abg on SBT:7.40/52/98. pt maintaining 02 sats in high 90s. minimal secretions sent for gm stain and cx. Pt maintained on PSV 5ps, 5 peep on fi02 35%. Rr remains in teens to low 20s with hr down to low 140s with cooling blanket and Tylenol (given pr).
Plan:
Continue PSV 5 ps 5 peep fi02 35% overnight. Treat fever with Tylenol, cooling blanket, and ice packs. f/u with urine lytes to see if pt needs small fluid bolus. Continue versed for sedation at 6mg/hr. only give bolus .5-2mg as needed. Attempt to wean sedation by 20% in am if fever trends down and tolerates. Continue methadone iv and ketamine iv for pain control.
Pancreatitis, acute
Assessment:
Abdomen remains firmly distended with + bowel sounds. NGT to LWS draining amber bile in large amts. pt remains with postpyloric feeding tube clogged.
Action:
Pt continues on meropenem [**Hospital1 **]. Tmax 102.7 axillary. Pan cultured (urine, bld cx from peripheral stick and left ij quad lumen central line, sputum cx and peritoneal cx from biliary drain).
Response:
Increased tachycardia up to 160 with agitation and fever in pm. Tachycardia decreasing with cooling blanket, ice packs, Tylenol. Pt not able to be extubated today, thus feeding resumed: vivonex at 55cc/hr.
Plan:
Continue to follow vitals, temp curve, abx, culture data, lfts. Cooling blanket, ice packs, Tylenol for temp. continue tube feedings until 12am.