Note ID: 13180007-DS-16

Extracted Subheadings

Here is the list of extracted subheadings:
* ALLERGIES
* ATTENDING
* CHIEF COMPLAINT
* HISTORY OF PRESENT ILLNESS
* MAJOR SURGICAL OR INVASIVE PROCEDURE
* REVIEW OF SYSTEMS
* PAST MEDICAL HISTORY
* SOCIAL HISTORY
* FAMILY HISTORY
* PHYSICAL EXAM
* PERTINENT RESULTS
* IMAGING
* BRIEF HOSPITAL COURSE
* ACTIVE ISSUES
* CHRONIC ISSUES
* TRANSITIONAL ISSUES
* CORE MEASURES
* DISCHARGE DIAGNOSIS
* DISCHARGE CONDITION
* DISCHARGE INSTRUCTIONS

Extracted Information

Here is the list of extracted subheadings:

Here is the list of extracted subheadings: Lab Results upon Admission: • 03:08AM Blood: • WBC-4.5 • RBC-3.12 • Hgb-8.2 • Hct-26.8 • MCV-86 • MCH-26.3 • MCHC-30.6 • RDW-14.6 • RDWSD-45.7 • Plt *[REDACTED]* • Neuts-80.1 • Lymphs-10.2 • Monos-7.1 • Eos-1.8 • Baso-0.4 • Im *[REDACTED]* • AbsNeut-3.62 • AbsLymp-0.46 • AbsMono-0.32 • AbsEos-0.08 • AbsBaso-0.02 • ProBNP-820 • cTropnT-0.02 • Albumin-3.6 • Calcium-8.3 • Phos-5.2 • Mg-1.9 • pO2-148 • pCO2-35 • pH-7.42 • Lac-2.5 • 12:50PM Blood: • cTropnT-0.01

: Active Issues * #Acute exacerbation of HFpEF (EF 57%) + Suspected by sudden onset worsening of subacute dyspnea + Flash pulmonary edema confirmed * #Possible ischemia given his positive stress test in ___ + Coronary angiogram deferred due to kidney function and suspicion of type 2 NSTEMI * #Likely triggered by pneumonia + Negative Legionella and strep tests + Influenza negative * #CAD w/ inducible ischemia + Continued aspirin and atorvastatin + Troponin peaked at 0.02, thought to be type 2 due to volume overload * #H/o CVA + Had an episode during hospitalization with dysarthria, confusion/mild expressive and receptive aphasia ___ > ___ + Code Stroke performed + CT Head non-con negative + MRA Brain/Neck, MRI Head with chronic changes, no acute infarct + EEG with slowing but no epileptiform changes + UCx and BCx negative * #Medication adherence + Blister-packed medications upon discharge through the ___ Pharmacy

* ALLERGIES

* ALLERGIES: No Known Allergies / Adverse Drug Reactions

* ATTENDING

* ATTENDING: - Attending physician: [NOT PROVIDED] - Vitals for Attending physician visit: None explicitly mentioned

* CHIEF COMPLAINT

* CHIEF COMPLAINT: • Shortness of breath • Presented with sudden onset worsening of subacute dyspnea • History of subacute shortness of breath over the last two weeks (e.g., having to sit down multiple times when going to grocery store or up steps at home) • Worsened acutely this morning when he woke-up struggling to breathe • EMS was called, SBP to 176 per ED documentation • Patient was given nitro x2 and started on CPAP • Found on the couch by his family was minimally responsive • Cough, rhinorrhea but no fever, no sputum • On the floor, he reports ongoing mild wheeze, improving shortness of breath, no current chest pain • Dyspnea: 3 on transfer • Patient described his diet as healthy but family concerned about salt intake

* HISTORY OF PRESENT ILLNESS

* HISTORY OF PRESENT ILLNESS: * Age: Not explicitly stated, but estimated to be around 70+ years old based on medical history and physical exam findings * Chief Complaint: Shortness of breath * History of Present Illness: + Patient was a 70-80 year old man with numerous cardiac risk factors, prior CVA + Presented with sudden onset worsening of subacute dyspnea + Found to have flash pulmonary edema + Admitted for acute HFpEF exacerbation + Symptoms worsened acutely this morning when he woke up struggling to breathe + EMS was called, SBP to 176 per ED documentation + Patient was given nitro x2 and started on CPAP + In the ED, he was started on bipap diuresed with OV Lasix, started on home BP medications and then transferred to floor + Initial vitals: HR 109 BP 176/67 RR 26 SpO2 90 + Patient was tachypneic, unable to speak in full sentences, crackles L>R, no focal deficits + Labs/studies notable for: NG x2, Lasix IV 40mg (at 4:30am), Zosyn/Vanc Amlodipine 10mg, Carvedilol 25mg, Lisinopril 2.5mg, levothyroxine, insulin 10U regular + Vitals on transfer: HR 1040 Temp: 98.4 PO BP: 115/45 R Lying HR: 68 RR: 20 O2 sat: 98% O2 delivery: 3LNC Dyspnea: 3 RASS: 0 Pain Score: + Per EMS and confirmed with family, patient was found on the couch by his family, sitting minimally responsive + Patient described subacute shortness of breath over the last two weeks, having to sit down multiple times when going to grocery store or up steps at home + He has also had a cough, rhinorrhea, but no fever, no sputum + This worsened acutely this morning when he woke-up struggling to breath * Inducible Ischemia: + Known inducible ischemia on LCX distribution from stress test + Decision was made to hold off on coronary angiogram due to kidney function and suspicion of type 2 NSTEMI * Recent Admission: + Recent admission to the heart failure service with uptitration of blood pressure control agents + Coronary angiogram was deferred at that time + ACEi was stopped given worsened CKD vs ___ + Low dose lisinopril was reinitiated at last visit with Dr. ___ * Medication Adherence: + Patient reportedly has difficulty with medication adherence + Multiple notes in OMR describe issues with ensuring consistent supply of medications + Patient and his family confirm this + Blister packed his medications upon discharge through the ___ Pharmacy

* MAJOR SURGICAL OR INVASIVE PROCEDURE

* MAJOR SURGICAL OR INVASIVE PROCEDURE: None.

* REVIEW OF SYSTEMS

* REVIEW OF SYSTEMS: Positive per HPI. This indicates that the review of systems is limited to simply stating that it was positive, but no further details or key-value pairs are provided for this subheading in the medical note.

* PAST MEDICAL HISTORY

* 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

* SOCIAL HISTORY: Family History: * Both parents have heart disease. * Mother: noted to have heart problems and diabetes. * Father: noted to have diabetes. * 16 brothers and sisters. * No known hx of early coronary artery disease or sudden cardiac death. No other Social History information is provided.

* FAMILY HISTORY

* FAMILY HISTORY: • Both parents have heart disease. + Mother: heart problems and diabetes + Father: diabetes • 16 brothers and sisters • No known hx of early coronary artery disease or sudden cardiac death

* PHYSICAL EXAM

* PHYSICAL EXAM: **ADMISSION PHYSICAL EXAM** * VS: Temperature: 98.4 Pulse: 1040 BP: 115/45 R Lying HR: 68 RR: 20 O2 sat: 98% O2 delivery: 3LNC Dyspnea: 3 RASS: 0 Pain Score: ___ * GENERAL: Speaking man, wearing nasal cannulae sititng in chair surrounded by family * NECK: Supple. JVP of 12 cm +hepatojugular reflux * CARDIAC: Regular rate and rhythm. Normal S1, S2. Right upper border systolic murmur III/VI. No thrills or lifts. * LUNGS: No chest wall deformities or tenderness. Respiration is unlabored with no accessory muscle use. No crackles, wheezes, or rhonchi. * ABDOMEN: Soft, non-tender, non-distended. No hepatomegaly. No splenomegaly. * EXTREMITIES: Warm, well-perfused. No clubbing, cyanosis, or peripheral edema. * SKIN: No significant skin lesions or rashes. * PULSES: Distal pulses palpable and symmetric. **DISCHARGE PHYSICAL EXAM** * VS: Temperature: 98.3 Pulse: 56 BP: 136/56 RR: 20 O2 sat: 97% O2 delivery: RA * GENERAL: Sitting up in a chair next to bed. NAD. * NECK: JVP 7-8 cm. * CARDIAC: Regular rate and rhythm. Normal S1, S2. Right upper border systolic murmur III/VI. * LUNGS: Respiration is unlabored with no accessory muscle use. No wheezes/rales/rhonchi. * ABDOMEN: +BS. Distended but soft. Non-tender to palpation. * EXTREMITIES: Warm. 1+ edema L > RLE.

* PERTINENT RESULTS

* PERTINENT RESULTS: ADMISSION LABS: • 03:08 AM BLOOD: • WBC-4.5 • RBC-3.12* • Hgb-8.2* • Hct-26.8* • MCV-86 • MCH-26.3 • MCHC-30.6* • RDW-14.6 • RDWSD-45.7 • Plt: [REDACTED] • 03:08 AM BLOOD: • Neuts-80.1* • Lymphs-10.2* • Monos-7.1 • Eos-1.8 • Baso-0.4 • Im: [REDACTED] • AbsNeut-3.62 • AbsLymp-0.46* • 03:08 AM BLOOD: • PTT-23.2* • 03:08 AM BLOOD: • Glucose-384* • UreaN-36* • Creat-2.5* • Na-135 • K-4.9 • Cl-100 • HCO3-22 • AnGap-13 • 03:08 AM BLOOD: • ALT-19 • AST-17 • AlkPhos-105 • TotBili-0.2 • 03:08 AM BLOOD: • proBNP-820* • 03:08 AM BLOOD: • cTropnT-0.02* • 12:50 AM BLOOD: • cTropnT-0.01 • 03:08 AM BLOOD: • Albumin-3.6 • Calcium-8.3* • Phos-5.2* • Mg-1.9 • 03:14 AM BLOOD: • pO2-148* • pCO2-35 • pH-7.42 • calTCO2-23 • Base XS-0 • 03:14 AM BLOOD: • Lactate-2.5* MICRO STUDIES: • URINE CULTURE: No Growth. • URINE LEGIONELLA ANTIGEN: Negative for Legionella Serogroup 1 Antigen. IMAGING: • CXR: Findings are compatible with moderate pulmonary edema with a moderate left pleural effusion. Underlying bibasilar atelectasis and/or pneumonia in the appropriate clinical setting should also be considered. • CT HEAD WO CON: Area of low-density left occipital represents subacute infarct, if there are clinical symptoms, consider brain MRI without contrast. Small chronic lacunar infarct right basal ganglia. Few calcifications at the pons, nonspecific, may be sequela of prior inflammatory or ischemic process, cavernoma cannot

be excluded. • TTE: The left atrial volume index is mildly increased. There is mild symmetric left ventricular hypertrophy with a normal cavity size. There is normal regional and global left ventricular systolic function. The visually estimated left ventricular ejection fraction is 55-60%. • MRI/MRA HEAD AND NECK: No hemorrhage or acute infarct. Chronic infarcts within the subcortical right frontal lobe and left temporal and occipital lobes. Atrophic pons likely a sequela of prior infarcts. Severe intracranial atherosclerotic disease resulting in narrowing of nearly all of the large intracranial vessels.

* IMAGING

* IMAGING: * CXR (___): + Impressions: - Compatible with moderate pulmonary edema with a moderate left pleural effusion. - Underlying bibasilar atelectasis and/or pneumonia in the appropriate clinical setting should also be considered. * CT HEAD WO CON (___): + Impressions: - Area of low-density left occipital region represents subacute infarct, if there are clinical symptoms, consider brain MRI without contrast. - Small chronic lacunar infarct right basal ganglia. - Few calcifications at the pons, nonspecific, may be sequela of prior inflammatory or ischemic process, cavernoma cannot be excluded. * TTE (___): + Conclusion: - Left atrial volume index is mildly increased. - Mild symmetric left ventricular hypertrophy with a normal cavity size. - Normal regional and global left ventricular systolic function. - Visually estimated left ventricular ejection fraction is 55-60%. - No resting left ventricular outflow tract gradient. - Normal right ventricular cavity size with normal free wall motion. - Aortic sinus diameter is normal for gender with normal ascending aorta diameter for gender. - Aortic valve leaflets appear structurally normal. - No aortic valve stenosis. - Trace aortic regurgitation. - Mitral valve leaflets appear structurally normal with no mitral valve prolapse. - Trivial mitral regurgitation. - Pulmonic valve leaflets are normal. - Tricuspid valve leaflets appear structurally normal. - Physiologic tricuspid regurgitation. - Pulmonary artery systolic pressure could not be estimated. - Trivial pericardial effusion. + Impressions: - Mild symmetric left ventricular hypertrophy with normal cavity size and regional/global biventricular systolic function. - No significant mitral regurgitation. * MRI/MRA HEAD AND NECK (___): + Impressions: - No hemorrhage or acute infarct. - Chronic infarcts within the subcortical right frontal lobe and left temporal and occipital lobes. - Atrophic pons likely a sequela of prior infarcts. - Severe intracranial atherosclerotic disease resulting in narrowing of nearly all of the large intracranial vessels. - Chronic occlusion of the distal right middle carotid artery M1 segment with collateral vessels seen distally. - Narrowing of the proximal bilateral internal carotid arteries, left greater than right. - Atherosclerotic disease narrowing the left vertebral artery proximally and causing chronic occlusion distally. - Large left-sided pleural effusion.

* BRIEF HOSPITAL COURSE

* BRIEF HOSPITAL COURSE: • Patient with numerous cardiac risk factors, prior CVA, and HFpEF presented with sudden onset worsening of subacute dyspnea and flash pulmonary edema. • On admission, patient was found to have: + Elevated blood pressure + Tachypneic and unable to speak in full sentences + Crackles in the lungs + Regular rate and rhythm on EKG + Labs/studies notable for: - Elevated creatinine - Hyperkalemia - Elevated glucose - Hyperphosphatemia - Elevated proBNP - Elevated cTropnT • Patient was started on: + Diuresis: bipap, diuresed with OV Lasix, and then transferred to floor + Medications: Torsemide 40 mg QD, Amlodipine 10 mg QD, Carvedilol 37.5 mg BID, Hydralazine 100 mg TID, and others • Patient underwent the following tests and procedures: + Admission labs (see Pertinent Results section) + EKG + Chest X-ray (Compatibility with moderate pulmonary edema and moderate left pleural effusion) + CT Head without contrast (Subacute infarct in the left occipital lobe) + TTE (Mildly increased left atrial volume index, mild symmetric left ventricular hypertrophy, and normal cavity size) + MRI/MRA Head and Neck (Chronic infarcts, severe intracranial atherosclerotic disease, and chronic occlusion of the distal right middle carotid artery) • Patient's active issues on discharge: + Acute exacerbation of HFpEF (EF 57%) + Potential ischemic event + Hypertension + Coronary artery disease with inducible ischemia + History of CVA + Asthma (suspected COPD) + Medication adherence issues • Patient's discharge medications: + Torsemide 40 mg QD + Amlodipine 10 mg QD + Carvedilol 37.5 mg BID + Hydralazine 100 mg TID + Lasix 40 mg IV (around time not specified) + Zosyn/Vanc + Amlodipine 10mg + Carvedilol 25mg + Lisinopril 2.5mg + Levothyroxine + Insulin 10U regular + Advair + Torsemide 40 mg QD + Atorvastatin 80 mg QPM +

Humalog + Glargine + Lantus + Humalog sliding scale + Albuterol Inhaler + Aspirin 81 mg PO DAILY + Atorvastatin 80 mg PO QPM + CloNIDine 0.2 mg PO BID + HydrALAZINE 100 mg PO TID + Levothyroxine Sodium 100 mcg PO DAILY + sevelamer CARBONATE 800 mg PO TID W/MEALS • Patient's follow-up instructions: + Weigh yourself every morning. + Follow up with your doctors as listed below. + Call Dr. ___ office at ___ if your weight goes up by 3 lbs or more. + Contact our ___ Heartline at ___ for 24/7 support.

* ACTIVE ISSUES

* ACTIVE ISSUES: #Acute exacerbation of HFpEF (EF 57%) #Hyperkalemia: Initially due to venous congestion, then likely due to overdiuresis Patient had underlying CKD and his creatinine did not return to his baseline upon discharge #Community acquired pneumonia Cough, worsened SOB, hypoxemia (although alternate explanation) but no leukocytosis or fevers Legionella and strep were negative Patient was given a 5-day course of ceftriaxone and azithromycin #Hypertension Goal <130/80 Patient is on several anti-hypertensives with still an elevated blood pressure He underwent a secondary hypertension workup His last renal ultrasound in ___ was within normal limits #CAD w/ inducible ischemia Troponin peaked at 0.02, thought to be type 2 due to volume overload #H/o CVA Patient had an episode while in hospital with dysarthria, confusion/mild expressive and receptive aphasia No acute infarct found EEG with slowing but no epileptiform changes #Hyperlipidemia Patient approved for PCSK9 inhibitor #Iron deficiency anemia Will need a colonoscopy as an outpatient #CKD Anticipate he may need dialysis in the future K on discharge was 4.8 and Cr on discharge was 3.7 LIKELY ISSUES: #Possible ischemia given his positive stress test in ___

* CHRONIC ISSUES

* CHRONIC ISSUES: #Anemia: + Suspect secondary to EPO deficiency in CKD + Iron studies showed iron deficiency + Patient was repleted with 4 doses of ferric gluconate #DM type II: + Patient has poorly controlled diabetes mellitus + Last A1c 12.3% (but off insulin at that time) + Hyperglycemic on admission + Titrated insulin regimen on discharge: - Lantus 30 u with breakfast - Lantus 10 u QHS - Standing Humalog 5 u with breakfast - Standing Humalog 5 u with lunch - Standing Humalog 5 u with dinner #Hyperlipidemia: + Continued Atorvastatin 80mg daily #Cerebrovascular accident: + Patient had an episode while in hospital with dysarthria, confusion/mild expressive and receptive aphia + CT Head non-con negative + MRA Brain/Neck, MRI Head with chronic changes, no acute infarct + No acute needs found + Continued on aspirin and high-dose atorvastatin #Intracranial atherosclerosis: + Continued ASA 81mg daily + Continued atorvastatin 80 mg QD #COPD: + Suspect COPD given patient's extensive smoking history + Started on Advair as an inpatient + Consider PFTs to confirm diagnosis #CKD: + Anticipate patient may need dialysis in the future + K on discharge was 4.8 and Cr on discharge was 3.7 + Labs: Please recheck a BMP at next follow-up to monitor K and Cr #CAD w/ inducible ischemia: + Continued aspirin, atorvastatin, carvedilol + Held off on coronary angiogram due to kidney function and suspicion of type 2 NSTEMI + Trop peaked at 0.02

* TRANSITIONAL ISSUES

* TRANSITIONAL ISSUES: • Follow-up: o PCP o Cardiology o Hopefully see ___ as an outpatient to monitor blood glucose • New medications: o Torsemide 40 mg qd o Advair o Discharging w/ insulin pens, currently Insulin (lantus 40 qam and 10 qpm w/ Novolog ___ w/ SSI with meals) • Changed medications: o Increased coreg to 37.5 mg BID o Amlodipine switched from qod to everyday • Instructions: o Monitor BP as an outpatient and consider starting imdur o Consider initiation of spironolactone once Cr is downtrending o Consider PFTs to see if patient has COPD o Please monitor his blood glucose as an outpatient as his blood glucoses ran elevated as an inpatient o Consider outpatient CT Chest given patient's smoking history o Per prior cardiology note, patient approved for PCSK9 inhibitor o Patient will need a colonoscopy as an outpatient for iron deficiency anemia o Labs: Please recheck a BMP at his next follow-up appointment to monitor K and Cr in addition to CKD, anticipating that he may need dialysis in the future o Diet: Low potassium diet o Followup appointment

for outpatient labs o Refer to adjuncts * ■■■■

* CORE MEASURES

* CORE MEASURES: #CODE: Full #CONTACT: [REDACTED] daughter HCP Preadmission Medication List: 1. Lisinopril 2.5 mg PO DAILY 2. CloNIDine 0.2 mg PO BID 3. amLODIPine 10 mg PO EVERY OTHER DAY 4. HydrALAZINE 100 mg PO TID 5. Aspirin 81 mg PO DAILY 6. CARVedilol 25 mg PO BID 7. Atorvastatin 80 mg PO QPM 8. liraglutide 1.2 mg subcutaneous DAILY 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Glargine 55 Units Breakfast 11. Furosemide 40 mg PO BID 12. Albuterol Inhaler __ PUFF IH Q6H:PRN wheezing, SOB Discharge Medications: 1. BD Ultra-Fine Short Pen Needle (pen needle, diabetic) 31 gauge x __ miscellaneous 2. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID 3. sevelamer CARBONATE 800 mg PO TID W/MEALS 4. Torsemide 40 mg PO DAILY 5. amLODIPine 10 mg PO DAILY 6. CARVedilol 37.5 mg PO BID 7. Glargine 30 Units Breakfast Glargine 10 Units Bedtime Humalog 5 Units Breakfast Humalog 5 Units Lunch Humalog 5 Units Dinner Insulin SC Sliding Scale using HUM Insulin 8. Albuterol Inhaler __ PUFF IH Q6H:PRN wheezing, SOB 9. Aspirin 81 mg PO DAILY 10. Atorvastatin 80 mg PO QPM 11. CloNIDine 0.2 mg PO BID 12. HydrALAZINE 100 mg PO TID 13. Levothyroxine Sodium 100 mcg PO DAILY

* DISCHARGE DIAGNOSIS

* DISCHARGE DIAGNOSIS: PRIMARY DIAGNOSIS ========== Acute on chronic heart failure with preserved ejection fraction SECONDARY DIAGNOSES ========== - Acute kidney injury - Coronary artery disease - Type 2 Diabetes Mellitus - Hyperkalemia Core Transitional Issues: - HFpEF - Consider initiation of spironolactone once Cr is downtrending - ?COPD - Consider PFTs to see if patient has COPD. Started on Advair as an inpatient - DM: Please monitor his blood glucose as an outpatient as his blood glucoses ran elevated as an inpatient - Lung cancer screening - Given patient's smoking history, consider outpatient CT Chest - Hyperlipidemia - Per prior cardiology note, patient approved for PCSK9 inhibitor - Iron deficiency anemia: Will need a colonoscopy as an outpatient - CKD - Anticipate he may need dialysis in the future

* DISCHARGE CONDITION

* DISCHARGE CONDITION: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure participating in your care. Please read through the following information. WHY WAS I ADMITTED TO THE HOSPITAL? - You were admitted to the hospital because you had been feeling short of breath and you were found to have fluid on your lungs. This was felt to be due to a condition called heart failure, where your heart does not pump hard enough and fluid backs up into your lungs. WHAT HAPPENED WHILE I WAS IN THE HOSPITAL? - You were given a diuretic medication through the IV to help get the fluid out. You improved considerably and were ready to leave the hospital. - You underwent an echocardiogram, which is an ultrasound of your heart; this showed that your heart is functioning the same as before. - You underwent an MRI/MRA of your head and neck because there was concern that you had a new stroke; you did not have a new stroke. - You were seen by ___ diabetes physician and your insulin regimen was adjusted. WHAT DO YOU NEED TO DO WHEN YOU LEAVE THE HOSPITAL? - Take all of your medications as prescribed (listed below) - Follow up with your doctors as listed below - Weigh yourself every morning. Your weight on discharge is 72.7 kg (160.27 lb). Please call Dr. ___ office at ___ if your weight goes up by 3 lbs or more. - If you have any questions or concerning symptoms after discharge, such as shortness of breath, leg swelling, or weight gain, please call our ___ Heartline at ___ to speak to a nurse practitioner or ___ cardiologist; this is available 24 hours a day, 7 days a week. We wish you the best! Your ___ Care Team Followup Instructions: _____ Discharge Diagnosis: PRIMARY DIAGNOSIS ========== Acute on chronic heart failure with preserved ejection fraction SECONDARY DIAGNOSES ========== Acute kidney injury Coronary artery disease Type 2 Diabetes Mellitus Hyperkalemia Discharge Condition Details: - Insulin regimen details: - Lantus 30 u with breakfast -

Lantus 10 u QHS - Standing Humalog 5 u with breakfast - Standing Humalog 5 u with lunch - Standing Humalog 5 u with dinner - Medications to be taken as prescribed: 1. Torsemide 40 mg PO DAILY 2. amLODIPine 10 mg PO DAILY 3. CARVedilol 37.5 mg PO BID 4. Glargine 30 Units Breakfast 5. Glargine 10 Units Bedtime 6. Humalog 5 Units Breakfast 7. Humalog 5 Units Lunch 8. Humalog 5 Units Dinner 9. Albuterol Inhaler ___ PUFF IH Q6H:PRN wheezing, SOB 10. Aspirin 81 mg PO DAILY 11. Atorvastatin 80 mg PO QPM 12. CloNIDine 0.2 mg PO BID 13. HydrALAZINE 100 mg PO TID 14. Levothyroxine Sodium 100 mcg PO DAILY

* DISCHARGE INSTRUCTIONS

* DISCHARGE INSTRUCTIONS: * Take all prescribed medications listed below: + Fluticasone-Salmeterol Diskus (Advair) 1 inhalation, twice a day + Sevelamer Carbonate 800 mg, three times a day with meals + Torsemide 40 mg, once a day + Amlodipine 10 mg, once a day + Carvedilol 37.5 mg, twice a day + Lantus (Glargine) 30 units in the morning and 10 units at bedtime + Humalog (insulin) 5 units with breakfast, lunch, and dinner + CloNIDine 0.2 mg, twice a day + Hydralazine 100 mg, three times a day + Levothyroxine Sodium 100 mcg, once a day + Aspirin 81 mg, once a day + Atorvastatin 80 mg, once a day * Weigh yourself every morning and report any weight gain of 3 lbs or more to Dr. ___ office at ___. * Contact the hospital's Heartline at ___ (available 24 hours, 7 days a week) if you experience any concerning symptoms, such as: + Shortness of breath + Leg swelling + Weight gain * Follow up with doctors as listed in the Transitional Issues section: + Primary Care Physician (PCP) + Cardiology + ___ diabetes physician * Monitor blood sugar levels and report any concerns to the diabetes physician * Consider starting immundur and initiating spironolactone once creatinine is downtrending * Schedule a colonoscopy to investigate iron deficiency anemia * Get a BMP at the next follow-up appointment to monitor potassium and creatinine levels

Original Note

Name: ___ Unit No: ___ Admission Date: ___ Discharge Date: ___ Date of Birth: ___ Sex: M Service: MEDICINE Allergies: No Known Allergies / Adverse Drug Reactions Attending: ___. Chief Complaint: shortness of breath Major Surgical or Invasive Procedure: None History of Present Illness: ___ year old man with numerous cardiac risk factors, prior CVA presented with sudden onset worsening of subacute dyspnea found to have flash pulmonary edema admitted for acute HFpEF exacerbation. Per EMS and confirmed with family, patient was found on the couch by his family was minimally responsive. Patient described subacute shortness of breath over the last two weeks (e.g., having to sit down multiple times when going to grocery store or up steps at home). He has also had a cough, rhinorrhea but no fever, no sputum. This worsened acutely this morning when he woke-up struggling to breath. EMS was called, SBP to 176 per ED documentation, patient was given nitro x2 and started on CPAP. In the ED, he was started on bipap diuresed with OV Lasix, started on home BP medications and then transferred to floor. - Initial vitals: HR 109 BP 176/67 RR 26 ___ 90, patient was tachypneic, unable to speak in full sentences, crackles L>R, no focal deficits - EKG: not commented upon - Labs/studies notable for: Patient was given: NG x2. Lasix IV 40mg (at 4:30am), Zosyn/Vanc Amlodipine 10mg, Carvedilol 25mg, Lisinopril 2.5mg, levothyroxine, insulin 10U regular, - Vitals on transfer: ___ 1040 Temp: 98.4 PO BP: 115/45 R Lying HR: 68 RR: 20 O2 sat: 98% O2 delivery: 3LNC Dyspnea: 3 RASS: 0 Pain Score: ___ Of note, since ___, he has had known inducible ischemia on LCX distribution from stress test. The risks (including dialysis after contrast load) and benefits were discussed with primary cardiologist Dr. ___. Coronary angiogram was deferred. He also had a recent admission to the heart failure service with uptitration of blood pressure control agents. Coronary angiogram was deferred at that time. ACEi was stopped (prior lisinopril 40mg) given worsened CKD vs ___. Low dose lisinopril was reinitiated at last visit with Dr. ___. Multiple notes in OMR describe issues with ensuring consistent supply of medications. The patient and his family confirm this. However, they state recently no change in medications, ___ comes once per week. He describes his diet as healthy but family concerned about salt intake. No h/o arrhythmia, no palpitations. On the floor, he reports ongoing mild wheeze, improving shortness of breath, no current chest pain. REVIEW OF SYSTEMS: Positive per HPI. 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: ___ 1040 Temp: 98.4 PO BP: 115/45 R Lying HR: 68 RR: 20 O2 sat: 98% O2 delivery: 3LNC Dyspnea: 3 RASS: 0 Pain Score: ___ GENERAL: ___ speaking man, wearing nasal cannulae sititng in chair surrounded by family NECK: Supple. JVP of 12 cm +hepatojugular reflux CARDIAC: Regular rate and rhythm. Normal S1, S2. Right upper border systolic murmur III/VI. no thrills or lifts. LUNGS: No chest wall deformities or tenderness. Respiration is unlabored with no accessory muscle use. No crackles, wheezes or rhonchi. ABDOMEN: Soft, non-tender, non-distended. No hepatomegaly. No splenomegaly. EXTREMITIES: Warm, well perfused. No clubbing, cyanosis, or peripheral edema. SKIN: No significant skin lesions or rashes. PULSES: Distal pulses palpable and symmetric. DISCHARGE PHYSICAL EXAM ========== VS: 24 HR Data (last updated ___ @ 817) Temp: 98.3 (Tm 98.4), BP: 136/56 (135-164/56-69), HR: 78 (57-84), RR: 20 (___), O2 sat: 97% (95-97), O2 delivery: RA 24 HR Data (last updated ___ @ 817) Temp: 98.3 (Tm 98.4), BP: 136/56 (135-164/56-69), HR: 78 (57-84), RR: 20 (___), O2 sat: 97% (95-97), O2 delivery: RA Fluid Balance (last updated ___ @ 600) Last 8 hours Total cumulative -405ml IN: Total 120ml, PO Amt 120ml OUT: Total 525ml, Urine Amt 525ml Last 24 hours Total cumulative -725ml IN: Total 1000ml, PO Amt 900ml, IV Amt Infused 100ml OUT: Total 1725ml, Urine Amt 1725ml WEIGHT: 74.3 kg (75.6 kg) GENERAL: Sitting up in a chair next to bed. NAD. NECK: JVP 7-8 cm. CARDIAC: Regular rate and rhythm. Normal S1, S2. Right upper border systolic murmur III/VI. LUNGS: Respiration is unlabored with no accessory muscle use. CTAB. No wheezes/rales/rhonchi. ABDOMEN: +BS. Distended but soft. Non-tender to palpation. EXTREMITIES: Warm. 1+ edema L > RLE. Pertinent Results: ADMISSION LABS ========== ___ 03:08AM BLOOD WBC-4.5 RBC-3.12* Hgb-8.2* Hct-26.8* MCV-86 MCH-26.3 MCHC-30.6* RDW-14.6 RDWSD-45.7 Plt ___ ___ 03:08AM BLOOD Neuts-80.1* Lymphs-10.2* Monos-7.1 Eos-1.8 Baso-0.4 Im ___ AbsNeut-3.62 AbsLymp-0.46* AbsMono-0.32 AbsEos-0.08

AbsBaso-0.02 ___ 03:08AM BLOOD ___ PTT-23.2* ___ ___ 03:08AM BLOOD Glucose-384* UreaN-36* Creat-2.5* Na-135 K-4.9 Cl-100 HCO3-22 AnGap-13 ___ 03:08AM BLOOD ALT-19 AST-17 AlkPhos-105 TotBili-0.2 ___ 03:08AM BLOOD proBNP-820* ___ 03:08AM BLOOD cTropnT-0.02* ___ 12:50PM BLOOD cTropnT-0.01 ___ 03:08AM BLOOD Albumin-3.6 Calcium-8.3* Phos-5.2* Mg-1.9 ___ 03:14AM BLOOD ___ pO2-148* pCO2-35 pH-7.42 calTCO2-23 Base XS-0 ___ 03:14AM BLOOD Lactate-2.5* MICRO STUDIES ========== UCx ___ 7:56 am URINE **FINAL REPORT ___ URINE CULTURE (Final ___: NO GROWTH. Legionella Urine Antigen ___ 3:49 pm URINE Source: ___. **FINAL REPORT ___ Legionella Urinary Antigen (Final ___: NEGATIVE FOR LEGIONELLA SEROGROUP 1 ANTIGEN. (Reference Range-Negative). Performed by Immunochromogenic assay. A negative result does not rule out infection due to other L. pneumophila serogroups or other Legionella species. Furthermore, in infected patients the excretion of antigen in urine may vary. BCx ___ _____ IMAGING ======== CXR (___) ---------- IMPRESSION: Findings are compatible with moderate pulmonary edema with a moderate left pleural effusion. Underlying bibasilar atelectasis and/or pneumonia in the appropriate clinical setting should also be considered. CT HEAD WO CON (___) IMPRESSION: Area of low-density left occipital ___ represent subacute infarct, if there are clinical symptoms, consider brain MRI without contrast. Small chronic lacunar infarct right basal ganglia. Few calcifications at the pons, nonspecific, may be sequela of prior inflammatory or ischemic process, cavernoma cannot be excluded. TTE (___) ---------- CONCLUSION: The left atrial volume index is mildly increased. There is mild symmetric left ventricular hypertrophy with a normal cavity size. There is normal regional and global left ventricular systolic function. The visually estimated left ventricular ejection fraction is 55-60%. There is no resting left ventricular outflow tract gradient. 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 valve leaflets (3) appear structurally normal. There is no aortic valve stenosis. There is trace aortic regurgitation. The mitral valve leaflets appear structurally normal with no mitral valve prolapse. There is trivial mitral regurgitation. The pulmonic valve leaflets are normal. The tricuspid valve leaflets appear structurally normal. There is physiologic tricuspid regurgitation. The pulmonary artery systolic pressure could not be estimated. There is a trivial pericardial effusion. IMPRESSION: Mild symmetric left ventricular hypertrophy with normal cavity size and regional/global biventricular systolic function. No significant mitral regurgitation. Compared with the prior TTE ___, the findings are similar. MRI/MRA HEAD AND NECK (___) IMPRESSION: 1. No hemorrhage or acute infarct. 2. Chronic infarcts within the subcortical right frontal lobe and left temporal and occipital lobes. 3. Atrophic pons likely a sequela of prior infarcts. 4. Severe intracranial atherosclerotic disease resulting in narrowing of nearly all of the large intracranial vessels. 5. Chronic occlusion of the distal right middle carotid artery M1 segment with collateral vessels seen distally. 6. Narrowing of the proximal bilateral internal carotid arteries, left greater than right. 7. Atherosclerotic disease narrowing the left vertebral artery proximally and causing chronic occlusion distally. 8. Large left-sided pleural effusion. Brief Hospital Course: ========== PATIENT SUMMARY ========== ___ year old man with numerous cardiac risk factors, prior CVA, HFpEF who presented with sudden onset worsening of subacute dyspnea found to have flash pulmonary edema admitted for acute HFpEF exacerbation. ========== ACTIVE ISSUES: ========== #Acute exacerbation of HFpEF (EF 57%) Likely ___s possible ischemia given his positive stress in ___. Also possibly triggered by pneumonia. Did endorse occasional angina symptoms, but trop was flat with no EKG changes. TTE showed no regional wall motion abnormalities and no mitral regurgitation. He was actively diuresed. His lisinopril was held due to ___. His heart failure regimen upon discharge: DIURESIS: Torsemide 40 mg QD AFTERLOAD: Hydralazine 100 mg TID Clonidine 0.2 mg BID Held lisinopril given ___ Amlodipine 10 mg QD NHBK: Carvedilol 37.5 mg BID; - Discharge weight: 72.7 kg (160.27 lb) - Discharge Cr: 3.7 ___ on CKD: #Hyperkalemia: Initially due to venous congestion, then likely due to overdiuresis. He had underlying CKD and his creatinine did not return to his baseline upon discharge. We suspect that he will need to initiate HD in the near future. His K rose to about 5.8 the week prior to discharge, but this improved with Lasix IV, kayexelate, and low potassium diet. #Community acquired pneumonia Cough, worsened SOB, hypoxemia (although alternate explanation) but no leukocytosis or fevers; influenza negative. Legionella and strep were negative. Patient was given a 5-day course of ceftriaxone and azithromycin. #Hypertension Goal <130/80. As patient is on several anti-hypertensives with still an elevated blood pressure, he underwent a secondary hypertension workup. His last renal ultrasound in ___ was within normal limits. He was placed on continuous O2 monitoring overnight, and patient did not desaturate. His aldosterone to renin ratio was 0.13, indicating no primary hyperaldosteronism. 24 hour urine metanephrines and

catecholamines were within normal limits. #CAD w/ inducible ischemia #NSTEMI Troponin peaked at 0.02, thought to be type 2 due to volume overload. Continued aspirin, atorvastatin, carvedilol. The decision was made to hold off on coronary angiogram due to kidney function and the suspicion that this was type 2. #H/o CVA Patient had an episode while in hospital with dysarthria, confusion/mild expressive and receptive aphasia ___ > ___ that led to a Code Stroke. CT Head non-con negative. MRA Brain/Neck, MRI Head with chronic changes, no acute infarct. ___ EEG with slowing but no epileptiform changes. UCx and BCx negative. ___ evaluated the patient and found no acute needs. He was continued to aspirin and high-dose atorvastatin. #H/o "asthma" Patient stated that he uses rescue inhaler daily. We started him on Advair, as we suspect that he has COPD given his extensive smoking history. #Medication adherence Patient reportedly has difficulty with medication adherence. We blister packed his medications upon discharge through the ___ Pharmacy. ========== CHRONIC ISSUES: ========== #Anemia: Suspect secondary to EPO deficiency in CKD, iron studies showed iron deficiency. Patient was repleted with 4 doses of ferric gluconate. #DM type II: Poorly controlled, on basal galargine as well as GLP-1, last A1c 12.3% (but off insulin at that time). Hyperglycemic on admission but without anion gap and bicarb 22 with strong ion difference 35 very reassuring against metabolic acidosis. The ___ diabetes team saw the patient and titrated his insulin regimen. His insulin regimen on discharge: - Lantus 30 u with breakfast - Lantus 10 u QHS - Standing Humalog 5 u with breakfast - Standing Humalog 5 u with lunch - Standing Humalog 5 u with dinner #Hyperlipidemia - Continued Atorvastatin 80mg daily #Cerebrovascular accident #Intracranial atherosclerosis - Continued ASA 81mg daily - Continued atorvastatin 80 mg QD as above ========== TRANSITIONAL ISSUES ========== [ ] Follow-up: PCP, ___, cardiology [ ] New medications: Torsemide 40 mg qd, advair [ ] Changed medications: Insulin (lantus 40 qam and 10 qpm w/ Novolog ___ w/ SSI with meals; discharged w/ insulin pens), coreg was increased to 37.5 mg BID. Amlodipine was switched from qod to everyday. [ ] Please monitor BP as an outpatient and consider starting imdur. [ ] HFpEF - Consider initiation of spironolactone once Cr is downtrending. [ ] ?COPD - Consider PFTs to see if patient has COPD. Started on advair as an inpatient. [ ] DM: Please monitor his blood glucose as an outpatient as his blood glucoses ran elevated as an inpatient. He should follow-up with ___ as an outpatient. [ ] Lung cancer screening - Given patient's smoking history, consider outpatient CT Chest. [ ] Hyperlipidemia - Per prior cardiology note, patient approved for PCSK9 inhibitor. [ ] Iron deficiency anemia: Will need a colonoscopy as an outpatient [ ] CKD - Anticipate he may need dialysis in the future. K on discharge was 4.8 and Cr on discharge was 3.7. [ ] Labs: Please recheck a BMP at his next follow-up appointment to monitor K and Cr. [ ] Discharge weight: 72.7 kg ========== CORE MEASURES ========== #CODE: Full #CONTACT: ___ daughter HCP ___ on Admission: The Preadmission Medication list is accurate and complete. 1. Lisinopril 2.5 mg PO DAILY 2. CloNIDine 0.2 mg PO BID 3. amLODIPine 10 mg PO EVERY OTHER DAY 4. HydrALAZINE 100 mg PO TID 5. Aspirin 81 mg PO DAILY 6. CARVedilol 25 mg PO BID 7. Atorvastatin 80 mg PO QPM 8. liraglutide 1.2 mg subcutaneous DAILY 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Glargine 55 Units Breakfast 11. Furosemide 40 mg PO BID 12. Albuterol Inhaler ___ PUFF IH Q6H:PRN wheezing, SOB Discharge Medications: 1. BD Ultra-Fine Short Pen Needle (pen needle, diabetic) 31 gauge x ___ miscellaneous ASDIR 2. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID RX *fluticasone-salmeterol [Advair Diskus] 250 mcg-50 mcg/dose 1 dose inhaled twice a day Disp #*1 Disk Refills:*0 3. sevelamer CARBONATE 800 mg PO TID W/MEALS RX *sevelamer carbonate 800 mg 1 tablet(s) by mouth three times a day with meals Disp #*90 Tablet Refills:*0 4. Torsemide 40 mg PO DAILY RX *torsemide 20 mg 2 tablet(s) by mouth once a day Disp #*60 Tablet Refills:*0 5. amLODIPine 10 mg PO DAILY 6. CARVedilol 37.5 mg PO BID RX *carvedilol 25 mg 1.5 tablet(s) by mouth twice a day Disp #*90 Tablet Refills:*0 7. Glargine 30 Units Breakfast Glargine 10 Units Bedtime Humalog 5 Units Breakfast Humalog 5 Units Lunch Humalog 5 Units Dinner Insulin SC Sliding Scale using HUM Insulin 8. Albuterol Inhaler ___ PUFF IH Q6H:PRN wheezing, SOB 9. Aspirin 81 mg PO DAILY RX *aspirin 81 mg 1 tablet(s) by mouth once a day Disp #*30 Tablet Refills:*0 10. Atorvastatin 80 mg PO QPM RX *atorvastatin 80 mg 1 tablet(s) by mouth once a day Disp #*30 Tablet Refills:*0 11. CloNIDine 0.2 mg PO BID RX *clonidine HCl 0.2 mg 1 tablet(s) by mouth twice a day Disp #*60 Tablet Refills:*0 12. HydrALAZINE 100 mg PO TID RX *hydralazine 100 mg 1 tablet(s) by mouth three times a day Disp #*90 Tablet Refills:*0 13. Levothyroxine Sodium 100 mcg PO DAILY RX *levothyroxine 100 mcg 1 tablet(s) by mouth once a day Disp #*30 Tablet Refills:*0 Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: PRIMARY DIAGNOSIS ========== Acute on chronic heart failure with preserved ejection fraction SECONDARY DIAGNOSES ========== Acute kidney injury

Coronary artery disease Type 2 Diabetes Mellitus Hyperkalemia Discharge Condition: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure participating in your care. Please read through the following information. WHY WAS I ADMITTED TO THE HOSPITAL? - You were admitted to the hospital because you had been feeling short of breath and you were found to have fluid on your lungs. This was felt to be due to a condition called heart failure, where your heart does not pump hard enough and fluid backs up into your lungs. WHAT HAPPENED WHILE I WAS IN THE HOSPITAL? - You were given a diuretic medication through the IV to help get the fluid out. You improved considerably and were ready to leave the hospital. - You underwent an echocardiogram, which is an ultrasound of your heart; this showed that your heart is functioning the same as before. - You underwent an MRI/MRA of your head and neck because there was concern that you had a new stroke; you did not have a new stroke. - You were seen by ___ diabetes physician and your insulin regimen was adjusted. WHAT DO YOU NEED TO DO WHEN YOU LEAVE THE HOSPITAL? - Take all of your medications as prescribed (listed below) - Follow up with your doctors as listed below - Weigh yourself every morning. Your weight on discharge is 72.7 kg (160.27 lb). Please call Dr. ___ office at ___ if your weight goes up by 3 lbs or more. - If you have any questions or concerning symptoms after discharge, such as shortness of breath, leg swelling, or weight gain, please call our ___ Heartline at ___ to speak to a nurse practitioner or ___ cardiologist; this is available 24 hours a day, 7 days a week. We wish you the best! Your ___ Care Team Followup Instructions: ___