Note ID: 13180007-DS-19

Extracted Subheadings

Here is the list of extracted subheadings:
* ALLERGIES
* ATTENDING
* CHIEF COMPLAINT
* HISTORY OF PRESENT ILLNESS
* MAJOR SURGICAL OR INVASIVE PROCEDURE
* IN THE ED:
+ INITIAL VS
+ EXAM
+ EKG
+ LABS NOTABLE FOR
+ STUDIES NOTABLE FOR
* VITALS ON TRANSFER
* ON THE MEDICAL WARD
* REVIEW OF SYSTEMS
* PAST MEDICAL HISTORY
* SOCIAL HISTORY
* FAMILY HISTORY
* PHYSICAL EXAM
+ ADMISSION PHYSICAL EXAM
+ DISCHARGE PHYSICAL EXAM
* PERTINENT RESULTS
+ ADMISSION LABS
+ PERTINENT STUDIES/RESULTS
* DISCHARGE LABS
* BRIEF HOSPITAL COURSE
* SUMMARY
* TRANSITIONAL ISSUES
* ACUTE PROBLEMS
+ ACUTE ON CHRONIC HFP Ef:
+ CHEST PAIN:
+ *** ON CKD:
+ HYPERTENSION:
+ ACUTE ON CHRONIC ANEMIA:
+ IDMM:
* CHRONIC PROBLEMS
+ HYPOTHYROIDISM:
+ HISTORY OF CVA:
* MEDICATIONS ON ADMISSION
* DISCHARGE MEDICATIONS:
* DISCHARGE DISPOSITION
* DISCHARGE DIAGNOSIS
* DISCHARGE CONDITION
* DISCHARGE INSTRUCTIONS

Extracted Information

Here is the list of extracted subheadings:

Here is the list of extracted subheadings: Medications Received: • IV Lasix 80mg Previous Medications: 1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 2. amLODIPine 10 mg PO DAILY 3.

Atorvastatin 80 mg PO QPM 4. CARVedilol 50 mg PO BID 5. Furosemide 80 mg PO DAILY 6. 70/30 30 Units Breakfast 7. 70/30 10 Units Lunch 8. Levothyroxine Sodium 100 mcg PO DAILY 9. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 10. Minoxidil 10 mg PO DAILY 11. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 12. sevelamer CARBONATE 800 mg PO TID W/MEALS 13. Aspirin 81 mg PO DAILY 14. Vitamin D 1000 UNIT PO DAILY Discharge Medications: 1. Torsemide 100 mg PO DAILY 2. 70/30 30 Units Breakfast 3. 70/30 10 Units Lunch 4. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 5. amLODIPine 10 mg PO DAILY 6. Aspirin 81 mg PO DAILY 7. Atorvastatin 80 mg PO QPM 8. CARVedilol 50 mg PO BID 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Minoxidil 10 mg PO DAILY 11. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 12. sevelamer CARBONATE 800 mg PO TID W/MEALS 13. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 14. Vitamin D 1000 UNIT PO DAILY Medication Mods: • Patient was transitioned to torsemide 100 daily after admission. • Ferric gluconate 250 mg IV was given on multiple days of the hospital admission.

HISTORY OF PRESENT ILLNESS: * "___ male with history of HFpEF (EF 55-60% in ___," * "prior CVA, CKD, DM, hypertension, and carotid artery disease" * "presenting with two days of dyspnea on exertion and chest discomfort on exertion" * "He was recently discharged from home cardiac telehealth" * "He has been unable to weigh himself at home as he does not have a scale" * "He does endorse worsening lower extremity edema and wheeze" * "He has had two hospitalizations over the past year for HF exacerbations resulting in admission to the ___ service" * "He is typically on Lasix 80mg daily and endorses compliance with his medications"

* ALLERGIES

* ALLERGIES: No Known Allergies / Adverse Drug Reactions

* ATTENDING

* ATTENDING: - Attending physician: [NOT PROVIDED]

* CHIEF COMPLAINT

* CHIEF COMPLAINT: • Dyspnea (shortness of breath) • Chest pain

* HISTORY OF PRESENT ILLNESS

* HISTORY OF PRESENT ILLNESS: • Male patient presenting with a history of Heart Failure with preserved Ejection Fraction (HFpEF) and multiple comorbid conditions including: + Prior Cerebrovascular Accident (CVA) + Chronic Kidney Disease (CKD) + Diabetes Mellitus (DM) + Hypertension + Carotid Artery Disease • Presents with two days of dyspnea on exertion and chest discomfort, improved with IV Lasix • Reports worsening lower extremity edema and wheeze • Has had two hospitalizations over the past year for HF exacerbations • Typically on Lasix 80mg daily and endorses compliance with his medications • Initial symptoms subsided with IV Lasix, but ongoing issue of volume overload and edema on discharge

* MAJOR SURGICAL OR INVASIVE PROCEDURE

* MAJOR SURGICAL OR INVASIVE PROCEDURE: - None

* IN THE ED:

* IN THE ED: • Initial VS: T 98.5, HR 102, BP 178/76, RR 22, SpO2 98% RA • Exam: + General- NAD + HEENT- PERRL, EOMI, normal oropharynx + Lungs- Non-labored breathing, CTAB + CV- RRR, systolic murmur, normal S1, S2 + Abd- Soft, nontender, nondistended, no guarding, rebound or masses + Msk- No spine tenderness, moving all 4 extremities, 2+ edema + Neuro- A&O x3, CN intact, normal strength and sensation in all extremities, normal speech and gait + Skin- No rash + Psych- Normal mood and affect • EKG: TWI in lateral leads • Labs notable for: + -Hgb 7.4 + -Chem: BUN 39, Cr 2.6 + -proBNP: 784 + -TropT: 0.03 • Medications: received IV Lasix 80mg • Studies notable for: + -CXR: Mild pulmonary vascular congestion with small bilateral pleural effusions, left greater than right • Vitals on transfer: T 97.3, HR 88, BP 120/54, RR 18, SpO2 98% RA

+ INITIAL VS

+ INITIAL VS: * T 98.5 at initial assessment * HR 102 * BP 178/76 * RR 22 * SpO2 98% RA * Vitals on transfer: T 97.3, HR 88, BP 120/54, RR 18, SpO2 98% RA

+ EXAM

+ EXAM: * General: NAD (No Acute Distress) * HEENT (Head, Eyes, Ears, Nose, Throat): + PERRL (Pupils Equal, Round, and Reactive to Light) + EOMI (Eyes move intact) + Normal oropharynx * Lungs: Non-labored breathing, CTAB (Clear to Total Auricle Basilarly) * CV (Cardiovascular): + RRR (Regular Rate and Rhythm) + Systolic murmur + Normal S1, S2 * Abd (Abdomen): + Soft + Nontender + Nondistended + No guarding, rebound, or masses * Msk (Musculoskeletal): + No spine tenderness + Moving all 4 extremities + 2+ edema * Neuro (Neurological): + A&O x3 (Alert and Oriented times 3) + CN [REDACTED] intact + Normal strength and sensation in all extremities + Normal speech and gait * Skin: No rash * Psych (Psychological): Normal mood and affect * VS (Vital Signs) on initial exam: + T 98.5 + HR 102 + BP 178/76 + RR 22 + SpO2 98% RA * VS on transfer: + T 97.3 + HR 88 + BP 120/54 + RR 18 + SpO2 98% RA

+ EKG

+ EKG: • TWI (T-wave inversion) in lateral leads.

+ LABS NOTABLE FOR

+ LABS NOTABLE FOR: * -Hgb 7.4 on ___09:01AM blood test * Chem: BUN 39, Cr 2.6 on ___09:01AM blood test * -proBNP: 784 on ___09:01AM blood test * -TropT: 0.03 on ___09:01AM blood test and ___02:28PM blood test * *Im ___ AbsNeut-3.75, AbsLymp-0.58*, AbsMono-0.36, AbsEos-0.06, AbsBaso-0.02 on ___09:01AM blood test (not a standard lab result) * -Ferritin 73 on ___05:53AM blood test * -TIBC 294 on ___05:53AM blood test * -eAG-280 on ___05:53AM blood test * -%HbA1c 11.4* on ___05:53AM blood test * -TSH 4.4 on ___05:53AM blood test

+ STUDIES NOTABLE FOR

+ STUDIES NOTABLE FOR: * CXR (Chest X-ray) notable for: mild pulmonary vascular congestion with small bilateral pleural effusions, left greater than right. * Lab results notable for: - Hgb 7.4 - Chem: BUN 39, Cr 2.6 - proBNP: 784 - TropT: 0.03 - Relevant labs from admission and discharge: - Admission lab results (09:01AM): + Hgb 7.4 + Chem: BUN 39, Cr 2.6 + proBNP: 784 + TropT: 0.03 + CK-MB: 4 - Discharge lab results (06:35AM): + Hgb 7.6 + Glucose 164* + UreaN 51* + Creat 2.9* + Na 140 + K 4.6 + Cl 99 + HCO3 25 + Cr 2.9 + Ca 8.4 + Phos 6.0* + Mg 2.1 * Pertinent studies: + Estimated right atrial pressure: [REDACTED] + Left atrial volume index: normal + Estimated right atrial pressure:

[REDACTED] mmHg

* VITALS ON TRANSFER

* VITALS ON TRANSFER: • T: 97.3 • HR: 88 • BP: 120/54 • RR: 18 • SpO2: 98% RA

* ON THE MEDICAL WARD

* ON THE MEDICAL WARD: * The patient endorses the story above, stating that their shortness of breath improved with IV Lasix. * The patient denies: + Chest pain + Orthopnea + PND (paroxysmal nocturnal dyspnea) + Abdominal discomfort + Nausea + Vomiting + Change in bowel habit or other concerning symptoms * The patient's 10-point review of systems is negative except for the noted above issues. Laboratory results from this period: * Vital signs: + T 97.3, HR 88, BP 120/54, RR 18, SpO2 98% RA * Medications: IV Lasix 80mg. Pertinent findings: * The patient was slightly volume up on exam with JVP ~12 and 1+ edema to ankles. * The patient was transitioned to PO torsemide 100mg daily.

* REVIEW OF SYSTEMS

* REVIEW OF SYSTEMS: Negative except as noted above

* PAST MEDICAL HISTORY

* PAST MEDICAL HISTORY: 1. Hypertension 2. Dyslipidemia 3. Diabetes mellitus type 2 4. Cerebrovascular disease, status post CVA in [REDACTED] 5. Extensive intracranial atherosclerosis, worse in the right MCA territory 6. Carotid artery disease 7. Secundum ASD 8. Mild AR 9. Osteoarthritis 10. Asthma

* SOCIAL HISTORY

* SOCIAL HISTORY: Family History: • His parents have heart disease. • Mother is "with heart problems" and diabetes. • Father, "with diabetes". • He has 16 brothers and sisters. Social History: (Note: There is no additional information provided under * SOCIAL HISTORY. The medical note abruptly ends with the subheading without providing further details.)

* FAMILY HISTORY

* FAMILY HISTORY: • His parents have heart disease. • Mother is ___ with heart problems and diabetes. • Father, ___, with diabetes. • He has 16 brothers and sisters. • There is no known history of early coronary artery disease or sudden cardiac death.

* PHYSICAL EXAM

* PHYSICAL EXAM: **ADMISSION PHYSICAL EXAM** * VS: + Temp: 97.8 (98.5 initially) + BP: 144/69 (178/76 initially) + HR: 86 (102 initially) + RR: 18 + O2 sat: 96% + O2 delivery: Ra * GENERAL: NAD. Oriented x3. Mood, affect appropriate. * HEENT: Normocephalic atraumatic. Sclera anicteric. PERRL. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma. * NECK: JVP of 13 cm. * CARDIAC: PMI located in ___ intercostal space, midclavicular line. Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. 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** * GENERAL: NAD. Mood, affect appropriate. * HEENT: Normocephalic atraumatic. Sclera anicteric. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma. * NECK: JVP 12 cm * CARDIAC: Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. * 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. * EXTREMITIES: Warm, well perfused. Lower extremity edema to ankles L>R (+1). * SKIN: No significant skin lesions or rashes.

+ ADMISSION PHYSICAL EXAM

+ ADMISSION PHYSICAL EXAM: VS: 24 HR Data (last updated(___ @ 1654) Temp: 97.8 (Tm 97.8), BP: 144/69, HR: 86, RR: 18, O2 sat: 96%, O2 delivery: Ra GENERAL: NAD. Oriented x3. Mood, affect appropriate. HEENT: Normocephalic atraumatic. Sclera anicteric. PERRL. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma. NECK: JVP of 13 cm. CARDIAC: PMI located in ___ intercostal space, midclavicular line. Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. 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

+ DISCHARGE PHYSICAL EXAM: bullet GENERAL: • NAD • Mood, affect appropriate bullet HEENT: • Normocephalic atraumatic • Sclera anicteric • PERRL • EOMI • Conjunctiva were pink • No pallor or cyanosis of the oral mucosa • No xanthelasma bullet NECK: • JVP 12 cm bullet CARDIAC: • Regular rate and rhythm • Normal S1, S2 • No murmurs, rubs, or gallops bullet LUNGS: • No chest wall deformities or tenderness • Respiration is unlabored with no accessory muscle use • No crackles, wheezes or rhonchi bullet ABDOMEN: • Soft, non-tender, non-distended bullet EXTREMITIES: • Warm, well perfused • 1+ edema to ankles bilaterally bullet SKIN: • No significant skin lesions or rashes

* PERTINENT RESULTS

* PERTINENT RESULTS: * Admission Labs: * 09:01 AM: • Hgb: 7.4 • Hct: 24.0 • MCV: 83 • MCH: 25.7 • MCHC: 30.8 • RDW: 16.1 • RDWSD: 48.5 • Neuts: 78.5 • Lymphs: 12.1 • Monos: 7.5 • Eos: 1.3 • Baso: 0.4 • AbsNeut: 3.75 • AbsLymp: 0.58 • AbsMono: 0.36 • AbsEos: 0.06 • AbsBaso: 0.02 • Glucose: 287 • UreaN: 39 • Creat: 2.6 • Na: 139 • K: 4.7 • Cl: 102 • HCO3: 24 • AnGap: 13 * 05:53 AM: • PTT: 32.1 • Calcium: 8.4 • Phos: 4.9 • Mg: 2.0 • Iron: 28 • calTIBC: 294 • Ferritn: 73 • TRF: 226 • %HbA1c: 11.4 • eAG: 280 • TSH: 4.4 * 07:35 PM: • CK-MB: 4 • cTropnT: 0.03 * 09:01 AM: • CK-MB: 4 • proBNP: 784 * Discharge Labs: * 06:35 AM: • Hgb: 7.6 • Hct: 24.3 • MCV: 83 • MCH: 26.0 • MCHC: 31.3 • RDW: 15.9 • RDWSD: 47.8 • Glucose: 164 • UreaN: 51 • Creat: 2.9 • Na: 140 • K: 4.6 • Cl: 99 • HCO3: 25 • AnGap: 16 • Calcium: 8.4 • Phos: 6.0 • Mg: 2.1 * Pertinent Studies/Results: * Left atrial volume index is normal. * Estimated right atrial pressure is [NOT PROVIDED] mmHg. * 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 65%. * No resting left ventricular outflow tract gradient. * Tissue Doppler suggests an increased left ventricular filling pressure (PCWP greater than 18 mmHg). * Echocardiographic evidence for diastolic dysfunction (grade indeterminate). * Small pericardial effusion. * Medications: * IV Lasix: 80 mg (received multiple doses) * Torsemide: 100 mg PO daily * 70/30 insulin: • 30 Units Breakfast • 10 Units Lunch * Albuterol Inhaler: 2 puff q8h PRN shortness of breath * amLODIPine: 10 mg PO daily * Aspirin: 81 mg PO daily * Atorvastatin: 80 mg PO qpm * CARVedilol: 50 mg PO BID * Levothyroxine Sodium: 100 mcg PO daily * Minoxidil: 10 mg PO daily * Polyethylene Glycol: 17 g PO daily: PRN Constipation - First Line * sevelamer CARBONATE: 800 mg

PO TID w/ meals * Victoza (liraglutide): 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous daily * Vitamin D: 1000 UNIT PO daily

+ ADMISSION LABS

+ ADMISSION LABS: * **Blood 09:01AM** + WBC-4.8 + RBC-2.88 + Hgb-7.4 + Hct-24.0 + MCV-83 + MCH-25.7 + MCHC-30.8 + RDW-16.1 + RDWSD-48.5 + Plt [REDACTED] * **Blood 09:01AM** + Neuts-78.5 + Lymphs-12.1 + Monos-7.5 + Eos-1.3 + Baso-0.4 + Im [REDACTED] + AbsNeut-3.75 + AbsLymp-0.58 + AbsMono-0.36 + AbsEos-0.06 + AbsBaso-0.02 * **Blood 05:53AM** + PTT-32.1 + [REDACTED] * **Blood 09:01AM** + Glucose-287 + UreaN-39 + Creat-2.6 + Na-139 + K-4.7 + Cl-102 + HCO3-24 + AnGap-13 * **Blood 02:28PM** + CK(CPK)-257 * **Blood 05:53AM** + ALT-9 + AST-13 + AlkPhos-100 + TotBili-0.3 * **Blood 09:01AM** + cTropnT-0.03 * **Blood 02:28PM** + cTropnT-0.03 * **Blood 07:35PM** + CK-MB-4 + cTropnT-0.03 * **Blood 09:01AM** + CK-MB-4 + proBNP-784 * **Blood 05:53AM** + Calcium-8.4 + Phos-4.9 + Mg-2.0 + Iron-28 * **Blood 05:53AM** + calTIBC-294 + Ferritn-73 + TRF-226 * **Blood 05:53AM** + %HbA1c-11.4 + eAG-280 + TSH-4.4

+ PERTINENT STUDIES/RESULTS

+ PERTINENT STUDIES/RESULTS ========== • **Echocardiogram results:** + Left atrial volume index is normal. + Estimated right atrial pressure is ___ mmHg. + 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 65%. + No resting left ventricular outflow tract gradient. + Tissue Doppler suggests an increased left ventricular filling pressure (PCWP > 18 mmHg). + Echocardiographic evidence for diastolic dysfunction (grade indeterminate). + Normal right ventricular cavity size with normal free wall motion. + Mild aortic valve leaflet thickening with no aortic stenosis or regurgitation. + Mild mitral valve leaflet thickening with trivial mitral regurgitation. + Physiologic tricuspid regurgitation. + Estimated pulmonary artery systolic pressure is normal. + Small pericardial effusion. • **Lab results:** + **Initial labs (not dated):** - Hgb: 7.4 - Chem: BUN 39, Cr 2.6 - proBNP: 784 - TropT: 0.03 - Initial CVS (time and date not specified): T 98.5, HR 102, BP 178/76, RR 22, SpO2 98% RA + **Admission Labs (09:01 AM):** - BLOOD: WBC-4.8, RBC-2.88*, Hgb-7.4*, Hct-24.0*, MCV-83, MCH-25.7*, MCHC-30.8*, RDW-16.1*, RDWSD-48.5*, Plt [REDACTED] - BLOOD (time and date not specified): Neuts-78.5*, Lymphs-12.1*, Monos-7.5, Eos-1.3, Baso-0.4, Im [REDACTED], AbsNeut-3.75, AbsLymp-0.58*, AbsMono-0.36, AbsEos-0.06, AbsBaso-0.02 - BLOOD (05:53 AM): PTT-32.1, [REDACTED] - BLOOD (09:01 AM): Glucose-287*, UreaN-39*, Creat-2.6*, Na-139, K-4.7, Cl-102, HCO3-24, AnGap-13 - BLOOD (02:28 PM): CK(CPK)-257 - BLOOD (05:53 AM): ALT-9, AST-13, AlkPhos-100, TotBili-0.3 - BLOOD (09:01 AM): cTropnT-0.03* - BLOOD (02:28 PM): cTropnT-0.03* - BLOOD (07:35 PM): CK-MB-4, cTropnT-0.03* - BLOOD (09:01 AM): CK-MB-4, proBNP-784* - BLOOD (05:53 AM): Calcium-8.4, Phos-4.9*, Mg-2.0, Iron-28* - BLOOD (05:53 AM): calTIBC-294, Ferritn-73, TRF-226 - BLOOD (05:53 AM): %HbA1c-11.4*, eAG-280* - BLOOD (05:53 AM): TSH-4.4* + **Discharge Labs (06:35 AM):** - BLOOD: WBC-5.4, RBC-2.92*, Hgb-7.6*, Hct-24.3*, MCV-83, MCH-26.0, MCHC-31.3*, RDW-15.9*, RDWSD-47.8*, Plt [REDACTED] - BLOOD: Glucose-164*, UreaN-51*, Creat-2.9*, Na-140, K-4.6, Cl-99, HCO3-25, AnGap-16 - BLOOD: Calcium-8.4, Phos-6.0*, Mg-2.1

* DISCHARGE LABS

* DISCHARGE LABS: • 06:35AM BLOOD: • WBC-5.4 • RBC-2.92 • Hgb-7.6 • Hct-24.3 • MCV-83 • MCH-26.0 • MCHC-31.3 • RDW-15.9 • RDWSD-47.8 • Plt [REDACTED] • 06:35AM BLOOD: • Glucose-164 • UreaN-51 • Creat-2.9 • Na-140 • K-4.6 • Cl-99 • HCO3-25 • AnGap-16 • 06:35AM BLOOD: • Calcium-8.4 • Phos-6.0 • Mg-2.1

* BRIEF HOSPITAL COURSE

* BRIEF HOSPITAL COURSE: • ***SUMMARY***: The patient presented with a history of HFpEF, prior CVA, CKD, DM, hypertension, and carotid artery disease, and was admitted for HF exacerbation. • ***Performed Diuresis***: With several doses of IV Lasix 80mg, the patient's symptoms improved. • ***Discharge Condition***: The patient was still slightly volume-up on examination, with JVP ~12cm and 1+ edema to ankles. • ***Medication Adjustments***: The patient was transitioned to torsemide 100mg daily for active diuresis, with about 3lbs of fluid still left to lose. • ***Laboratory Results* : • ***Discharge Labs***: The patient's Cr remained elevated at 2.9 on the day of discharge. • ***Hematology***: Ferritin 73 and TIBC 294. The patient received 3 doses of ferric gluconate 250mg IV, upon review of recent outpatient visit notes. • ***Glucose***: 164mg at discharge, the patient's baseline glucose levels were not provided. • ***Chronic Diagnostic Monitoring*: • ***Kidney Function***: Cr 2.6 on admission from a baseline of 1.8-2.2. • ***Diabetes Mellitus*: D/d N/MLic; A1c at discharge was 11.4%, compared to 14.4 in an unknown date metric.

* SUMMARY

* SUMMARY: • Patient: ___ male with history of HFpEF (EF 55-60% in ___, prior CVA, CKD, DM, hypertension, and carotid artery disease • Reason for Admission: HF exacerbation, unclear trigger, possibly medication non-compliance • IV Lasix 80mg diuresis: patient's symptoms improved • Discharge: + Volume overloaded on exam, JVP ~12, 1+ edema to ankles + Started on torsemide 100 daily for active diuresis + Follow-up labs to be drawn on ___ + Consider completing 4-day course of ferric gluconate • Transitional Issues: + Volume overload subsided, but still slightly volume up + Elevated Cr on discharge (2.9) from baseline (2.0-2.2) + Iron studies showed ferritin 73 and TIBC 294, started on ferric gluconate • Discharge Medications: + Torsemide 100mg daily + Albuterol Inhaler + Amlodipine + Aspirin + Atorvastatin + Carvedilol + Levothyroxine Sodium + Minoxidil + Polyethylene Glycol + Sevelamer + Victoza + Vitamin D • Discharge Condition: + Mental Status: Clear and coherent + Level of Consciousness: Alert and interactive + Activity Status: Ambulatory - Independent

* TRANSITIONAL ISSUES

* TRANSITIONAL ISSUES: • At discharge, his symptoms associated with volume overload had subsided, but he was still slightly volume up on exam with 1+ edema to ankles bilaterally and JVP of 12cm. • He is being discharged on torsemide 100 daily for active diuresis, with about 3lb of fluid still left to lose. • He should have follow-up labs drawn on [DATE NOT SPECIFIED]. His Cr was still elevated on day of discharge to 2.9 (baseline 2.0-2.2). • Consider completing the 4-day course of ferric gluconate which was started during this admission. He received ferric gluconate 250 mg IV on [DATE NOT SPECIFIED]. • Consider one additional infusion of ferric gluconate 250 mg IV.

* ACUTE PROBLEMS

* ACUTE PROBLEMS: • # Acute on chronic HFpEF: o Patient presented with dyspnea and lower extremity edema and found to be volume overloaded on exam. o Trigger for HF exacerbation unclear. o Patient reports compliance with medications but has reported non-compliance in the past. o C/o chest pain with mild troponin elevation (0.03). o No evidence of dietary indiscretion. o TTE performed showing EF 65% and diastolic dysfunction. o Iron studies showed ferritin 73 and TIBC 294, and he was started on ferric gluconate (received 3 doses ___). o Upon review of recent outpatient visit notes, it appears his volume exam is similar to baseline, and patient was asymptomatic during hospital course. o He was diuresed effectively with IV Lasix 80. o He was transitioned to PO torsemide 100. • # Chest pain: o No known history of CAD. o Presented with chest pain and mild troponin elevation with flat CK-MB. o As noted above, troponin elevation difficult to interpret in setting of CKD, and appears at or lower than levels earlier this year. o He has denied chest pain during admission. o He does have risk factors for ischemia and has not had stress since ___. o However, findings and history to date are not suggestive of ischemia and he has an ___. o TTE did not show evidence of focal wall motion abnormalities or other findings suggestive of ischemia, so further workup was not pursued. o He was continued on ASA and atorvastatin. • # ___ on CKD: o Cr elevated to 2.6 on admission from baseline of

1.8-2.2. o Given evidence of congestion elsewhere, concerns for renal congestion causing renal dysfunction. o Cr remained stable and was 2.9 on day of discharge. o He was continued on home sevelamer. • # Acute on chronic anemia: o Hb on admission was 7.4. o No evidence of bleeding per history or exam. o Possibly related to worsening of his renal function vs dilutional iso heart failure. o His Hb was 7.6 on discharge. o He received 3 doses of ferric gluconate 250 mg IV on ___. • # IDDM: o Poorly controlled. o A1c 14.4 in ___ in ___ at ___. o Repeat A1c ___ was 11.4%. o He was given Lantus 30u night of admission, then transitioned to home insulin ___ with 70/30 30u with breakfast and 20u with lunch. o He was also on ISS while inpatient.

+ ACUTE ON CHRONIC HFP Ef:

+ ACUTE ON CHRONIC HFP Ef: lab values: * Creatinine: + Admission: 2.6 + Discharge: 2.9 Diastolic function: + Echocardiogram notes: diastolic dysfunction (grade indeterminate) EF: + Admission: 55-60% + TTE: 65% Hemoglobin: + Admission: 7.4 + Discharge: 7.6 History: + Prior CVA, CKD, DM, hypertension, and carotid artery disease Treatment: + IV Lasix 80mg + Followed by PO torsemide 100mg daily Triggers: + Unclear trigger for HF exacerbation + Possible medication non-compliance Physical exam: + Volume overloaded on exam + Warm and wet on exam + Lower extremity edema and 1+ edema to ankles

+ CHEST PAIN:

+ CHEST PAIN: * Denies chest pain during admission. * Presents with chest discomfort on exertion. * History of hypertension, CKD, DM, and carotid artery disease, all of which are risk factors for ischemia. * Trop T: 0.03, CK-MB: 4, cTropnT: 0.03, troponin elevation difficult to interpret in setting of CKD. * No evidence of focal wall motion abnormalities or other findings suggestive of ischemia on TTE. * Continued on ASA and atorvastatin. * Further workup not pursued.

+ *** ON CKD:

+ *** ON CKD: * Cr elevated to 2.6 on admission from baseline of 1.8-2.2 * Concerns for renal congestion causing renal dysfunction * Cr remained stable and was 2.9 on day of discharge * Continued on home sevelamer

+ HYPERTENSION:

+ HYPERTENSION: * History of hypertension, currently well controlled * Diastolic blood pressure on admission: 76 * Systolic blood pressure on admission: 178 * Current medications: + Amlodipine 10mg PO daily + Coreg 50mg PO BID + Minoxidil 10mg PO daily * Discharge medications: + Amlodipine 10mg PO daily + Minoxidil 10mg PO daily * Blood pressure at discharge: 144/69 * Note: Further workup for hypertension was not pursued

+ ACUTE ON CHRONIC ANEMIA:

+ ACUTE ON CHRONIC ANEMIA: • Hb on admission was 7.4 • No evidence of bleeding per history or exam • Possibly related to worsening of renal function vs dilutional iso heart failure • His Hb was 7.6 on discharge • Received 3 doses of ferric gluconate 250 mg IV on ___ • Iron studies showed ferritin 73 and TIBC 294

+ IDMM:

+ IDMM: * Poorly controlled: * A1c 14.4 in [REDACTED] in [REDACTED] at [REDACTED]. * Repeat A1C [REDACTED] was 11.4% * Medications on admission: - No IDMM specific medications listed * Discharge Medications: - No IDMM specific medications listed

* CHRONIC PROBLEMS

* CHRONIC PROBLEMS: #1. Hypertension #2. Dyslipidemia #3. Diabetes Mellitus Type 2 #4. Cerebrovascular Disease, Status Post CVA #5. Extensive Intracranial Atherosclerosis, Worse in the Right MCA Territory #6. Carotid Artery Disease #7. Secundum Atrial Septal Defect (ASD) #8. Mild Aortic Regurgitation (AR) #9. Osteoarthritis #10. Asthma #1. Type 2 Diabetes Mellitus Poorly controlled, HbA1c 11.4%, currently on ISS (insulin sliding scale) Medications on Admission: - Lantus 30u night - Home insulin (70/30 30 units breakfast, 20 units lunch) Medications at Discharge: - Keep current insulin regimen #2. Hypothyroidism Continued on home levothyroxine 100mcg daily

+ HYPOTHYROIDISM:

+ HYPOTHYROIDISM: • Medication: levothyroxine Sodium 100 mcg PO DAILY • No laboratory results or laboratory findings mentioned under this subheading.

+ HISTORY OF CVA:

+ HISTORY OF CVA: * Prior CVA documented in medical history * Cerebrovascular disease with extensive intracranial atherosclerosis, worse in the right MCA territory * Recieved home aspirin and atorvastatin 80mg via home medications

* MEDICATIONS ON ADMISSION

* MEDICATIONS ON ADMISSION: 1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 2. amLODIPine 10 mg PO DAILY 3. Atorvastatin 80 mg PO QPM 4. CARVedilol 50 mg PO BID 5. Furosemide 80 mg PO DAILY 6. Levothyroxine Sodium 100 mcg PO DAILY 7. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 8. Minoxidil 10 mg PO DAILY 9. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 10. sevelamer CARBONATE 800 mg PO TID W/MEALS 11. Aspirin 81 mg PO DAILY 12. Vitamin D 1000 UNIT PO DAILY Medication administered in the ED: IV Lasix 80mg

* DISCHARGE MEDICATIONS:

* DISCHARGE MEDICATIONS: * 1. Torsemide 100 mg PO DAILY Rx *torsemide 20 mg 5 tablet(s) by mouth once a day Disp #*70 Tablet Refills:*0 * 2. Lantus 30u (nighttime insulin) * 3. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath * 4. amLODIPine 10 mg PO DAILY * 5. Aspirin 81 mg PO DAILY * 6. Atorvastatin 80 mg PO QPM * 7. CARVedilol 50 mg PO BID * 8. Levothyroxine Sodium 100 mcg PO DAILY * 9. Minoxidil 10 mg PO DAILY * 10. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line * 11. sevelamer CARBONATE 800 mg PO TID W/MEALS * 12. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY * 13. Vitamin D 1000 UNIT PO DAILY Discharge Disposition: Home With Service Followup Instructions: ___

* DISCHARGE DISPOSITION

* DISCHARGE DISPOSITION: • Discharge Diagnosis: - Primary Diagnosis: Acute on chronic diastolic heart failure exacerbation - Secondary Diagnosis: • Acute kidney injury • Acute on chronic anemia • Type 2 diabetes mellitus • Discharge Condition: - Mental Status: Clear and coherent - Level of

Consciousness: Alert and interactive - Activity Status: Ambulatory - Independent • Discharge Instructions: - Dear Hospitalized, ... follow the instructions to manage conditions and follow up with healthcare providers. • Discharge Medications: 1. Torsemide 100 mg PO DAILY (Disp #*70 Tablet Refills:*0) 2. 70/30 30 Units Breakfast 70/30 10 Units Lunch 3. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 4. Amlodipine 10 mg PO DAILY 5. Aspirin 81 mg PO DAILY 6. Atorvastatin 80 mg PO QPM 7. carvedilol 50 mg PO BID 8. Levothyroxine Sodium 100 mcg PO DAILY 9. Minoxidil 10 mg PO DAILY 10. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 11. Sevelamer CARBONATE 800 mg PO TID W/MEALS 12. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 13.Vitamin D 1000 UNIT PO DAILY • Discharge Transitions: • At discharge, his symptoms associated with volume overload had subsided, but he was still slightly volume up on exam with 1+ edema to ankles bilaterally and JVP of 12cm. • He will have follow-up labs drawn on ___ to monitor renal function, and his creatinine level at discharge was 2.9 (baseline 2.0-2.2). • Consider completing a 4-day course of ferric gluconate, which was started during admission. • Discharge Weight: 166.6lb • Discharge Fluid Status: He was slightly volume up on exam and 1+ edema to ankles bilaterally, and his weight on discharge was 166.7 pounds. He is advised to call his doctor if his weight goes up or down more than 3 pounds in one day or 5 lb in one week.

* DISCHARGE DIAGNOSIS

* DISCHARGE DIAGNOSIS: • **Primary Diagnosis:** - **Acute on Chronic Diastolic Heart Failure Exacerbation** • **Secondary Diagnosis:** - **Acute Kidney Injury** - **Acute on Chronic Anemia** - **Type 2 Diabetes Mellitus**

* DISCHARGE CONDITION

* DISCHARGE CONDITION: • Mental Status: Clear and coherent. • Level of Consciousness: Alert and interactive. • Activity Status: Ambulatory - Independent. • Medications: • Torsemide 100 mg PO DAILY • 70/30 30 Units Breakfast • 70/30 10 Units Lunch • Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath • amLODIPine 10 mg PO DAILY • Aspirin 81 mg PO DAILY • Atorvastatin 80 mg PO QPM • CARVedilol 50 mg PO BID • Levothyroxine Sodium 100 mcg PO DAILY • Minoxidil 10 mg PO DAILY • Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line • sevelamer CARBONATE 800 mg PO TID W/MEALS • Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY • Vitamin D 1000 UNIT PO DAILY • Discharge Weight: 166.6lb • Discharge Creatinine (Cr): 2.9 • Followup Instructions: Outpatient followup and labs as needed • Status: Home With Service

* DISCHARGE INSTRUCTIONS

* DISCHARGE INSTRUCTIONS: * Take all medications as prescribed: 1. Torsemide 100mg PO daily 2. 70/30 insulin (30 Units Breakfast, 10 Units Lunch) 3. Albuterol Inhaler 2 puffs IH Q8H (as needed for shortness of breath) 4. Amlodipine 10mg PO daily 5. Aspirin 81mg PO daily 6. Atorvastatin 80mg PO QPM 7. Carvedilol 50mg PO BID 8. Levothyroxine Sodium 100mcg PO daily 9. Minoxidil 10mg PO daily 10. Polyethylene Glycol 17g PO daily (as needed for constipation) 11. Sevelamer Carbonate 800mg PO TID with meals 12. Victoza 2-Pak (liraglutide) 0.6mg/0.1mL subcutaneous daily 13. Vitamin D 1000 Unit PO daily * Follow up with doctors as listed below * Weigh yourself every morning and call your doctor if: - Weight increases by more than 3 pounds in one day - Weight increases by more than 5 pounds in one week - You experience any of the "danger signs" below "danger signs" are not explicitly listed in the provided text.

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: dyspnea, chest pain Major Surgical or Invasive Procedure: None History of Present Illness: ___ male with history of HFpEF (EF 55-60% in ___, prior CVA, CKD, DM, hypertension, and carotid artery disease presenting with two days of dyspnea on exertion and chest discomfort on exertion. He was recently discharged from home cardiac telehealth. He has been unable to weigh himself at home as he does not have a scale. He does endorse worsening lower extremity edema and wheeze. He has had two hospitalizations over the past year for HF exacerbations resulting in admission to the ___ service. He is typically on Lasix 80mg daily and endorses compliance with his medications. In the ED: Initial VS: T 98.5, HR 102, BP 178/76, RR 22, SpO2 98% RA Exam: General- NAD HEENT- PERRL, EOMI, normal oropharynx Lungs- Non-labored breathing, CTAB CV- RRR, systolic murmur, normal S1, S2 Abd- Soft, nontender, nondistended, no guarding, rebound or masses Msk- No spine tenderness, moving all 4 extremities, 2+ edema Neuro-A&O x3, CN ___ intact, normal strength and sensation in all extremities, normal speech and gait. Skin- No rash Psych- Normal mood and affect EKG: TWI in lateral leads Labs notable for: -Hgb 7.4 -Chem: BUN 39, Cr 2.6 -proBNP: 784 -TropT: 0.03 Medications: received IV Lasix 80mg Studies notable for: -CXR: Mild pulmonary vascular congestion with small bilateral pleural effusions, left greater than right. Vitals on transfer: T 97.3, HR 88, BP 120/54, RR 18, SpO2 98% RA On the medical ward, patient endorses story above. He reports his shortness of breath improved with IV Lasix. He denies chest pain, orthopnea, PND, abdominal discomfort, nausea, vomiting, change in bowel habit or other concerning symptoms. REVIEW OF SYSTEMS: 10-point review of systems is negative except as noted above. Past Medical History: 1. Hypertension. 2. Dyslipidemia. 3. Diabetes mellitus type 2. 4. Cerebrovascular disease, status post CVA in ___. 5. Extensive intracranial atherosclerosis, worse in the right MCA territory. 6. Carotid artery disease. 7. Secundum ASD. 8. Mild AR. 9. Osteoarthritis. 10. Asthma. Social History: ___ Family History: His parents have heart disease. Mother is ___ with heart problems and diabetes. Father, ___, with diabetes. He has 16 brothers and sisters. There is no known history of early coronary artery disease or sudden cardiac death. Physical Exam: ADMISSION PHYSICAL EXAM ========== VS: 24 HR Data (last updated ___ @ 1654) Temp: 97.8 (Tm 97.8), BP: 144/69, HR: 86, RR: 18, O2 sat: 96%, O2 delivery: Ra GENERAL: NAD. Oriented x3. Mood, affect appropriate. HEENT: Normocephalic atraumatic. Sclera anicteric. PERRL. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma. NECK: JVP of 13 cm. CARDIAC: PMI located in ___ intercostal space, midclavicular line. Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. 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 ========== GENERAL: NAD. Mood, affect appropriate. HEENT: Normocephalic atraumatic. Sclera anicteric. EOMI. Conjunctiva were pink. No pallor or cyanosis of the oral mucosa. No xanthelasma. NECK: JVP 12 cm CARDIAC: Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. 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. EXTREMITIES: Warm, well perfused. ___ lower extremity edema to ankles L>R SKIN: No significant skin lesions or rashes. Pertinent Results: ADMISSION LABS ========== ___ 09:01AM BLOOD WBC-4.8 RBC-2.88* Hgb-7.4* Hct-24.0* MCV-83 MCH-25.7* MCHC-30.8* RDW-16.1* RDWSD-48.5* Plt ___ ___ 09:01AM BLOOD Neuts-78.5* Lymphs-12.1* Monos-7.5 Eos-1.3 Baso-0.4 Im ___ AbsNeut-3.75 AbsLymp-0.58* AbsMono-0.36 AbsEos-0.06 AbsBaso-0.02 ___ 05:53AM BLOOD ___ PTT-32.1 ___ ___ 09:01AM BLOOD Glucose-287* UreaN-39* Creat-2.6* Na-139 K-4.7 Cl-102 HCO3-24 AnGap-13 ___ 02:28PM BLOOD CK(CPK)-257 ___ 05:53AM BLOOD ALT-9 AST-13 AlkPhos-100 TotBili-0.3 ___ 09:01AM BLOOD cTropnT-0.03* ___ 02:28PM BLOOD cTropnT-0.03* ___ 07:35PM BLOOD CK-MB-4 cTropnT-0.03* ___ 09:01AM BLOOD CK-MB-4 proBNP-784* ___ 05:53AM BLOOD Calcium-8.4 Phos-4.9* Mg-2.0 Iron-28* ___ 05:53AM BLOOD calTIBC-294 Ferritn-73 TRF-226 ___ 05:53AM BLOOD %HbA1c-11.4* eAG-280* ___ 05:53AM BLOOD TSH-4.4* PERTINENT STUDIES/RESULTS ========== ___ CONCLUSION: The left atrial volume index is normal. 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. The visually estimated left ventricular ejection fraction is 65%. There is no resting left ventricular outflow tract gradient. Tissue Doppler suggests an increased left ventricular filling pressure (PCWP greater than 18 mmHg). There is echocardiographic evidence for diastolic dysfunction (grade indeterminate). Normal right ventricular cavity size with normal free wall motion. The aortic sinus diameter is normal for gender with a normal ascending aorta diameter for gender. The aortic arch diameter is normal. The aortic valve leaflets (3) are mildly thickened. There is no aortic valve stenosis. There is no aortic regurgitation. The mitral valve leaflets are mildly thickened 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 estimated pulmonary artery systolic pressure is normal. There is a small pericardial effusion. There is increased respiratory variation in transmitral/transtricuspid inflow but no right atrial/right ventricular diastolic collapse. IMPRESSION: Suboptimal image quality. Stiff left ventricle. Small pericardial effusion. No frank tamponade. DISCHARGE LABS ========== ___ 06:35AM BLOOD WBC-5.4 RBC-2.92* Hgb-7.6* Hct-24.3* MCV-83 MCH-26.0 MCHC-31.3* RDW-15.9* RDWSD-47.8* Plt ___ ___ 06:35AM BLOOD Glucose-164* UreaN-51* Creat-2.9* Na-140 K-4.6 Cl-99 HCO3-25 AnGap-16 ___ 06:35AM BLOOD Calcium-8.4 Phos-6.0* Mg-2.1 Brief Hospital Course: SUMMARY ======= ___ male with history of HFpEF (EF 55-60% in ___, prior CVA, CKD, DM, hypertension, and carotid artery disease who presented with 1 day of dyspnea and discomfort, and was admitted for HF exacerbation. The trigger was unclear, possible medication non-compliance. He was diuresed with several doses of IV Lasix 80 and by time of discharge symptoms had improved. He was still slightly volume up on exam, with JVP ~12 and 1+ edema to ankles. TRANSITIONAL ISSUES ========== [ ] At discharge his symptoms associated with volume overload had subsided, but he was still slightly volume up on exam with 1+ edema to ankles bilaterally and JVP of 12cm. He is being discharged on torsemide 100 daily for active diuresis, with about 3lb of fluid still left to lose. [ ] He should have follow up labs drawn on ___. His Cr was still elevated on day of discharge to 2.9 (baseline 2.0-2.2). [ ] Consider completing the 4 day course of ferric gluconate which was started during this admission. He received ferric gluconate 250 mg IV on ___, and ___. Consider one additional infusion of ferric gluconate 250 mg IV. Discharge weight: 166.6lb Discharge Cr: 2.9 Discharge diuretic: torsemide 100mg daily ACUTE PROBLEMS ========== # Acute on chronic HFpEF: Patient presented with dyspnea and lower extremity edema and found to be volume overloaded on exam. Warm and wet on exam. Trigger for HF exacerbation unclear. Patient reports compliance with medications but has reported non-compliance in the past. C/o chest pain with mild troponin elevation (0.03 seems to be at or lower than levels checked in prior months this year in setting of CKD). No evidence of dietary indiscretion. TTE was performed which showed EF 65% and diastolic dysfunction. Iron studies showed ferritin 73 and TIBC 294, and he was started on ferric gluconate (received 3 doses ___. Upon review of recent outpatient visit notes, it appears his volume exam is similar to baseline, and patient was asymptomatic during hospital course. He was diuresed effectively with IV Lasix 80. He was transitioned to PO torsemide 100. His BP was well controlled with regimen as described below. # Chest pain: No known history of CAD. Presented with chest pain and mild troponin elevation with flat CK-MB. As noted above, troponin elevation difficult to interpret in setting of CKD, and appears at or lower than levels earlier this year. He has denied chest pain during admission. He does have risk factors for ischemia and has not had stress since ___. However, findings and history to date are not suggestive of ischemia and he has an ___. TTE did not show evidence of focal wall motion abnormalities or other findings suggestive of ischemia, so further workup was not pursued. He was continued on ASA and atorvastatin. # ___ on CKD: Cr elevated to 2.6 on admission from baseline of 1.8-2.2. Given evidence of congestion elsewhere, concerns for renal congestion causing renal dysfunction. Cr remained stable and was 2.9 on day of discharge. He was continued on home sevelamer. # Hypertension: History of hypertension, currently well controlled. He was warm on exam. He was continued on home amlodipine 10, Coreg 50 BID and minoxidil 10 daily. # Acute on chronic anemia: Hb on admission was 7.4. No evidence of bleeding per history or exam. Possibly related to worsening of his renal function vs dilutional iso heart failure. His Hb was 7.6 on discharge. He received 3 doses of ferric gluconate 250 mg IV on ___. #IDDM Poorly controlled. A1c 14.4 in ___ in ___ at ___. Repeat A1C ___ was 11.4%. He was given Lantus 30u night of admission, then transitioned to home insulin ___ with 70/30 30u with breakfast and 20u with lunch. He was also on ISS while inpatient. CHRONIC PROBLEMS ========== #Hypothyroidism He was continued on home levothyroxine 100mcg daily. #History of CVA He was continued on home aspirin and atorvastatin 80. Medications on Admission: The Preadmission Medication list is accurate and complete.

1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 2. amLODIPine 10 mg PO DAILY 3. Atorvastatin 80 mg PO QPM 4. CARVedilol 50 mg PO BID 5. Furosemide 80 mg PO DAILY 6. 70/30 30 Units Breakfast 70/30 10 Units Lunch 7. Levothyroxine Sodium 100 mcg PO DAILY 8. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 9. Minoxidil 10 mg PO DAILY 10. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 11. sevelamer CARBONATE 800 mg PO TID W/MEALS 12. Aspirin 81 mg PO DAILY 13. Vitamin D 1000 UNIT PO DAILY Discharge Medications: 1. Torsemide 100 mg PO DAILY RX *torsemide 20 mg 5 tablet(s) by mouth once a day Disp #*70 Tablet Refills:*0 2. 70/30 30 Units Breakfast 70/30 10 Units Lunch 3. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 4. amLODIPine 10 mg PO DAILY 5. Aspirin 81 mg PO DAILY 6. Atorvastatin 80 mg PO QPM 7. CARVedilol 50 mg PO BID 8. Levothyroxine Sodium 100 mcg PO DAILY 9. Minoxidil 10 mg PO DAILY 10. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 11. sevelamer CARBONATE 800 mg PO TID W/MEALS 12. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 13. Vitamin D 1000 UNIT PO DAILY Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: Primary Diagnosis: -Acute on chronic diastolic heart failure exacerbation Secondary Diagnosis: -acute kidney injury -acute on chronic anemia -type 2 diabetes mellitus Discharge Condition: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure taking care of you at ___ ___. WHY WAS I ADMITTED TO THE HOSPITAL? You were having swelling in your legs because of fluid accumulation in your body. This was caused by a condition called heart failure, where your heart does not pump hard enough and fluid builds up. WHAT HAPPENED WHILE I WAS IN THE HOSPITAL? You were given medications to help get the fluid out. Your symptoms got better and were ready to leave the hospital. 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 166.7 pounds. Call your doctor if your weight goes up or down more than 3 pounds (increases to a weight of 170 pounds) in one day or 5 lb in one week. - Call you doctor if you notice any of the "danger signs" below. We wish you the best! Your ___ Care Team Followup Instructions: ___