OE ORDER

Expect patient to be here equal to or greater than two midnights: Y: Yes
Patient Status: IP: Admit to Inpatient
Medical Reason: Bronchiectasis with acute exacerbation
Medical Reason: Acute on chronic respiratory failure with hypoxia
Medical Reason: Emphysematous COPD

ED PHYSICIAN RECORD

Chief Complaint: Cough, Shortness of breath, back pain

Past Medical History - Adult:
Stated Complaint COUGH, NEEDS IV ANTIBOTICS
Allergies:
Coded Allergies:
phenylbutazone (From BUTAZOLIDIN) (Severe, AIRWAY CLOSED 06/30/19)
latex (Mild, BLISTERS 02/20/24)
NSAIDS (Non-Steroidal Anti-Inflamma (HEMOPHILLIAC 06/30/19)
aspirin (Intermediate, HEMOPHILIAC, INCREASES CHANCE OF BLEED 06/30/19)
Tape - Plastic (bleeding 06/05/22)

Home Medications:

Reported Medications:
metHOTREXate 15 MG PO Q7D
SOLIFENACIN (VESICARE) 10 MG PO DAILY
ALPRAZolam (XANAX) 2 MG PO BEDTIME
CITALOPRAM (CeleXA) 40 MG PO DAILY
[HUMIRA(CF) PEN 40 MG]
lisinopriL (ZESTRIL) 10 MG PO DAILY
levalbuterol (XOPENEX HFA 45 MCG/ACT) 2 PUFF INH Q6H PRN PRN COPD
GLYCOPYRROLATE/FORMOTEROL (BEVESPI AEROSPHERE) 2 PUFF INH BID
ADALIMUMAB (HUMIRA) 40 MG SUBQ Q7D
MIRABEGRON (MYRBETRIQ) 50 MG PO DAILY
traMADol (ULTRAM) 50 MG PO Q6H PRN PRN PAIN
ARIPiprazole (ABILIFY) 15 MG PO DAILY
MONTELUKAST (SINGULAIR) 5 MG PO DAILY
prednisoLONE ACETATE 0.12% (PRED MILD 0.12%) 1 DROP EACH EYE Q4HR
methocarbamoL (ROBAXIN) 1,000 MG PO Q6H PRN PRN MUCLE PAIN
DEXTROAMPHETAMINE/AMPHETAMINE (ADDERALL) 20 MG PO DAILY

Past Medical History:
Reports: COPD.
Additional Medical History:
COPD, recurrent pneumonia,
Psoriatic arthritis

Rheumatoid arthritis
Left upper lobe aspergilloma
Chronic hepatitis-C
Chronic pain syndrome

Additional Surgical History: skin cancer removed

Additional Family History:
Father died in his 80s after complications of a stroke
Mother died in her 80s from renal failure
2 sisters, one died
One brother who died of bleeding diastasis due to his hemophilia
Alcohol Use No alcohol since 1995
Drug Use Denies recreational drugs
Other Social History Primary family support

Vital Signs:
First Documented:
Result Date Time
Pulse Ox 96 02/20 1039
B/P 148/74 02/20 1039
B/P Mean 98 02/20 1039
O2 Delivery Nasal cannula 02/20 1039
O2 Flow Rate 4 02/20 1039
Temp 101.3 02/20 1039
Pulse 96 02/20 1039
Resp 20 02/20 1039

Last Documented:
Result Date Time
O2 Delivery Nasal cannula 02/20 1042
O2 Flow Rate 4 02/20 1042
Pulse Ox 96 02/20 1039
B/P 148/74 02/20 1039
B/P Mean 98 02/20 1039
Temp 101.3 02/20 1039
Pulse 96 02/20 1039
Resp 20 02/20 1039

Laboratory Tests:
02/20 02/20
1054 1054
Chemistry
Sodium (137 - 145 mmol/l) 140
Potassium (3.5 - 5.1 mmol/l) 4.9
Chloride (98 - 107 mmol/l) 101
Carbon Dioxide (22 - 30 mmol/l) 30
BUN (9 - 20 mg/dl) 28 H

Creatinine (0.66 - 1.25 mg/dl) 1.6 H
Est GFR (CKD-EPI 2021) (>=60) 45 L
BUN/Creatinine Ratio ((CALC)) 17
Glucose (74 - 106 mg/dl) 87
Lactic Acid (0.7 - 2.0 mmol/l) 1.1
Calcium (8.4 - 10.2 mg/dl) 9.6
Total Bilirubin (0.2 - 1.0 mg/dl) 0.7
AST (17 - 59 U/L) 24
ALT (21 - 72 U/L) 11 L
Alkaline Phosphatase (38 - 126 U/L) 92
Total Protein (6.3 - 8.2 g/dl) 8.3 H
Albumin (3.5 - 5.0 g/dl) 4.8
Globulin (g/dL) 3.5
Albumin/Globulin Ratio 1.4
Hematology
WBC (3.8 - 10.7 K/cmm) 10.9 H
RBC (3.92 - 5.83 MIL/mm) 3.70 L
Hgb (12.0 - 17.5 gm/dl) 11.9 L
Hct (35.8 - 52.9 %) 35.3 L
MCV (81.2 - 99.8 fL) 95.4
MCH (26.6 - 34.5 pg) 32.0
MCHC (32.1 - 35.5 %) 33.5
RDW (12.4 - 16.2 %) 14.5
Plt Count (139 - 358 K/cmm) 269
MPV (6.8 - 10.7 fL) 6.8
Neut % (Auto) (%) 81.2
Lymph % (Auto) (%) 10.4
Mono % (Auto) (%) 7.4
Eos % (Auto) (%) 0.8
Baso % (Auto) (%) 0.2
Neut # (Auto) (1.9 - 7.3 K/mm3) 8.8 H
Lymph # (Auto) (0.9 - 3.8 K/mm3) 1.1
Mono # (Auto) (0.2 - 0.9 K/mm3) 0.8
Eos # (Auto) (0.0 - 0.5 K/mm3) 0.1
Baso # (Auto) (0.0 - 0.1 K/mm3) 0.0

Free Text MDM Notes:
Cefepime and doxycycline were ordered by request of the hospitalist

Clinical Impression:
Primary Impression: Bronchiectasis
Secondary Impressions: Acute febrile illness

H&P

Chief complaint: Worsening shortness of breath

HPI:
F is referred to the hospitalist service from the emergency department for evaluation for admission with suspicion of a bronchiectasis exacerbation. He was at the ED 24 hours ago with complaints of increased sputum and increasing dyspnea. He has required an increase on supplemental oxygen from his baseline of 2 L via nasal cannula to 4 L for advanced emphysematous COPD. He is followed very closely by outpatient pulmonology who has reported that with the increasing sputum production and color change as well as physical worsening he most likely has a bronchiectasis exacerbation despite apparent stable imaging 24 hours ago. In the emergency department, the ED physician advises that he spiked a fever to 38.5 degrees centigrade. I have reviewed the imaging and diagnostic workup from 24 hours ago with the ED physician. I agree with the decision to admit. I shall notify the on-call pulmonologist of the bronchiectasis exacerbation

Past medical history:
Reports: COPD.
Additional medical history:
COPD, recurrent pneumonia,
Psoriatic arthritis
Rheumatoid arthritis
Left upper lobe aspergilloma
Chronic hepatitis-C
Chronic pain syndrome
Additional surgical history: skin cancer removed
Additional family history:
Father died in his 80s after complications of a stroke
Mother died in her 80s from renal failure 2 sisters, one died
One brother who died of bleeding diastasis due to his hemophilia
Alcohol use: No alcohol since 1995
Drug use: Denies recreational drugs

Allergies:
Coded Allergies:
phenylbutazone (From BUTAZOLIDIN) (Severe, AIRWAY CLOSED 06/30/19)
latex (Mild, BLISTERS 02/20/24)
NSAIDS (Non-Steroidal Anti-Inflamma (HEMOPHILLIAC 06/30/19)
aspirin (Intermediate, HEMOPHILIAC, INCREASES CHANCE OF BLEED 06/30/19)
Tape - Plastic (bleeding 06/05/22)

Code status: do not resuscitate

Free Text DxA P Notes:
Bronchiectasis with acute exacerbation
Acute on chronic respiratory failure with hypoxia
Emphysematous COPD

Chronic immunosuppression on Humira/methotrexate
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Hypertensive heart disease

Plan:
Admit. Inpatient. Telemetry.
Initiate cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o. b.i.d. and
monitor against toxicity pending blood and sputum cultures.
Consult pulmonology.
Titrate supplemental oxygen via nasal cannula and maintain appropriate O2 sats
Monitor blood pressure closely and avoid hypotension.
Continue on inhaled bronchodilators
Monitor liver profile with chemistry renal profile
Monitor against continuous bleed especially with hemophilia. SCDs for DVT prophylaxis.
Consider consult to Infectious Disease following culture results
Consult to case management for safe disposition and discharge planning
Minimum of 2 inpatient midnights.

CONSULT REPORT

Pulmonology consultation note

Reason for consult: bronchiectasis/emphysematous COPD
Chief complaint: Shortness of breath
HPI:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3.Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse is at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

History - Adult longitudinal
Past medical history:
Reports: COPD.
Additional medical history:
COPD, recurrent pneumonia,
Psoriatic arthritis
Rheumatoid arthritis
Left upper lobe aspergilloma
Chronic hepatitis-C
Chronic pain syndrome
Additional surgical history: skin cancer removed
Additional family history:
Father died in his 80s after complications of a stroke
Mother died in her 80s from renal failure
2 sisters, one died
One brother who died of bleeding diastasis due to his hemophilia
Alcohol use:
No alcohol since 1995
Drug use: Denies recreational drugs
Smoking status for patients 13 years old or older: Former Smoker
Other social history: Primary family support
Allergies:
Coded Allergies:
phenylbutazone (From BUTAZOLIDIN) (Severe, AIRWAY CLOSED 06/30/19)
latex (Mild, BLISTERS 02/20/24)
NSAIDS (Non-Steroidal Anti-Inflamma (HEMOPHILLIAC 06/30/19)
aspirin (Intermediate, HEMOPHILIAC, INCREASES CHANCE OF BLEED 06/30/19)
Tape - Plastic (bleeding 06/05/22)

Diagnosis, Assessment Plan:
Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Consultants: pulmonary

Free Text DxA P Notes:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
2) Bronchiectasis
* Imaging reviewed. Obtain sputum culture.
* Continue current antibiotics, bronchodilators - Duonebs, Pulmicort nebs.

Cultures are pending. It is important to note that pt usually takes Rituxan and methotrexate for RA.
Continue above treatment, aggressive pulmonary toilet.
Case discussed with attending MD
We appreciate the opportunity to participate in the care of this patient. We will follow closely with you.

PROGRESS NOTE

Advance care planning progress note: Day 1

Code status: do not resuscitate
Plan discussed with: patient, spouse/partner
DC disposition needs: home O2

Assessment and Plan:
These active diagnoses are of sufficient risk that focused discussion on advance care planning is indicated in order to allow the patient to thoroughly consider personal goals of care; and if situations arise that prevent the ability to personally give input, to ensure appropriate representation of their personal desires for different levels and aggressiveness of care.

Discussion:
F has a standing do not attempt resuscitation order. This has been reviewed with his wife who mentions that he has been chronically ill and has never been amenable to intubation and mechanical ventilation. He does not expect CPR or defibrillation to increase his quality of life.

Free text DxA P notes:
Bronchiectasis with acute exacerbation
Acute on chronic respiratory failure with hypoxia
Emphysematous COPD
Chronic immunosuppression on Humira/methotrexate
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Hypertensive heart disease

Plan:
Admit. Inpatient. Telemetry.
Initiate cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o. b.i.d. and monitor against toxicity pending blood and sputum cultures.
Consult pulmonology.
Titrate supplemental oxygen via nasal cannula and maintain appropriate O2 sats
Monitor blood pressure closely and avoid hypotension.
Continue on inhaled bronchodilators
Monitor liver profile with chemistry renal profile
Monitor against continuous bleed especially with hemophilia. SCDs for DVT prophylaxis.
Consider consult to Infectious Disease following culture results
Consult to case management for safe disposition and discharge planning

Pulmonology progress note: Day 2

Chief complaint: Cough

Respiratory effort appears comfortable on nasal cannula today. Patient reports intermittent cough that is productive of sputum. Spouse at bedside. Chart reviewed. Ten point ROS completed and otherwise negative.

HPI:
Imported from initial consultation:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
2) Bronchiectasis
* Imaging reviewed. Obtain sputum culture.
* Continue current antibiotics, bronchodilators - Duonebs, Pulmicort nebs, VEST

Cultures are pending. It is important to note that pt usually takes Rituxan and methotrexate for RA.
Continue above treatment, aggressive pulmonary toilet.

Hospitalist progress note: Day 2

Chief complaint: Worsening shortness of breath
Comments: Wife reports altered mental status

Free text DxA P notes:
Bronchiectasis with acute exacerbation
Acute on chronic respiratory failure with hypoxia
Emphysematous COPD
CKD 2 creatinine above 60, BUN/ creatinine 28/1.6 on admission was seen in line 2022
Chronic immunosuppression on Humira/methotrexate
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Hypertensive heart disease

Plan:
Continue monitoring on telemetry
Continue cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o. b.i.d. and monitor against toxicity pending blood and sputum cultures.
Breathing treatments as needed
Intranasal oxygen as needed
Pulmonary reviewed today. We will await sputum and blood cultures (pending).
Titrate supplemental oxygen via nasal cannula and maintain appropriate O2 sats
Continue on inhaled bronchodilators

CKD
BUN creatinine 28/1.6 yesterday, 35/1.5 today
Creatinine 1.4 September 2020
Monitor
Avoid nephrotoxins.

Patient's spouse requesting early DC with home therapy for antibiotics as needed.
We will await confirmation of prolonged IV therapy from Pulmonary.

Hemophilia
Stop Prophylactic heparin
SCDs for deep vein thrombosis prophylaxis.

Arthritic psoriasis
Weekly Humira/methotrexate on hold

Pulmonology progress note: Day 3

Chief complaint: Cough

Respiratory effort appears comfortable on nasal cannula today. Patient reports intermittent cough that is not productive. Daughter at bedside. Chart reviewed. Ten point ROS completed and otherwise negative.

HPI:
Imported from initial consultation:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3.Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
2) Bronchiectasis
* Imaging reviewed. Sputum culture unacceptable specimen.
* Continue current antibiotics (Cefepime/Doxy), bronchodilators - Duonebs, Pulmicort nebs, VEST

Blood cultures are pending. It is important to note that pt usually takes Rituxan and methotrexate for RA, therefore chronically immunosuppressed. Continue above treatment, aggressive pulmonary toilet.

Hospitalist progress note: Day 3

Chief complaint: Worsening shortness of breath, AMS

HPI:
More alert this AMm daughter at bed side answered her questions

Free text DxA P notes:
Bronchiectasis with acute exacerbation
Acute on chronic respiratory failure with hypoxia
Emphysematous COPD
AKI, BUN/ creatinine 28/1.6 on admission
Chronic immunosuppression on Humira/methotrexate
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Hypertensive heart disease

Plan:
Continue monitoring on telemetry
Immunosuppressed Continue cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o.
b.i.d. and pending blood and sputum cultures.
Breathing treatments as needed
Intranasal oxygen as needed
Pulmonary reviewed today. We will await sputum and blood cultures (pending).
Aggressive pulmonary toilet.
Recommends: Continue current antibiotics , bronchodilators - Duonebs, Pulmicort nebs, VEST
Titrate supplemental oxygen via nasal cannula and maintain appropriate O2 sats
Continue on inhaled bronchodilators

AKI
BUN creatinine 28/1.6 on admission Creatinine 1.2 today
Monitor
Avoid nephrotoxins.

Hemophilia
Stop Prophylactic heparin
SCDs for deep vein thrombosis prophylaxis.

Arthritic psoriasis
Weekly Humira/methotrexate on hold

Disp:
Patient's spouse requesting early DC with home therapy for antibiotics as needed.
We will await confirmation of prolonged IV therapy from Pulmonary
Discussed safe DC with case management
Will add PTOT.

Pulmonology progress note: Day 4

Chief complaint: Cough

Respiratory effort appears comfortable on nasal cannula today. Patient reports productive cough with use of vest and chest pain with cough. Chart reviewed. Ten point ROS completed and otherwise negative.

HPI:
Imported from initial consultation:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
2) Bronchiectasis
* Imaging reviewed. Sputum culture specimen unacceptable. However, leukocytosis resolved.
* Continue current antibiotics (Cefepime/Doxy), bronchodilators - Duonebs, Pulmicort nebs, VEST

Continue to follow blood cultures.
Continue above treatment, aggressive pulmonary toilet.

Hospitalist progress note: Day 4

Chief complaint: Worsening shortness of breath, AMS

HPI:
More alert this AM
Daughter/wife at bed side answered questions
Family is requesting skilled on skilled home health following discharge

Free text DxA P notes:
Bronchiectasis with acute exacerbation
Acute on chronic respiratory failure with hypoxia
Emphysema
AKI, BUN/ creatinine 28/1.6 on admission
Chronic immunosuppression on Humira/methotrexate
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Hypertensive heart disease

Plan:
Patient improving
Continue monitoring on telemetry
Immunosuppressed Continue cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o.
b.i.d. and Review blood and sputum cultures when available
Breathing treatments as needed
Intranasal oxygen as needed
Pulmonary reviewed today. We will await sputum and blood cultures (pending).
Aggressive pulmonary toilet.
Recommends: Continue current antibiotics, bronchodilators - Duonebs, Pulmicort nebs, VEST
Titrate supplemental oxygen via nasal cannula and maintain appropriate O2 sats
Continue on inhaled bronchodilators

AKI
BUN creatinine 28/1.6 on admission Creatinine 1.2 today
Monitor
Avoid nephrotoxins.

Hemophilia
Stop Prophylactic heparin
SCDs for deep vein thrombosis prophylaxis.

Arthritic psoriasis
Weekly Humira/methotrexate on hold

Disp:
Patient's spouse requesting early DC with home therapy for antibiotics as needed.
We will await confirmation of blood culture and pulmonary

Discussed safe DC with case management
Will add PTOT for mobilization.

Pulmonology progress note: Day 5

Chief complaint: Cough

Respiratory effort appears comfortable on 3L nasal cannula today. Patient given Haldol last night due to altered mental status. She is requesting repeat sputum culture due to previous unacceptable specimen results. Chart reviewed. Ten point ROS completed and otherwise negative.

HPI:
Imported from initial consultation:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status,cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
2) Bronchiectasis
* Imaging reviewed.

* Sputum culture specimen unacceptable. Repeat sputum culture ordered.
* Continue current antibiotics (Cefepime/Doxy), bronchodilators - Duonebs, Pulmicort nebs, VEST

Continue to follow blood cultures.
Continue above treatment, aggressive pulmonary toilet.

Chief complaint:
Agitated last night required Haldol slow to answer today and seems out of it" per wife. Wife also states that he gets confused and agitated whenever he is in the hospital. He has been awake for the past three nights despite receiving Haldol last night. She is concerned about worsening pneumonia as well as agitation. Per nursing patient has not been able to void. Bladder scan showed greater than 400 mL. The 1st time that he had episode of urinary retention this admission they were able to have him stand and then he urinated.

Code status: full code
Plan discussed with: patient, spouse/partner, interdisc care team

Free text DxA P notes:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Urinary retention
Agitation, confusion
Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension

Slowly improving, intermittently on 2-3 L nasal cannula, he is on 3 L as needed at home. Suspect agitation related to sundowning, not unexpected. However, wife increasingly concerned about progressive pneumonia and oxygen levels. Will obtain an ABG to ensure no CO2 retention. Will reassess chest x-ray. Blood cultures remain negative. His sputum culture was not acceptable for culture. Await final Pulmonary recommendations. No recent dysrhythmia, however, on high-risk medications so will continue telemetry another 24 hours.

Trial of Zyprexa if needed this evening.
Resume appropriate home medications including Adderall
Immunosuppressed Continue cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o. b.i.d.
Inhaled Steroids/bronchodilators/Supplemental oxygen/Incentive spirometry
DVT prophylaxis SCDs for deep vein thrombosis
Trial avoiding if fails, then straight cath

Pulmonary consultation in progress

ABG
Repeat chest x-ray
Reassess electrolytes and renal and hepatic function serially secondary to high-risk medications
Monitor for bleeding diathesis

PT/OT

Hospitalist progress note: Day 6

Chief complaint: Slept better last night per wife and nursing staff did not require Zyprexa. No further urinary retention today. He feels less short of breath.

Code status: full code
Plan discussed with: patient, spouse/partner, interdisc care team

Free text DxA P notes:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Urinary retention
Agitation, confusion
Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension

Still requiring intermittently on 2-3 L nasal cannula, he is on 3 L as needed at home. Chest x-ray a little worse concerning for progressing pneumonia. Solu-Medrol added per Pulmonary. Continue cefepime and doxycycline for now.

Reassess tomorrow need for antibiotic change or advanced imaging. Not able to get inappropriate sputum sample yet. Will discuss with Pulmonary team. Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

No recent dysrhythmia, however, on high-risk medications so will continue telemetry another 24 hours.

Continue cefepime 2 g IV q.8 hours and doxycycline 100 mg p.o. b.i.d.
Continue IV and Inhaled Steroids/bronchodilators/Supplemental oxygen/Incentive spirometry
Trial of Zyprexa if needed this evening.
Continue appropriate home medications including Adderall
DVT prophylaxis

Pulmonary consultation in progress

Reassess electrolytes and renal and hepatic function serially secondary to high-risk medications
Monitor for bleeding diathesis
PT/OT

Pulmonology progress note: Day 6

Chief complaint: Cough

Patient easily arousable and resting comfortably on 3 L nasal cannula. Wife concerned patient has pneumonia. Chart reviewed. Ten point ROS completed and otherwise negative.

HPI:
Imported from initial consultation:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3.Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Recent Impressions:
RADIOLOGY - Chest AP Port 02/24 1345
*** Report Impression - Status: SIGNED Entered: 02/24/2024 1503

IMPRESSION: New opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic resp. failure
* Continue supplemental oxygen as needed to maintain sats greater than 90%.
* Chronic baseline is 2 L
* Chest CT arteriogram 02/19/2024, impression: Similar advanced chronic changes. No acute intrathoracic abnormality. Advanced COPD. Old granulomatous disease. Chronic loculated fluid collection at the left lower thorax with associated lung scarring. Multifocal lung scarring.
* Chest x-ray 04/24/2024: New opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity.
* Add Solu-Medrol x3 doses due to wheezing
2) Bronchiectasis

* Imaging reviewed.
* Sputum culture specimen unacceptable. Repeat sputum culture ordered.
* Continue current antibiotics (Cefepime/Doxy), bronchodilators - Duonebs, Pulmicort nebs, VEST

Blood cultures and sputum cultures pending
Continue above treatment, aggressive pulmonary toilet.

Pulmonology progress note: Day 7

Chief complaint: Follow-up acute on chronic respiratory failure with hypercapnia, acute bronchiectasis exacerbation

Patient seen and examined at the bedside. He is awake and alert. Reports significant improvement in respiratory status and rib pain today. Reports comfortable respiratory status on 3L/NC.

EMR Reviewed. 10-point review of systems completed and otherwise negative

HPI:
Per Initial Consult:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3.Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

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Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic hypoxemic respiratory failure with hypercapnia
* Bronchiectasis exacerbation, chronic lung disease, chronic pulmonary aspergillosis
* Supplemental oxygen as needed to maintain SpO2 greater than 90%; currently on 3 liters/minute

* Chronic supplemental oxygen of 2 liters/minute

2) Acute bronchiectasis exacerbation
* Antibiotics: Cefepime; completed oral doxycycline
* Pulmonary toilet: Encourage incentive spirometry and vest therapy
* Solu-Medrol 60 mg x 3 doses ordered yesterday for persistent wheezing
* Continue DuoNebs 4 times daily and albuterol nebulizer every 4 hours as needed
* Continue Pulmicort nebulizer twice daily
* Repeat sputum culture 1+ normal flora

Imaging:
Chest x-ray 2/24/24: Impression - new opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity

Hospitalist progress note: Day 7

Chief complaint: F/U COPD, Resp Failure, Bronchiectasis

HPI:
73-year-old male who presented emergency room with complaints of increasing shortness of breath and cough. His symptoms have been gradually worsening over the last 2 days. He is also developed problems with back pain in addition to the shortness of breath. His white count was 10900 with shift to the left. Chest x-ray did not reveal any acute findings.

Patient reports:
Yes: cough, shortness of breath. No: abdominal pain, chest pain, nausea, vomiting.

Diagnosis, Assessment Plan:
Consultants:
pulmonary
DC disposition needs: home O2

Free text DxA P notes:
Assessment:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Pneumonia -- right mid and lower lung opacities on chest x-ray
Urinary retention
Agitation, confusion
Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension

Plan:
The patient is encouraged to use incentive spirometer every hour. The doxycycline has been discontinued. He is still receiving the Maxipime at 2 g IV q.12 hours. The patient is currently on Pulmicort 0.5 mg b.i.d. and DuoNeb hand -held nebulizers q.i.d.. Will add Perforomist 20 mcg b.i.d.. The Robitussin DM will be changed from q.6 hours p.r.n. to scheduled dose q.i.d.. Feel patient benefit from the guaifenesin in the Robitussin DM. Review of the chart reveals the patient has not had a BM in several days. He is started on Senokot S2 tabs b.i.d.. The patient is encouraged to use the incentive spirometer every hour while awake. His wife did bring his Acupella from home. Continue to monitor his blood pressure and heart rate. Follow up labs in am.

Since admission: Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

Pulmonology progress note: Day 8

Chief complaint: Follow-up acute on chronic respiratory failure with hypercapnia, acute bronchiectasis exacerbation

Patient seen and evaluated. Wife at bedside. Reports patient had a difficult night due to nausea with vomiting. Wife is worried that patient may have aspirated. Patient reports feeling well overall. He denies acute respiratory complaints and continues to feel improvement. He remains on 3L/NC.

EMR Reviewed. 10-point review of systems completed and otherwise negative

HPI:
Per Initial Consult:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic hypoxemic respiratory failure with hypercapnia
* Bronchiectasis exacerbation, chronic lung disease, chronic pulmonary aspergillosis
* Supplemental oxygen as needed to maintain SpO2 greater than 90%; currently on 3 liters/minute with SPO2 95%
* Chronic supplemental oxygen of 2 liters/minute

2) Acute bronchiectasis exacerbation
* Antibiotics: Cefepime; completed oral doxycycline
* Pulmonary toilet: Encourage incentive spirometry, flutter valve and vest therapy
* Solu-Medrol 60 mg x 3 doses ordered yesterday for persistent wheezing
* Continue DuoNebs 4 times daily and albuterol nebulizer every 4 hours as needed
* Continue Pulmicort nebulizer twice daily
* Repeat sputum culture 1+ normal flora

Imaging:
Chest x-ray 2/24/24: Impression - new opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity
Chest x-ray 2/27/24: Impression - Stable chest with no acute superimposed finding

Hospitalist progress note: Day 8

Chief complaint: F/U COPD, Resp Failure, Bronchiectasis

HPI:
73-year-old male who presented emergency room with complaints of increasing shortness of breath and cough. His symptoms have been gradually worsening over the last 2 days. He is also developed problems with back pain in addition to the shortness of breath. His white count was 10900 with shift to the left. Chest x-ray did not reveal any acute findings.

Patient reports:
Yes: complaints (Difficulty swallowing), cough (worse when eat), shortness of breath (worse with exertion).No: abdominal pain, chest pain, nausea, vomiting.

Comments:
Patient was seen and examined. Patient had an episode earlier this morning where he experienced an episode of choking when eating. His wife is concerned that he may have aspirated at time.

Free text DxA P notes:
Assessment:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Pneumonia -- right mid and lower lung opacities on chest x-ray
Urinary retention
Agitation, confusion

Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension

Plan:
The patient is having problems with difficulty swallowing. His wife reports that he experienced an episode of getting choked earlier in the day and she is concerned that he may have aspirated. Patient has had problems with swallowing for quite some time and she does report a history of esophageal stricture that has required dilatation. A portable chest x-ray possible aspiration. The chest x-ray did reveal hyperinflation of the right lung with scattered healed parenchymal granulomatous calcifications bilaterally that were unchanged. Also noted to have elevation of the left hemidiaphragm with left basilar scarring and left pleural thickening/blunting that is unchanged. Given the patient's symptoms, he is scheduled for a barium swallow. His chest x-ray did not reveal any acute changes therefore will continue the Maxipime 2 g IV q.12 hours and not adjust his antibiotics at this time. The patient's wife also requests that his respiratory treatments be changed to Xopenex. She feels he is having problems with tremors related to the albuterol. The DuoNeb hand-held nebulizers are discontinued. The patient will be started on Xopenex 1.25 mg q.i.d. with Atrovent nebulized treatments 0.5 mg q.i.d.. Continue monitor his blood pressure and heart rate. Follow-up labs in a.m..

Since admission:
Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

Pulmonology progress note: Day 9

Chief complaint: Follow-up acute on chronic respiratory failure with hypercapnia, acute bronchiectasis exacerbation

Patient seen and evaluated. Wife at bedside reports concern over issues with choking/coughing when he eats. Patient does have a history of an esophageal stricture. Patient reports stable respiratory symptoms. He is alert and oriented.

EMR Reviewed. 10-point review of systems completed and otherwise negative

HPI:
Per Initial Consult:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic hypoxemic respiratory failure with hypercapnia
* Bronchiectasis exacerbation, chronic lung disease, chronic pulmonary aspergillosis
* Supplemental oxygen as needed to maintain SpO2 greater than 90%; currently on 3 liters/minute with SPO2 95%
* Chronic supplemental oxygen of 2 liters/minute

2) Acute bronchiectasis exacerbation
* Antibiotics: Cefepime; completed oral doxycycline
* Pulmonary toilet: Encourage incentive spirometry, flutter valve and vest therapy
* Solu-Medrol 60 mg x 3 doses ordered yesterday for persistent wheezing
* Continue DuoNebs 4 times daily and albuterol nebulizer every 4 hours as needed
* Continue Pulmicort nebulizer twice daily
* Repeat sputum culture 1+ normal flora

3) Dysphagia
* Reported history of esophageal stricture
* Barium swallow ordered by primary team - will follow up on results

Imaging:
Chest x-ray 2/24/24: Impression - new opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity
Chest x-ray 2/27/24: Impression - Stable chest with no acute superimposed finding

Disposition:
Consider PICC placement as patient may need to go home on IV antibiotics
Plan of care has been discussed with attending MD
Will continue to follow

Plan:
I would like to thank the primary team for allowing us to participate in rendering a consultative opinion in this case. Prior to signing off this patient, we will continue to make recommendations related to the reason for our

consultation. Our recommendations and treatments will be focused on but not limited to the critical issues which are listed in the problem list above.

During my clinical assessment on the date indicated by the NP on pulmonary consult rounds, I have reviewed the old records in the chart including but not limited to pulmonary labs, pulmonary images, and previous notes in the EMR. Some chronic issues are relatively stable when compared to previous records. However, admitting diagnosis and the associated issues are concerning. During today's evaluation, I have discussed all options to maximize pulmonary treatments as well as complications that may arise from treatments. Differential diagnosis was generated for the pulmonary issues and important points were discussed at length. I have addressed all questions. The Nurse Practitioner and I have discussed the case together and the contents of the note. I am in agreement with the plan in this note

Hospitalist progress note: Day 9

Chief complaint: F/U COPD, Resp Failure, Bronchiectasis

HPI:
73-year-old male who presented emergency room with complaints of increasing shortness of breath and cough. His symptoms have been gradually worsening over the last 2 days. He is also developed problems with back pain in addition to the shortness of breath. His white count was 10900 with shift to the left. Chest x-ray did not reveal any acute findings.

Patient reports:
Yes: complaints (difficulty swallowing), cough, shortness of breath. No: abdominal pain, chest pain, nausea, vomiting.

Free text DxA P notes:
Assessment:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Pneumonia -- right mid and lower lung opacities on chest x-ray
Urinary retention
Agitation, confusion
Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension

Plan:
The patient has been having problems with difficulty swallowing. He underwent a barium swallow today. He was noted to have moderate esophageal dysmotility with mild cricopharyngeal bar at level of C5-C6.The 13 mm barium tablet was not held at this location and ultimately passes to the stomach with significant delay. The patient may benefit from the addition of levbid 1 tab bid. He will be continued on the IV Maxipime. The patient will have a PICC line placed for possible IV antibiotics at home. Although, the patient was changed to Xopenex respiratory treatments yesterday. However, pharmacy changed him

back to Albuterol treatments. Continue to monitor the patient's blood pressure and heart rate. Follow up labs in am.

Since admission:
Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

Pulmonology progress note: Day 10

Chief complaint: Follow-up acute on chronic respiratory failure with hypercapnia, acute bronchiectasis exacerbation

Patient seen and examined at bedside. Wife in the room. Patient underwent barium swallow yesterday showing esophageal dysmotility. Patient reports feeling well this morning. Reports stable respiratory symptoms.

EMR Reviewed. 10-point review of systems completed and otherwise negative

HPI:
Per Initial Consult:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3.Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

Problem List/A P:
1. Acute and chronic respiratory failure (acute-on-chronic)

2. Bronchiectasis

Free Text A P:
1) Acute on chronic hypoxemic respiratory failure with hypercapnia
* Bronchiectasis exacerbation, chronic lung disease, chronic pulmonary aspergillosis

* Supplemental oxygen as needed to maintain SpO2 greater than 90%; currently on 3L/NC
* Chronic supplemental oxygen of 2 liters/minute

2) Acute bronchiectasis exacerbation
* Antibiotics: Cefepime; completed oral doxycycline
* Pulmonary toilet: Encourage incentive spirometry, flutter valve and vest therapy
* Solu-Medrol 60 mg x 3 doses ordered yesterday for persistent wheezing
* Continue DuoNebs 4 times daily and albuterol nebulizer every 4 hours as needed
* Continue Pulmicort nebulizer twice daily
* Repeat sputum culture 1+ normal flora

3) Dysphagia
* Reported history of esophageal stricture
* Barium swallow 2/28/24: Moderate esophageal dysmotility
* Discussed with patient regarding importance of sitting at 90 degree angle during meals. Also instructed to avoid laying flat up to 2-3 hours after eating a meal.

Hospitalist progress note: Day 10

Chief complaint: F/U COPD, Resp Failure, Bronchiectasis

HPI:
73-year-old male who presented emergency room with complaints of increasing shortness of breath and cough. His symptoms have been gradually worsening over the last 2 days. He is also developed problems with back pain in addition to the shortness of breath. His white count was 10900 with shift to the left. Chest x-ray did not reveal any acute findings.

Patient reports: Yes: shortness of breath. No: abdominal pain, chest pain, cough, nausea, vomiting.
Comments: Patient was seen and examined. The patient does have intermittent problems with difficulty swallowing

Free text DxA P notes:
Assessment:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Pneumonia -- right mid and lower lung opacities on chest x-ray
Urinary retention
Agitation, confusion
Immunosuppressed host
Hemophilia on recombinant factors as needed
Chronic pulmonary aspergillosis
Psoriatic arthritis
Essential hypertension
Esophageal Dysmotility

Plan:
Reviewed results of the Barium Swallow with the patient and his wife. He does have esophageal dysmotility. He will need to further evaluation. Speech therapy will be consulted for further evaluation of his dysphagia and esophageal dysmotility. Continue to monitor his blood pressure and heart rate. The patient's wife is concerned that he may need to be discharged home on IV antibiotics. She has requested that a PICC line be placed for IV antibitotics. The patient has hemophilia. He will need to be given DDAVP prior to the procedure. Follow up labs in am.

Since admission: Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

Pulmonology progress note: Day 11

Chief complaint: Follow-up acute on chronic respiratory failure with hypercapnia, acute bronchiectasis exacerbation

Patient seen and evaluated at the bedside. Reports stable respiratory symptoms at this time. Continues on 3 L nasal cannula.

EMR Reviewed. 10-point review of systems completed and otherwise negative

HPI:
Per Initial Consult:
Patient is a 73-year-old male with history of COPD, psoriatic arthritis, cavitary lesions, aspergillosis, hemophilia and Rocky Mountain spotted fever. Followed in Augusta Georgia by several specialists including Dr. T. Presented to the ER with his spouse with complaints of altered mental status, cough productive of thick white phlegm, intermittent fevers and shortness of breath. Upon arrival to the ER, labs and imaging were obtained. ABG reveals pH 7.34, pCO2 50, PO2 64, HC03 27.WBC mildly elevated at 10.9.Lactic acid 1.1. Chest x-ray shows hyperinflation with scattered healed parenchymal granulomatous changes. He was noted to be febrile with temp of 101.3. Urinalysis has been ordered. Blood cultures and sputum cultures have been obtained. He has been initiated on cefepime, doxycycline, DuoNebs and Pulmicort nebs. Pulmonary team consulted for bronchiectasis/emphysematous COPD.

Mr. H is well known to our pulmonary service. At baseline, he wars 2L nightly and during the day as needed. He uses Bevespi inhaler daily and has levalbuterol nebs for PRN use. For pulmonary toilet, he uses vest therapy.

Today, patient is seen and examined. He is unable to provide reliable history, therefore his history is obtained from his spouse at bedside. Patient is awake alert, reports cough, pleuritic chest pain. Respiratory effort appears comfortable on nasal cannula. Ten point ROS completed and otherwise negative.

DISCHARGE SUMMARY

Admission diagnosis:

COPD, recurrent pneumonia, Psoriatic arthritis, Rheumatoid arthritis, Left upper lobe aspergilloma
Chronic hepatitis-C, Chronic pain syndrome

Discharge diagnosis:

Acute on chronic respiratory failure with hypoxia, Acute COPD /bronchiectasis exacerbation, Pneumonia -- right mid and lower lung opacities on chest x-ray, Chronic pulmonary aspergillosis, Immunosuppressed host, Hemophilia on recombinant factors as needed, Psoriatic arthritis, Urinary retention, Agitation, confusion, Esophageal Dysmotility

Hospital course:
73-year-old male who presented emergency room with complaints of increasing shortness of breath and cough. He is also developed problems with back pain in addition to the shortness of breath. His white count was 10k with shift to the left. Chest x-ray did not reveal any acute findings. He is followed very closely by outpatient pulmonology who has reported that with the increasing sputum production and color change as well as physical worsening he most likely has a bronchiectasis exacerbation despite apparent stable imaging 24 hours ago. In the emergency department, the ED physician advises that he spiked a fever to 38.5 degrees. Patient was initiated on antibiotics for possible pneumonia in the setting of bronchiectasis. He was adequately treated. Pulmonologist evaluated patient during this hospitalization. Recommended continuing home antibiotics until 3/10. Midline placed for patient to complete antibiotics at home. Patient also had an episode of possible aspiration. Swallow test noted esophageal dysmotility. Discussed with wife wheeze at bedside. Recommended following up with GI in clinic. They will follow with clinic in Augusta.

Consultants: pulmonary

Free text DxA P notes:
Assessment:
Acute on chronic respiratory failure with hypoxia
Acute COPD /bronchiectasis exacerbation
Pneumonia -- right mid and lower lung opacities on chest x-ray
Chronic pulmonary aspergillosis
-at baseline on 2 L nasal cannula. Requiring 3 L this admission.
-on cefepime for pneumonia per pulmonology recommendations. Tentative end date 03/10.
-continue with breathing treatments for the above.

Immunosuppressed host
Hemophilia on recombinant factors as needed
Psoriatic arthritis
-patient on methotrexate for psoriatic arthritis , resume
-on factor 8 p.r.n. for hemophilia. Received 3000 units(1 vial) on 3/1 pending midline. I discussed with his hematologist prior to administration

Urinary retention
-Resolved. On condom catheter. No indwelling Foley

Agitation, confusion
Suspect agitation related to sundowning, not unexpected. Not retaining CO2, and oxygenation stable past 24 hours

Essential hypertension
-blood pressure remained stable. Chronic medications resumed

Esophageal Dysmotility
Reviewed results of the Barium Swallow with the patient and his wife. He does have esophageal dysmotility. Speech therapist was subsequently consulted. Recommend mechanical soft diet sitting up at 90 during feeds.

Disposition: Likely to discharge in the a.m. after home antibiotics at up.

DIAGNOSTIC RADIOLOGY REPORT

Chest AP port - Day 1

FINDINGS:
Hyperinflation with scattered healed parenchymal granulomatous changes are unaltered. Stable scarring at the left base with some loss of volume of the left.

Stable cardiomegaly. Normal mediastinum and hila. Normal visualized pulmonary arteries. Aortic tortuosity unchanged.

No abnormality of the visualized soft tissue structures of the upper abdomen.

IMPRESSION: Stable chest with no acute superimposed finding.

Chest AP port - Day 4

FINDINGS:
LINES/TUBES: None.
CARDIOMEDIASTINAL BORDERS: Stable.
LUNGS:
Calcified granulomas in both lungs. New patchy opacities in the right mid to lower lung. Persistent left basilar consolidation.
PLEURA: Mild left pleural effusion again seen.

IMPRESSION:
New opacities in the right mid to lower lung, concerning for pneumonia. Unchanged left basilar opacity.

Chest AP or PA - Day 7

FINDINGS:
Hyperinflation of the right lung with scattered healed parenchymal granulomatous calcifications bilaterally, unchanged. Elevation of the left hemidiaphragm with left basilar scarring and left pleural thickening/blunting unchanged.

Stable cardiomegaly. Normal mediastinum and hila. Normal visualized pulmonary arteries. Aortic tortuosity unchanged.

Stable mild thoracic dextroscoliosis. Normal visualized ribs, clavicles, and shoulders.

No abnormality of the visualized soft tissue structures of the upper abdomen.

IMPRESSION:
Stable chest with no acute superimposed finding.

Barium swallow double contrast - Day 8

Findings:
Fluoroscopic observation of patient swallowing showed no evidence of laryngeal penetration or aspiration. On lateral swallow, there is mild narrowing of the cervical esophagus secondary to smooth, rounded posterior extrinsic compression from the cricopharyngeus muscle at the level of C5-C6.Single contrast images show abnormal conduction of the contrast bolus via the primary stripping wave from the upper esophagus to the stomach with moderate nonpropulsive tertiary waves noted. Double contrast images of the esophagus show a normal mucosal pattern without evidence of significant ulceration or mass. Slight dilatation and tortuosity of the thoracic esophagus is noted. No evidence of significant hiatal hernia. There was no spontaneous gastroesophageal reflux, and none was elicited with Valsalva. A 13 mm barium tablet passes from the distal esophagus to the stomach without significant delay. After curvature of the thoracic spine noted. Retained ingested material is noted in the stomach and distal esophagus.

141 seconds of fluoroscopic time was used.
135.6 mGy fluoroscopic dose

Impression:
Moderate esophageal dysmotility.
Mild cricopharyngeal bar at the level of C5-C6. The 13 mm barium tablet was not held at this location and ultimately passes to the stomach without significant delay.

Electrocardiogram report : Day 2

Normal sinus rhythm
Normal ECG
When compared with ECG of 19-FEB-2024 03:32,
No significant change was found

NURSES NOTE

Lines/Drains/Airways + 03/01/2024 - 03:20 PM
- - LINES, DRAINS, AIRWAY - -
- - CVC/PICC/MIDLINE - -
Location (L/R): Right
CVC/PICC procedure: Active
CVC/PICC procedure type: Midline
CVC/PICC location: Brachial vein
CVC/PICC insertion date: 20240301
CVC/PICC insertion time: 1445
CVC/PICC/Dialysis line status: Start
Number of line attempts: 1
Guide wire removed: Yes
Method of catheter tip termination: in extremity
ultrasound
Device placed: Yes
Inserted: Inserted
Cath/PICC/Dialysis details: Non tunneled

CASE MANAGEMENT

Comments:
--- 3/2/2024 01:40 PM by M H ---
CM contacted Ms. F at 000000000, as she has left the building. She states that she does not need skilled home health at this time and that her daughter works with an agency that offers non skilled services and they will follow up with them. Patient's wife states that she can give the iv antibiotics herself.

--- 3/2/2024 11:29 AM by M H ---
A on call pharmacy called to verify that medications have been sent and are being delivered by 12 pm today.

--- 3/1/2024 03:56 PM by K M ---
WIFE HAS ASKED THE NURSE TO MESSAGE CM THAT THE PHARMACY HAS CALLED AND THEY
ARE NOT ABLE TO GET THE MEDS UNTIL MONDAY. THE WIFE HAS REQUESTED OTHER OPTIONS AS TO SHE WANTS TO DC HOME TODAY. CM PLACED A CALL TO IV CARE OPTIONS AND THEY CAN NOT WORK ON A REFERRAL THIS LATE IN THE DAY. CM SPOKE WITH CLAY AT AMERITA AND HE REQUESTS THE REFERRAL BE SENT VIA CAREPORT.

--- 3/1/2024 02:26 PM by K M ---
WIFE HAS REQUESTED NON SKILLED SERVICES THROUGH ALWAYS CARING.CM SPOKE WITH
S AT ALWAYS CARING AND THEY NEED AN H+P FAXED AND THIS IS ALL.

ORDER - DNR

RESUS-20240220-0013
DNR:DNR/Allow Natural Death

RESUS-20240223-0013
FC: Full Code