Admission Date: [\*\*3363-9-9\*\*] Discharge Date: [\*\*3363-9-29\*\*]

Date of Birth: [\*\*3300-1-6\*\*] Sex: M

Service: MEDICINE

Allergies:

Nitroglycerin

Attending:[\*\*First Name3 (LF) 6489\*\*]

Chief Complaint:

admitted from [\*\*Hospital \*\*] clinic w/ 5 days worsening SOB, DOE

Major Surgical or Invasive Procedure:

thoracentesis

cardiac catheterization

History of Present Illness:

Pt is a 63M w/ h/o metastatic carcinoid tumor, HTN,

hyperlipidemia who reports increasing SOB and DOE starting about

a month ago but worsening significantly within the last 5 days.

It has recently gotten so bad he can barely get up out of a

chair without getting short of breath. He reports orthopnea but

no PND. In clinic today, he was using accessory muscles of

respiration and was mildly diaphoretic, and his O2 sat on room

air was 97%, dropping to 94% with ambulation. He reports no

fever or chills, no URI symptoms, no recent travel, no changes

in his medications.

Pt also reports ~5 episodes of chest pain in the last few weeks

which he describes as pressure on his mid-sternum and usually

occurs during exertion. There is no associated nausea or

vomiting. He says he takes a [\*\*2-6\*\*] tablet of Xanax when he gets

this pain sometimes which seems to help. He cannot take

nitroglycerin because of his Viagra.

Past Medical History:

1. metastatic carcinoid tumor, Dx'ed 2002

-was on a study drug for a year and a half (ended about a year

ago) and was on octreotide for a few months earlier this year

but stopped because of diarrhea

2. hypertension

3. hyperlipidemia

4. carotid endarterectomy 1999

5. depression/anxiety

6. cellulitis 2 weeks ago, given Keflex IV at [\*\*Hospital3 184\*\*], now resolved

7. DM2/prediabetic state: random blood sugar was high, was on

glyburide for a brief time but made his sugars low so stopped

8. anxiety attack 1989 (collapsed), diagnosed in [\*\*3357\*\*] as MI

9. basal cell carcinoma (chest, low back, MOHS on cheek [\*\*5-9\*\*] and

[\*\*8-9\*\*])

Social History:

Lives alone, has two daughters

Distant [\*\*Name2 (NI) 2678\*\*] use (25 pack-years, quit 30 years ago), distant

EtOH use (quit 28 yrs ago), no drugs

Family History:

early CAD

Physical Exam:

VS: T 97.7, HR 97, BP 140/52, RR 20, O2sat 97% on RA

Gen: awake, alert, conversant, elderly man, mildly short of

breath

HEENT: PERRL, EOMI, MMM

Neck: supple, JVP elevated (~8cm)

Chest: fine cracles at left base, otherwise CTA

CV: RRR, nl S1S2, no m/r/g, distant heart sounds

Abd: S/ND, mildy tender to palpation in LLQ

Ext: WWP, 1+ LE edema bilaterally, no c/c

Neuro: nonfocal

Pertinent Results:

[\*\*3363-9-9\*\*] 03:30PM PLT COUNT-201

[\*\*3363-9-9\*\*] 03:30PM NEUTS-69.9 LYMPHS-23.5 MONOS-4.8 EOS-1.1

BASOS-0.7

[\*\*3363-9-9\*\*] 03:30PM WBC-9.2 RBC-4.68 HGB-14.6 HCT-42.0 MCV-90

MCH-31.3 MCHC-34.8 RDW-13.7

[\*\*3363-9-9\*\*] 03:30PM TSH-4.0

[\*\*3363-9-9\*\*] 03:30PM CK-MB-NotDone cTropnT-<0.01

[\*\*3363-9-9\*\*] 03:30PM CK(CPK)-50

[\*\*3363-9-9\*\*] 03:30PM GLUCOSE-125\* UREA N-14 CREAT-1.0 SODIUM-138

POTASSIUM-4.1 CHLORIDE-101 TOTAL CO2-22 ANION GAP-19

Brief Hospital Course:

1. SOB: likely from CHF

The patient was initially diuresed for mild pulmonary edema: he

received 20 IV Lasix on night of admission and 40mg [\*\*9-10\*\*], with

good UOP. On [\*\*9-10\*\*], pt was reporting improvement of symptoms and

able to walk around his room with 4L O2 NC. The following day he

reported feeling worse, with increasing SOB, and was found to

now be in oliguric renal failure. CXR [\*\*9-11\*\*] 8am showed showed

atelectasis with possible superimposed pneumonia. Emergent TTE

showed decreased EF (30%), anteroapical infarct with

moderate-to-severe overall left ventricular contractile

dysfunction; bicusapid aortic valve with at least mild aortic

stenosis. He was sent to the MICU [\*\*9-11\*\*] to [\*\*9-18\*\*] (see below for

course).

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On transfer back from the MICU, SOB was much improved, and he

was on 2L NC intermittently for comfort. After his ARF resolved,

he was cathed [\*\*9-23\*\*], showing persisting right heart failure [\*\*3-9\*\*]

tricuspid regurg. He was monitored in the CCU post-cath and

diuresed 1.3L until transfer back to the floor on [\*\*9-25\*\*]. There,

diuresis was continued with stable Cr, and the pt was weaned off

O2, able to maintain O2 saturation throughout PT exercise and

reporting much improvement from initial symptoms.

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2. chest pain

-MI (no ischemic changes on EKG) vs. GERD vs. anxiety vs. PE

(CTA negative)

Cardiac enzymes were negative. Viagra was discontinued while

in-house so nitrates could be used if necessary. He was

monitored on tele, with no abnormalities. Xanax was continued

0.25mg prn.

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3. HTN/hyperlipidemia/CAD

Norvasc and Lipitor were continued initially, but the

anti-hypertensive regimen was changed in MICU (see below), and

lipitor was stopped due to transaminitis. He had clean

coronaries on cath [\*\*9-23\*\*]. A repeat TTE on [\*\*9-26\*\*] showed no change

from [\*\*9-11\*\*]. On [\*\*9-27\*\*], given restoration of renal and hepatic

function, he was restarted on lipitor, and hydralazine and

nitrate were replaced with toprol XL 25qd per cardiology recs.

He may benefit from lisinopril in the future. Aspirin was

continued throughout his hospital course.

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4. diabetes/pre-diabetic state

-diabetic diet, RISS

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5. depression/anxiety

-continued Paxil, Xanax

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6. PPx: subq heparin, H2B/PPI

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7. PT: pt was started on physical therapy during his hospital

stay. By the time of discharge, he was tolerating [\*\*2-6\*\*] physical

therapy sessions a day and maintaining O2 sats in high 90s. PT

felt he would be able to tolerate a total of 3-4 hours of PT per

day spread across multiple sessions in an acute rehab setting.

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MICU Course

1. Hypoxic respiratory failure: On hospital day 3, the patient

began to have desaturations requiring 100% NRB to maintain

oxygen saturation. His hypoxia was attributed to a right lower

lobe pneumonia and congestive heart failure given his new wall

motion abnormality with an EF of 35-40%. He completed a 7-day

course of Levofloxacin and Vancomycin for empiric treatment of

hospital acquired pneumonia. He was also given lasix for

diuresis given his positive fluid status. Several times during

his ICU stay, he desaturated to the low 70% for brief episodes.

Some of these episodes were attributed to anxiety since his

saturations improved with ativan. However, anxiety alone could

not explain his persistent oxygen requirement. A chest CT was

performed to look for parenchymal disease that was not evident

on plain films. The CT showed bilateral pleural effusions with

the right greated than the left. The effusions were attributed

to CHF. He was started on hydralazine and insosorbide

mononitrate for afterload reduction. Given his persistent

oxygen requirement a diagnostic and therapeutic thoracentesis

was performed to rule out a malignant or infected effusion.

Approximately 1 litre of clear yellow fluid that was consistent

with a transudate was removed from the right. Pleural cultures

showed no growth at the time of transfer from the ICU. His

oxygenation improved post-thoracentesis and he was able to

tolerate being on room air.

2. Hypotension: His hypotension was concerning for SIRS/early

sepsis given his intial concurrent leukocytosis and elevated

lactate. His pressure stabilized after fluid boluses during his

first 24 hours in the ICU. After resolution of the hypotension,

his blood pressure was elevated and he required metoprolol to

maintain adequate blood pressure control.

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3. Metabolic acidosis: His initial metabolic acidosis was

likely due to lactic acidosis secondary to hypoperfusion. He

received bicarbonate infusion with correction of the acidosis

during the first 24 hours of his ICU stay.

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4. ARF: The acute renal failure was likely secondary to

contrast nephropathy and overdiuresis with lasix given his

intial presentation with CHF. His FeUrea was consistent with

pre-renal. Renal felt that he had a resolving ATN in the

setting of hypotension and recommended repleting half his urine

output with 1/2NS for a resolving ATN. He initially appeared to

be volume overloaded on exam and aggressive diuresis was

attempted once his creatinie returned to [\*\*Location 2541\*\*]. However, he

experience a bump in his creatinine. Subsequently, lasix was

used sparingly and his creatinine and electrolytes were followed

closely. His ARF was resolving upon transfer from the MICU.

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5. Hepatitis: He had normal LFTs prior to his episode of

hypotension. His LFTs drastically increased. An ultrasound

showed old metastasis and fluid overload. Initially, the

possibility of cyanide toxicity was thought to contribute to his

presentation give his herbal supplements. He received one dose

of mucomyst and sodium thiosulfate. Per Toxicology consult, his

hepatitis was unlikely from his medications/supplements. His

hepatitis serologies were negative. His AST/ALT peaked on ICU

day 2 and his tbili peaked on ICU day 6. This pattern is

consistent with shock liver.

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6. Coagulopathy: His elevated PT/PTT was likely secondary to

acute liver failure. There was no evidence of aute bleeding

initially, but his hematocrit decreased 48 to 39 after two

liters iv fluids. His platelets and fibrinogen also trended

down. His coagulopathy could be attributed to live dysfunction,

however, a mild DIC could not be ruled out. He was given a

total of 20 mg vitamin K, 5 units of 6 units FFP, and 1 unit

cryoprecipitate to decrease INR prior to placing central line on

the day of transfer to the ICU. He was also given 3 Units of

FFP prior to performing a thoracentesis for an elevated INR.

Upon transfer from the ICU, his platelets, fibrinogen, and INR

were returning to normal levels.

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7. CAD: He had a history of a previous MI and now has new

anterior wall hypokinesis on echo and reduced EF 35%. He ruled

out for an acute MI by serial enzymes. His ASA and statin were

held in the setting of liver dysfuntion. On ICU day 4, low dose

metoprolol was started once his blood pressure was stable. He

will need a stress MIBI once stable.

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8. DM: He initially required an insulin drip for glycemic

control and was transitioned to an insulin SS on ICU day 3. His

blood glucose remained in good control generally between

110-160.

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9. FEN: He was intially NPO. His diet was advanced as

tolerated. He initially required fluid resucitation to maintain

his blood pressure. On admission to the ICU, he had an elevated

potassium to 7.0. He received calcium gluconate, insulin with

D50, kayexelate, and bicarb. His potassium overcorrected and he

required repletion. His magnesium and calcium were also

repleted.

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10. Access: He had a left IJ central line.

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11. Prophylaxis: He was maintained on a PPI and pneumoboots.

Medications on Admission:

ASA 81mg po qd

Lipitor 20mg po qpm

Norvasc 5mg po qd

Paxil 30mg po qd

ranitidine 150mg po bid

Viagra 25mg po qd

[\*\*Doctor First Name 912\*\*] 180mg po qd

Xanax 0.25 mg po qd prn

Discharge Medications:

1. Paroxetine HCl 30 mg Tablet Sig: One (1) Tablet PO DAILY

(Daily).

2. Bisacodyl 10 mg Suppository Sig: One (1) Suppository Rectal

HS (at bedtime) as needed.

3. Insulin Regular Human 100 unit/mL Solution Sig: as directed

Injection ASDIR (AS DIRECTED).

4. Sodium Chloride 0.65 % Aerosol, Spray Sig: [\*\*2-6\*\*] Sprays Nasal

TID (3 times a day) as needed.

5. Docusate Sodium 100 mg Capsule Sig: One (1) Capsule PO BID (2

times a day).

6. Aspirin 81 mg Tablet, Chewable Sig: One (1) Tablet, Chewable

PO DAILY (Daily).

7. Pantoprazole Sodium 40 mg Tablet, Delayed Release (E.C.) Sig:

One (1) Tablet, Delayed Release (E.C.) PO Q24H (every 24 hours).

8. Heparin Sodium (Porcine) 5,000 unit/mL Solution Sig: One (1)

injection Injection TID (3 times a day).

9. Lactulose 10 g/15 mL Syrup Sig: Thirty (30) ML PO Q8H (every

8 hours) as needed.

10. Furosemide 40 mg Tablet Sig: One (1) Tablet PO BID (2 times

a day).

11. Toprol XL 25 mg Tablet Sustained Release 24HR Sig: One (1)

Tablet Sustained Release 24HR PO once a day.

12. Atorvastatin Calcium 20 mg Tablet Sig: One (1) Tablet PO

DAILY (Daily). Tablet(s)

Discharge Disposition:

Extended Care

Facility:

[\*\*Hospital3 2029\*\*] Rehabilitation Hospital - [\*\*Location (un) \*\*]

Discharge Diagnosis:

Primary: congestive heart failure

Secondary: metastatic carcinoid tumor, hypertension,

hyperlipidemia, diabetes mellitus type 2, basal cell carcinoma

Discharge Condition:

good, stable

Discharge Instructions:

If [\*\*Doctor First Name \*\*] experience worsening shortness of breath, fevers/chills,

chest pain, seek medical attention immediately.

If [\*\*Doctor First Name \*\*] gain more than 3 lbs, contact Dr. [\*\*First Name (STitle) 1772\*\*].

Your anti-hypertensive medications have been changed while [\*\*Doctor First Name \*\*]

were in the hospital. [\*\*Doctor First Name 54\*\*] are currently prescribed for Toprol XL

25mg daily. [\*\*Doctor First Name 54\*\*] may benefit from an ACE inhibitor in the future.

Followup Instructions:

Provider: [\*\*First Name11 (Name Pattern1) \*\*] [\*\*Last Name (NamePattern4) 870\*\*], M.D. [\*\*MD Number 60\*\*]: [\*\*Hospital6 64\*\*]

CARDIAC SERVICES Phone:[\*\*Telephone/Fax (1) 2353\*\*] Date/Time:[\*\*3363-10-19\*\*] 4:15

Provider: [\*\*First Name8 (NamePattern2) \*\*] [\*\*Last Name (NamePattern1) \*\*], [\*\*Name Initial (NameIs) \*\*].D. [\*\*MD Number 60\*\*]: [\*\*Hospital6 64\*\*]

[\*\*Hospital3 2052\*\*] Phone:[\*\*Telephone/Fax (1) 66\*\*] Date/Time:[\*\*3363-10-19\*\*] 6:40

Provider: [\*\*Name10 (NameIs) \*\*] [\*\*Name11 (NameIs) 7262\*\*] [\*\*Name12 (NameIs) 2647\*\*] VASCULAR [\*\*Name12 (NameIs) 2647\*\*] (NHB) Where: VASCULAR

[\*\*Name12 (NameIs) 2647\*\*] (NHB) Date/Time:[\*\*3364-1-10\*\*] 2:00

[\*\*First Name11 (Name Pattern1) \*\*] [\*\*Last Name (NamePattern4) 6492\*\*] MD, [\*\*MD Number 6493\*\*]

Completed by: [\*\*First Name11 (Name Pattern1) \*\*] [\*\*Last Name (NamePattern4) 2440\*\*] MD [\*\*MD Number 2441\*\*] [\*\*3363-10-2\*\*] @ 1409

Signed electronically by: DR. [\*\*First Name11 (Name Pattern1) \*\*] [\*\*Initials (NamePattern4) \*\*] [\*\*Last Name (NamePattern4) \*\*]

on: SUN [\*\*3363-10-16\*\*] 4:48 PM

(End of Report)