

CHIEF COMPLAINT:, The patient is a 49-year-old Caucasian male transported to the emergency room by his wife, complaining of shortness of breath.,HISTORY OF PRESENT ILLNESS:, The patient is known by the nursing staff here to have a long history of chronic obstructive pulmonary disease and emphysema. He has made multiple visits in the past. Today, the patient presents himself in severe respiratory distress. His wife states that since his recent admission of three weeks ago for treatment of pneumonia, he has not seemed to be able to recuperate, and has persistent complaints of shortness of breath.,Today, his symptoms worsened and she brought him to the emergency room. To the best of her knowledge, there has been no fever. He has persistent chronic cough, as always. More complete history cannot be taken because of the patient's acute respiratory decompensation.,PAST MEDICAL HISTORY:, Hypertension and emphysema.,MEDICATIONS:, Lotensin and some water pill as well as, presumably, an Atrovent inhaler.,ALLERGIES:, None are known.,HABITS:, The patient is unable to cooperate with the history.,SOCIAL HISTORY:, The patient lives in the local area with his wife.,REVIEW OF BODY SYSTEMS:, Unable, secondary to the patient's condition.,PHYSICAL EXAMINATION:,VITAL SIGNS: Temperature 96 degrees, axillary. Pulse 128. Respirations 48. Blood pressure 156/100. Initial oxygen saturations on room air are 80.,GENERAL: Reveals a very anxious, haggard and exhausted-appearing male, tripodding, with labored breathing.,HEENT: Head is normocephalic and atraumatic.,NECK: The neck is supple

without obvious jugular venous distention.,LUNGS:  
Auscultation of the chest reveals very distant and faint breath sounds, bilaterally, without obvious rales.,HEART: Cardiac examination reveals sinus tachycardia, without pronounced murmur.,ABDOMEN: Soft to palpation.,Extremities: Without edema.,DIAGNOSTIC DATA:, White blood count 25.5, hemoglobin 14, hematocrit 42.4, 89 polys, 1 band, 4 lymphocytes. Chemistry panel within normal limits, with the exception of sodium of 124, chloride 81, CO2 44, BUN 6, creatinine 0.7, glucose 182, albumin 3.3 and globulin 4.1. Troponin is 0.11. Urinalysis reveals yellow clear urine. Specific gravity greater than 1.030 with 2+ ketones, 1+ blood and 3+ protein. No white cells and 0-2 red cells.,Chest x-ray suboptimal in quality, but without obvious infiltrates, consolidation or pneumothorax.,CRITICAL CARE NOTE:, Critical care one hour.,Shortly after the patient's initial assessment, the patient apparently began to complain of chest pain and appeared to the nurse to have mounting exhaustion and respiratory distress. Although O2 had been placed, elevating his oxygen saturations to the mid to upper 90s, he continued to complain of symptoms, as noted above. He became progressively more rapidly obtunded. The patient did receive one gram of magnesium sulfate shortly after his arrival, and the BiPAP apparatus was being readied for his use. However, the patient, at this point, became unresponsive, unable to answer questions, and preparations were begun for intubation. The BiPAP apparatus was briefly placed while supplies and medications were assembled for

intubation. It was noted that even with the BiPAP apparatus, in the duration of time which was required for transfer of oxygen tubing to the BiPAP mask, the patient's O<sub>2</sub> saturations rapidly dropped to the upper 60 range.,All preparations for intubation having been undertaken, Succinylcholine was ordered, but was apparently unavailable in the department. As the patient was quite obtunded, and while the Dacuronium was being sought, an initial trial of intubation was carried out using a straight blade and a cupped 7.9 endotracheal tube. However, the patient had enough residual muscle tension to make this impractical and further efforts were held pending administration of Dacuronium 10 mg. After approximately two minutes, another attempt at intubation was successful. The cords were noted to be covered with purulent exudates at the time of intubation.,The endotracheal tube, having been placed atraumatically, the patient was initially then nebulated on 100% oxygen, and his O<sub>2</sub> saturations rapidly rose to the 90-100% range.,Chest x-ray demonstrated proper placement of the tube. The patient was given 1 mg of Versed, with decrease of his pulse from the 140-180 range to the 120 range, with satisfactory maintenance of his blood pressure.,Because of a complaint of chest pain, which I myself did not hear, during the patient's initial triage elevation, a trial of Tridil was begun. As the patient's pressures held in the slightly elevated range, it was possible to push this to 30 mcg per minute. However, after administration of the Dacuronium and Versed, the patient's blood pressure fell somewhat, and this medication was

discontinued when the systolic pressure briefly reached 98. Because of concern regarding pneumonia or sepsis, the patient received one gram of Rocephin intravenously shortly after the intubation. A nasogastric and Foley were placed, and an arterial blood gas was drawn by respiratory therapy. Dr. X was contacted at this point regarding further orders as the patient was transferred to the Intensive Care Unit to be placed on the ventilator there. The doctor's call was transferred to the Intensive Care Unit so he could leave appropriate orders for the patient in addition to my initial orders, which included Albuterol or Atrovent q. 2h. and Levaquin 500 mg IV, as well as Solu-Medrol. Critical care note terminates at this time. EMERGENCY DEPARTMENT COURSE: See the critical care note. MEDICAL DECISION MAKING (DIFFERENTIAL DIAGNOSIS): This patient has an acute severe decompensation with respiratory failure. Given the patient's white count and recent history of pneumonia, the possibility of recurrence of pneumonia is certainly there. Similarly, it would be difficult to rule out sepsis. Myocardial infarction cannot be excluded. COORDINATION OF CARE: Dr. X was contacted from the emergency room and asked to assume the patient's care in the Intensive Care Unit. FINAL DIAGNOSIS: Respiratory failure secondary to severe chronic obstructive pulmonary disease. DISCHARGE INSTRUCTIONS: The patient is to be transferred to the Intensive Care Unit for further management.