HISTORY OF PRESENT ILLNESS: , Hospitalist followup is required for continuing issues with atrial flutter with rapid ventricular response, which was resistant to treatment with diltiazem and amiodarone, being followed by Dr. X of cardiology through most of the day. This afternoon, when I am seeing the patient, nursing informs me that rate has finally been controlled with esmolol, but systolic blood pressures have dropped to the 70s with a MAP of 52. Dr. X was again consulted from the bedside. We agreed to try fluid boluses and then to consider Neo-Synephrine pressure support if this is not successful. In addition, over the last 24 hours, extensive discussions have been held with the family and questions answered by nursing staff concerning the patient's possible move to Tahoe Pacific or a long-term acute care. Other issues requiring following up today are elevated transaminases, continuing fever, pneumonia, resolving adult respiratory distress syndrome, ventilatory-dependent respiratory failure, hypokalemia, non-ST-elevation MI, hypernatremia, chronic obstructive pulmonary disease, BPH, atrial flutter, inferior vena cava filter, and diabetes.,PHYSICAL EXAMINATION,VITAL SIGNS: T-max 103.2, blood pressure at this point is running in the 70s/mid 40s with a MAP of 52, heart rate is 100.,GENERAL: The patient is much more alert appearing than my last examination of approximately 3 weeks ago. He denies any pain, appears to have intact mentation, and is in no apparent distress.,EYES: Pupils round, reactive to light, anicteric with external ocular motions intact.,CARDIOVASCULAR: Reveals an irregularly irregular

rhythm.,LUNGS: Have diminished breath sounds but are clear anteriorly.,ABDOMEN: Somewhat distended but with no guarding, rebound, or obvious tenderness to palpation.,EXTREMITIES: Show trace edema with no clubbing or cyanosis.,NEUROLOGICAL: The patient is moving all extremities without focal neurological deficits.,LABORATORY DATA: , Sodium 149; this is down from 151 yesterday. Potassium 3.9, chloride 114, bicarb 25, BUN 35, creatinine 1.5 up from 1.2 yesterday, hemoglobin 12.4, hematocrit 36.3, WBC 16.5, platelets 231,000. INR 1.4. Transaminases are continuing to trend upwards of SGOT 546, SGPT 256. Also noted is a scant amount of very concentrated appearing urine in the bag.,IMPRESSION: , Overall impressions continues to be critically ill 67-year-old with multiple medical problems probably still showing signs of volume depletion with hypotension and atrial flutter with difficult to control rate.,PLAN,1. Hypotension. I would aggressively try and fluid replete the patient giving him another liter of fluids. If this does not work as discussed with Dr. X, we will start some Neo-Synephrine, but also continue with aggressive fluid repletion as I do think that indications are that with diminished and concentrated urine that he may still be down and fluids will still be required even if pressure support is started.,2. Increased transaminases. Presumably this is from increased congestion. This is certainly concerning. We will continue to follow this. Ultrasound of the liver was apparently negative.,3. Fever and elevated white count. The patient does have a history of pneumonia and empyema. We

will continue current antibiotics per infectious disease and continue to follow the patient's white count. He is not exceptionally toxic appearing at this time. Indeed, he does look improved from my last examination.,4. Ventilatory-dependent respiratory failure. The patient has received a tracheostomy since my last examination. Vent management per PMA.,5. Hypokalemia. This has resolved. Continue supplementation.,6. Hypernatremia. This is improving somewhat. I am hoping that with increased fluids this will continue to do so.,7. Diabetes mellitus. Fingerstick blood glucoses are reviewed and are at target. We will continue current management. This is a critically ill patient with multiorgan dysfunction and signs of worsening renal, hepatic, and cardiovascular function with extremely guarded prognosis. Total critical care time spent today 37 minutes.