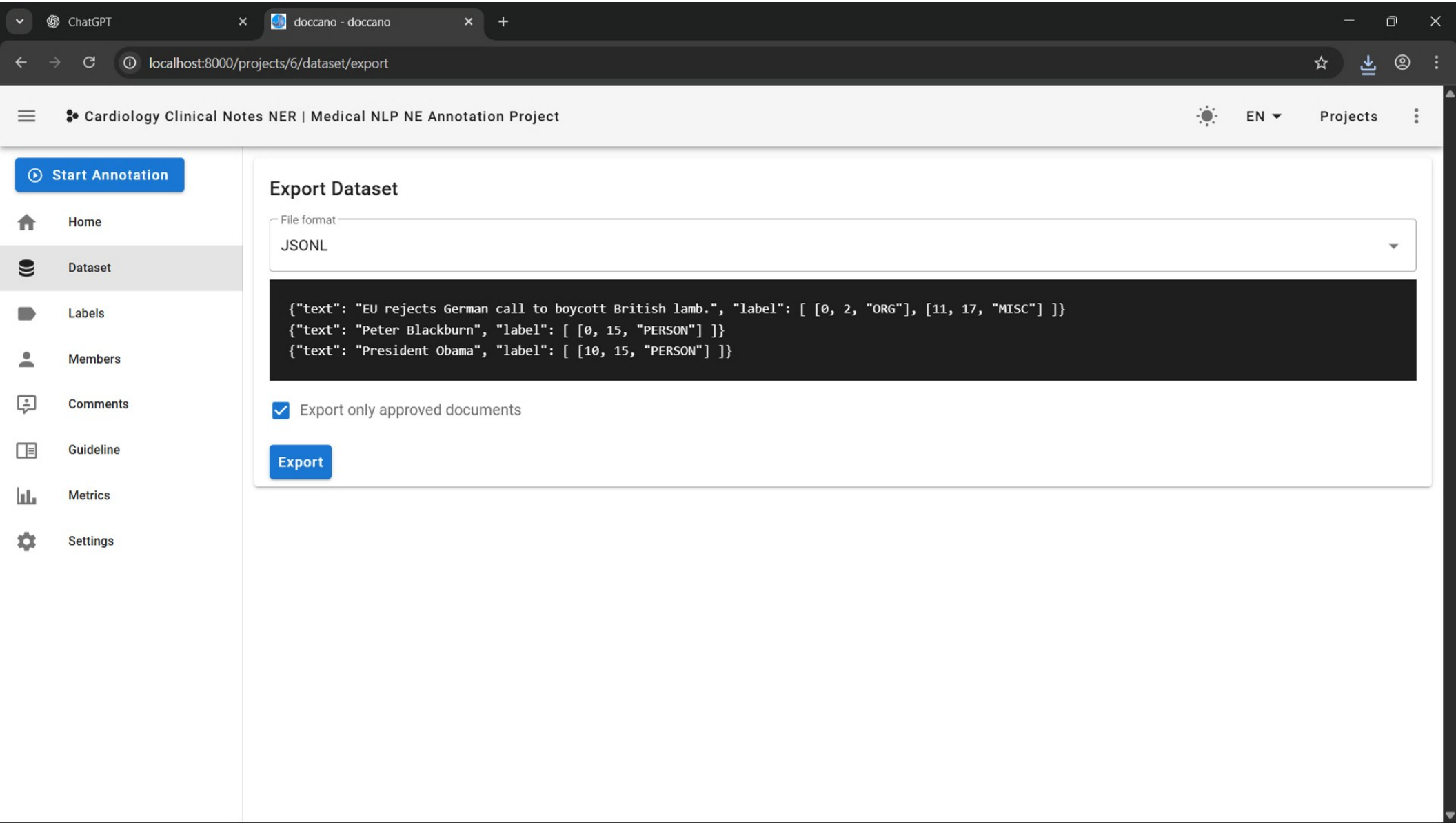
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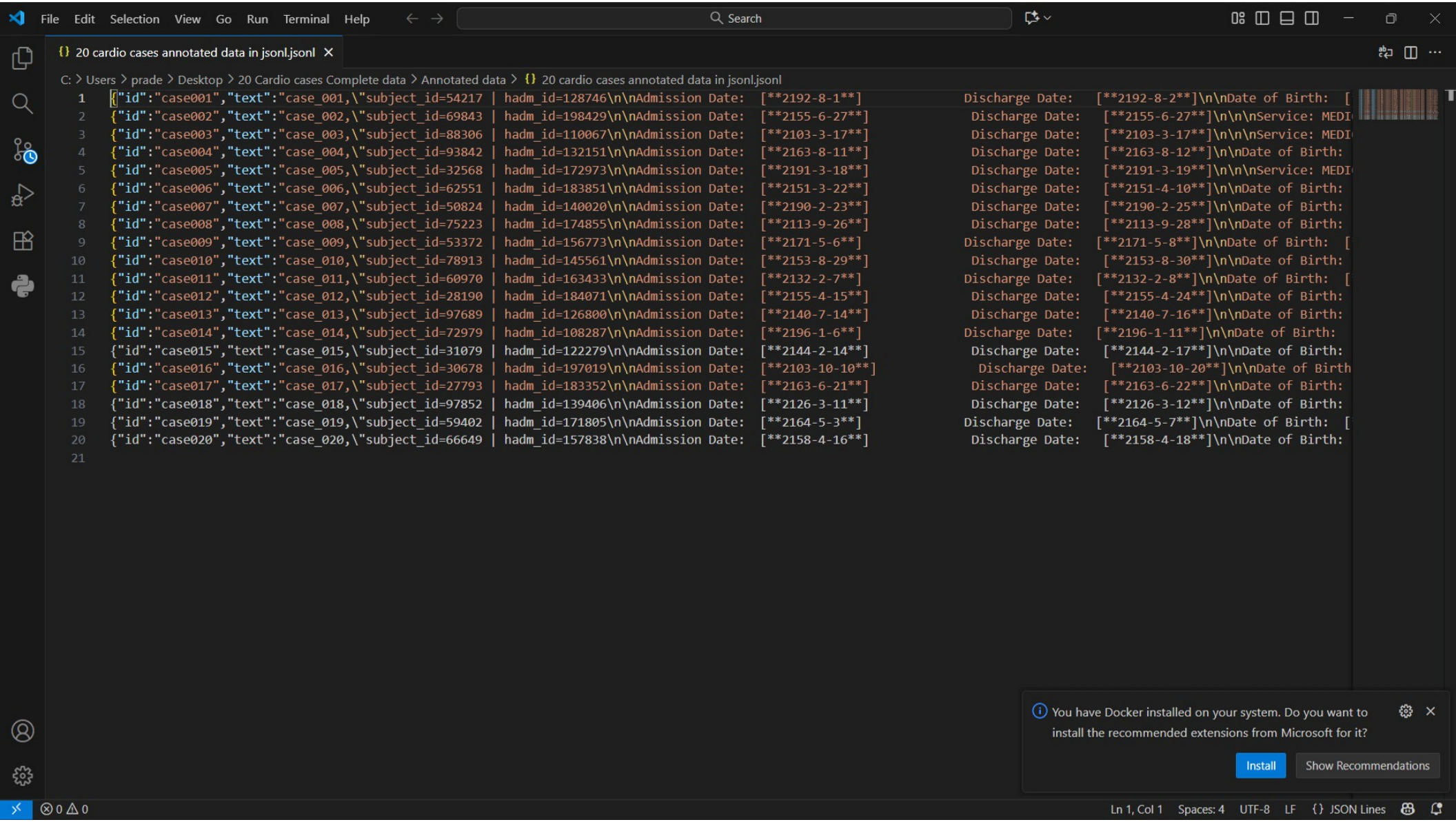
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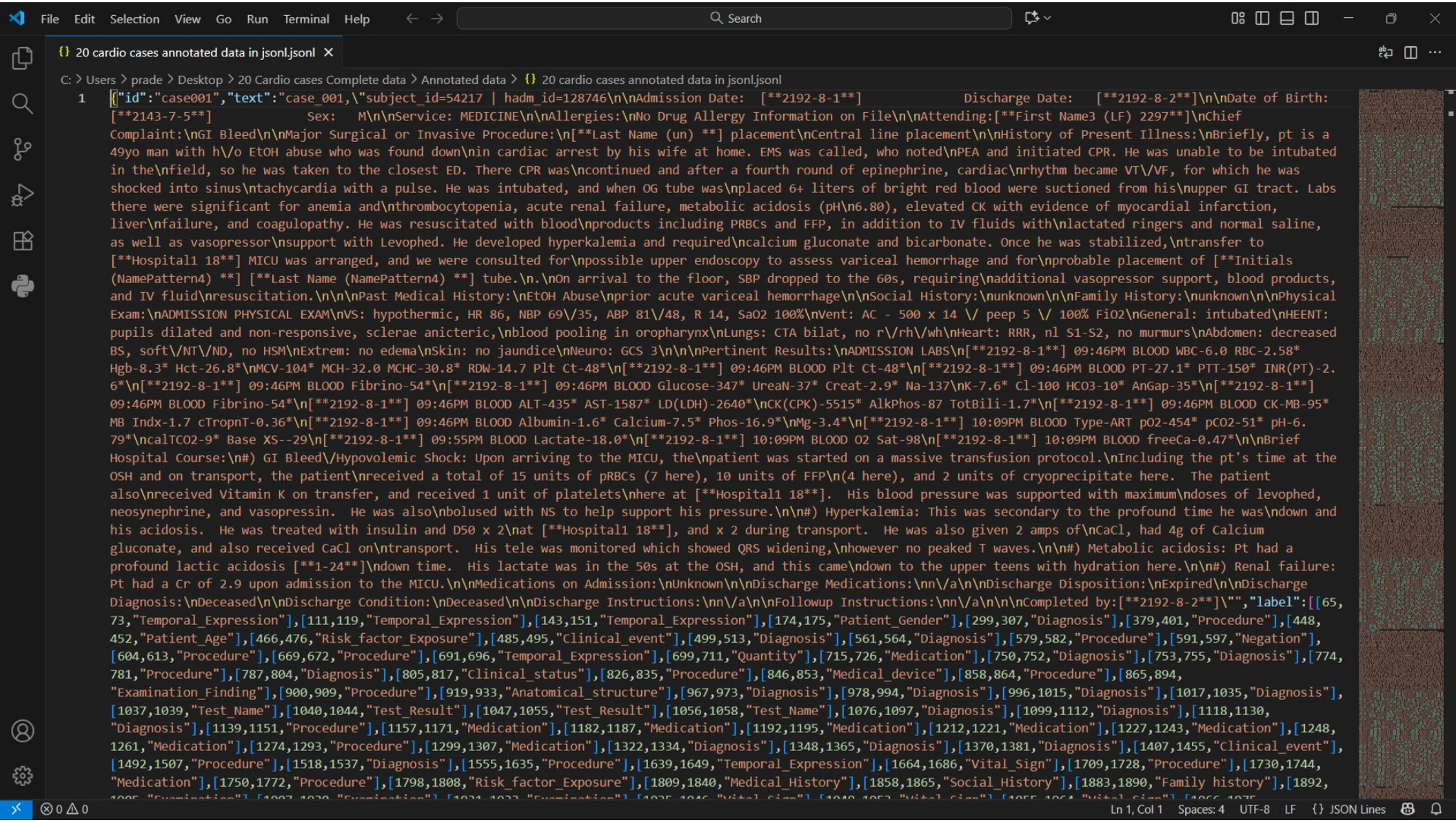
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Labs there were significant for anemia and\nthrombocytopenia, acute renal failure, metabolic acidosis (pH\n6.80), elevated CK with evidence of myocardial infarction, liver\nfailure, and coagulopathy. He was resuscitated with blood\nproducts including PRBCs and FFP, in addition to IV fluids with\nlactated ringers and normal saline, as well as vasopressor\nsupport with Levophed. He developed hyperkalemia and required\ncalcium gluconate and bicarbonate. Once he was stabilized,\ntransfer to [**Hospital1 18**] MICU was arranged, and we were consulted for\npossible upper endoscopy to assess variceal hemorrhage and for\nprobable placement of [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] tube.\n.\nOn arrival to the floor, SBP dropped to the 60s, requiring\nadditional vasopressor support, blood products, and IV fluid\nresuscitation.\n\n\nPast Medical History:\nEtOH Abuse\nprior acute variceal hemorrhage\n\nSocial History:\nunknown\n\nFamily History:\nunknown\n\nPhysical Exam:\nADMISSION PHYSICAL EXAM\nVS: hypothermic, HR 86, NBP 69\/35, ABP 81\/48, R 14, SaO2 100%\nVent: AC - 500 x 14 \/ peep 5 \/ 100% FiO2\nGeneral: intubated\nHEENT: pupils dilated and non-responsive, sclerae anicteric,\nblood pooling in oropharynx\nLungs: CTA bilat, no r\/rh\/wh\nHeart: RRR, nl S1-S2, no murmurs\nAbdomen: decreased BS, soft\/NT\/ND, no HSM\nExtrem: no edema\nSkin: no jaundice\nNeuro: GCS 3\n\n\nPertinent Results:\nADMISSION LABS\n[**2192-8-1**] 09:46PM BLOOD WBC-6.0 RBC-2.58* Hgb-8.3* Hct-26.8*\nMCV-104* MCH-32.0 MCHC-30.8* RDW-14.7 Plt Ct-48*\n[**2192-8-1**] 09:46PM BLOOD Plt Ct-48*\n[**2192-8-1**] 09:46PM BLOOD PT-27.1* PTT-150* INR(PT)-2.6*\n[**2192-8-1**] 09:46PM BLOOD Fibrino-54*\n[**2192-8-1**] 09:46PM BLOOD Glucose-347* UreaN-37* Creat-2.9* Na-137\nK-7.6* Cl-100 HCO3-10* AnGap-35*\n[**2192-8-1**] 09:46PM BLOOD Fibrino-54*\n[**2192-8-1**] 09:46PM BLOOD ALT-435* AST-1587* LD(LDH)-2640*\nCK(CPK)-5515* AlkPhos-87 TotBili-1.7*\n[**2192-8-1**] 09:46PM BLOOD CK-MB-95* MB Indx-1.7 cTropnT-0.36*\n[**2192-8-1**] 09:46PM BLOOD Albumin-1.6* Calcium-7.5* Phos-16.9*\nMg-3.4*\n[**2192-8-1**] 10:09PM BLOOD Type-ART pO2-454* pCO2-51* pH-6.79*\ncalTCO2-9* Base XS--29\n[**2192-8-1**] 09:55PM BLOOD Lactate-18.0*\n[**2192-8-1**] 10:09PM BLOOD O2 Sat-98\n[**2192-8-1**] 10:09PM BLOOD freeCa-0.47*\n\nBrief Hospital Course:\n#) GI Bleed\/Hypovolemic Shock: Upon arriving to the MICU, the\npatient was started on a massive transfusion protocol.\nIncluding the pt's time at the OSH and on transport, the patient\nreceived a total of 15 units of pRBCs (7 here), 10 units of FFP\n(4 here), and 2 units of cryoprecipitate here. The patient also\nreceived Vitamin K on transfer, and received 1 unit of platelets\nhere at [**Hospital1 18**]. His blood pressure was supported with maximum\ndoses of levophed, neosynephrine, and vasopressin. He was also\nbolused with NS to help support his pressure.\n\n#) Hyperkalemia: This was secondary to the profound time he was\ndown and his acidosis. He was treated with insulin and D50 x 2\nat [**Hospital1 18**], and x 2 during transport. He was also given 2 amps of\nCaCl, had 4g of Calcium gluconate, and also received CaCl on\ntransport. His tele was monitored which showed QRS widening,\nhowever no peaked T waves.\n\n#) Metabolic acidosis: Pt had a profound lactic acidosis [**1-24**]\ndown time. His lactate was in the 50s at the OSH, and this came\ndown to the upper teens with hydration here.\n\n#) Renal failure: Pt had a Cr of 2.9 upon admission to the MICU.\n\nMedications on Admission:\nUnknown\n\nDischarge Medications:\nn\/a\n\nDischarge Disposition:\nExpired\n\nDischarge Diagnosis:\nDeceased\n\nDischarge Condition:\nDeceased\n\nDischarge Instructions:\nn\/a\n\nFollowup Instructions:\nn\/a\n\n\nCompleted by:[**2192-8-2**]\"","label":[[65,73,"Temporal_Expression"],[111,119,"Temporal_Expression"],[143,151,"Temporal_Expression"],[174,175,"Patient_Gender"],[299,307,"Diagnosis"],[379,401,"Procedure"],[448,452,"Patient_Age"],[466,476,"Risk_factor_Exposure"],[485,495,"Clinical_event"],[499,513,"Diagnosis"],[561,564,"Diagnosis"],[579,582,"Procedure"],[591,597,"Negation"],[604,613,"Procedure"],[669,672,"Procedure"],[691,696,"Temporal_Expression"],[699,711,"Quantity"],[715,726,"Medication"],[750,752,"Diagnosis"],[753,755,"Diagnosis"],[774,781,"Procedure"],[787,804,"Diagnosis"],[805,817,"Clinical_status"],[826,835,"Procedure"],[846,853,"Medical_device"],[858,864,"Procedure"],[865,894,"Examination_Finding"],[900,909,"Procedure"],[919,933,"Anatomical_structure"],[967,973,"Diagnosis"],[978,994,"Diagnosis"],[996,1015,"Diagnosis"],[1017,1035,"Diagnosis"],[1037,1039,"Test_Name"],[1040,1044,"Test_Result"],[1047,1055,"Test_Result"],[1056,1058,"Test_Name"],[1076,1097,"Diagnosis"],[1099,1112,"Diagnosis"],[1118,1130,"Diagnosis"],[1139,1151,"Procedure"],[1157,1171,"Medication"],[1182,1187,"Medication"],[1192,1195,"Medication"],[1212,1221,"Medication"],[1227,1243,"Medication"],[1248,1261,"Medication"],[1274,1293,"Procedure"],[1299,1307,"Medication"],[1322,1334,"Diagnosis"],[1348,1365,"Diagnosis"],[1370,1381,"Diagnosis"],[1407,1455,"Clinical_event"],[1492,1507,"Procedure"],[1518,1537,"Diagnosis"],[1555,1635,"Procedure"],[1639,1649,"Temporal_Expression"],[1664,1686,"Vital_Sign"],[1709,1728,"Procedure"],[1730,1744,"Medication"],[1750,1772,"Procedure"],[1798,1808,"Risk_factor_Exposure"],[1809,1840,"Medical_History"],[1858,1865,"Social_History"],[1883,1890,"Family history"],[1892,
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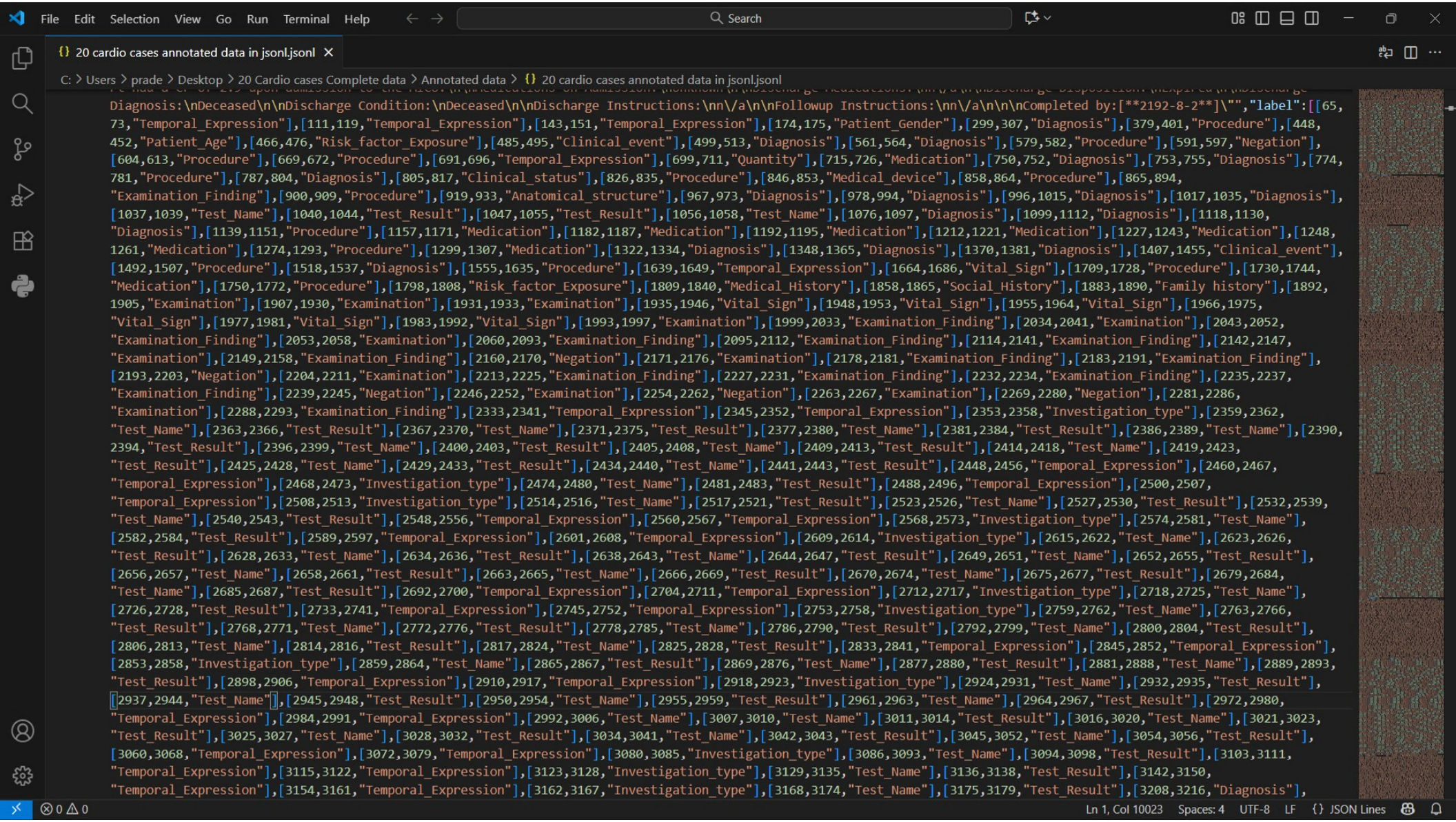
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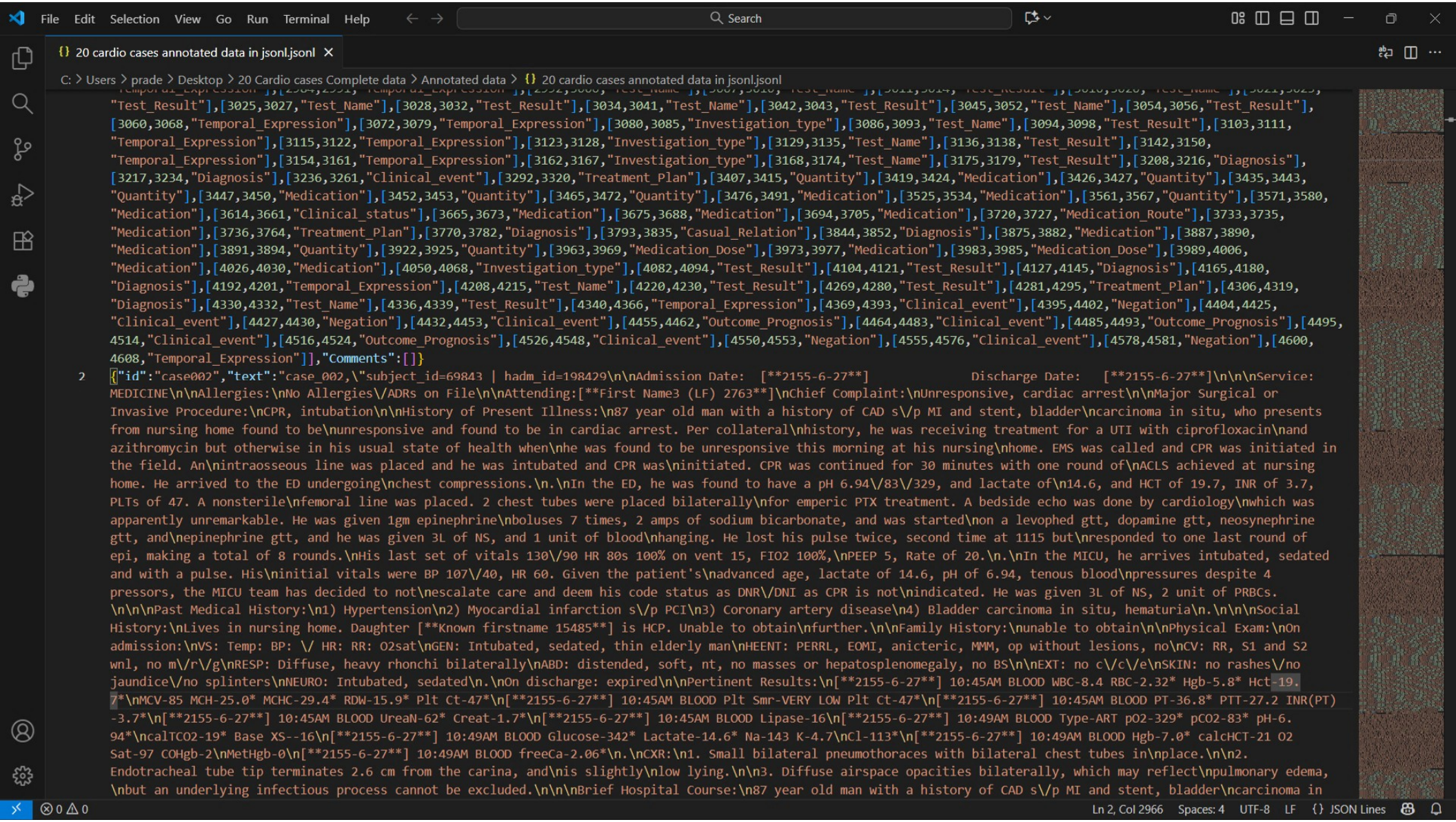
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2 {"id":"case002","text":"case_002,\"subject_id=69843 | hadm_id=198429\n\nAdmission Date: [**2155-6-27**] Discharge Date: [**2155-6-27**]\n\n\nService:
MEDICINE\n\nAllergies:\nNo Allergies\/ADRs on File\n\nAttending:[**First Name3 (LF) 2763**]\nChief Complaint:\nUnresponsive, cardiac arrest\n\nMajor Surgical or
Invasive Procedure:\nCPR, intubation\n\nHistory of Present Illness:\n87 year old man with a history of CAD s\/p MI and stent, bladder\ncarcinoma in situ, who presents
from nursing home found to be\nunresponsive and found to be in cardiac arrest. Per collateral\nhistory, he was receiving treatment for a UTI with ciprofloxacin\nand
azithromycin but otherwise in his usual state of health when\nhe was found to be unresponsive this morning at his nursing\nhome. EMS was called and CPR was initiated in
the field. An\nintraosseous line was placed and he was intubated and CPR was\ninitiated. CPR was continued for 30 minutes with one round of\nACLS achieved at nursing
home. He arrived to the ED undergoing\nchest compressions.\n.\nIn the ED, he was found to have a pH 6.94\/83\/329, and lactate of\n14.6, and HCT of 19.7, INR of 3.7,
PLTs of 47. A nonsterile\nfemoral line was placed. 2 chest tubes were placed bilaterally\nfor emperic PTX treatment. A bedside echo was done by cardiology\nwhich was
apparently unremarkable. He was given 1gm epinephrine\nboluses 7 times, 2 amps of sodium bicarbonate, and was started\non a levophed gtt, dopamine gtt, neosynephrine
gtt, and\nepinephrine gtt, and he was given 3L of NS, and 1 unit of blood\nhanging. He lost his pulse twice, second time at 1115 but\nresponded to one last round of
epi, making a total of 8 rounds.\nHis last set of vitals 130\/90 HR 80s 100% on vent 15, FIO2 100%,\nPEEP 5, Rate of 20.\n.\nIn the MICU, he arrives intubated, sedated
and with a pulse. His\ninitial vitals were BP 107\/40, HR 60. Given the patient's\nadvanced age, lactate of 14.6, pH of 6.94, tenous blood\npressures despite 4
pressors, the MICU team has decided to not\nescalate care and deem his code status as DNR\/DNI as CPR is not\nindicated. He was given 3L of NS, 2 unit of PRBCs.
\n\n\nPast Medical History:\n1) Hypertension\n2) Myocardial infarction s\/p PCI\n3) Coronary artery disease\n4) Bladder carcinoma in situ, hematuria\n.\n\n\nSocial
History:\nLives in nursing home. Daughter [**Known firstname 15485**] is HCP. Unable to obtain\nfurther.\n\nFamily History:\nunable to obtain\n\nPhysical Exam:\nOn
admission:\nVS: Temp: BP: \/ HR: RR: O2sat\nGEN: Intubated, sedated, thin elderly man\nHEENT: PERRL, EOMI, anicteric, MMM, op without lesions, no\nCV: RR, S1 and S2
wnl, no m\/r\/g\nRESP: Diffuse, heavy rhonchi bilaterally\nABD: distended, soft, nt, no masses or hepatosplenomegaly, no BS\n\nEXT: no c\/c\/e\nSKIN: no rashes\/no
jaundice\/no splinters\nNEURO: Intubated, sedated\n.\nOn discharge: expired\n\nPertinent Results:\n[**2155-6-27**] 10:45AM BLOOD WBC-8.4 RBC-2.32* Hgb-5.8* Hct-19.
7*\nMCV-85 MCH-25.0* MCHC-29.4* RDW-15.9* Plt Ct-47*\n[**2155-6-27**] 10:45AM BLOOD Plt Smr-VERY LOW Plt Ct-47*\n[**2155-6-27**] 10:45AM BLOOD PT-36.8* PTT-27.2 INR(PT)
-3.7*\n[**2155-6-27**] 10:45AM BLOOD UreaN-62* Creat-1.7*\n[**2155-6-27**] 10:45AM BLOOD Lipase-16\n[**2155-6-27**] 10:49AM BLOOD Type-ART pO2-329* pCO2-83* pH-6.
94*\ncalTCO2-19* Base XS--16\n[**2155-6-27**] 10:49AM BLOOD Glucose-342* Lactate-14.6* Na-143 K-4.7\nCl-113*\n[**2155-6-27**] 10:49AM BLOOD Hgb-7.0* calcHCT-21 O2
Sat-97 COHgb-2\nMetHgb-0\n[**2155-6-27**] 10:49AM BLOOD freeCa-2.06*\n.\nCXR:\n1. Small bilateral pneumothoraces with bilateral chest tubes in\nplace.\n\n2.
Endotracheal tube tip terminates 2.6 cm from the carina, and\nis slightly\nlow lying.\n\n3. Diffuse airspace opacities bilaterally, which may reflect\npulmonary edema,
\nbut an underlying infectious process cannot be excluded.\n\n\nBrief Hospital Course:\n87 year old man with a history of CAD s\/p MI and stent, bladder\ncarcinoma in
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