"Admission Date: [**2167-2-16**] Discharge Date: [**2167-2-24**]

Date of Birth: [**2099-5-5**] Sex: F

Service: [**Hospital Unit Name 196**]

CHIEF COMPLAINT: Shortness of breath, cough, and fever.

HISTORY OF PRESENT ILLNESS: The patient is a 67 -year-old Russian speaking female with a past medical history significant for diabetes type II, congestive heart failure of unknown etiology, and hypertension. The patient presents with a three day history of progressively worsening shortness of breath and dyspnea on exertion, wheezing, nonproductive cough, and fever to 102 F on the day prior to admission. Per patient's husband, she denies any nausea or vomiting, chills at night, night sweats, or chest pain. She denies diarrhea. She has been constipated. The patient does have paroxysmal nocturnal dyspnea and two pillow orthopnea. The patient denies dysuria. Fingersticks at home have been running approximately 200 to 270's. The patient denies any sick contacts.

On the morning of presentation, the patient was noted to be more lethargic by her husband. [**Name (NI) **] report, her oxygen saturation upon arrival of the EMS, was in the 80's. The patient was placed on 100% nonrebreather and arrived at [**Hospital3 **] - [**Hospital **] [**First Name (Titles) **] [**Last Name (Titles) **] where she was noted to be wheezing on examination. She was given Albuterol and

Atrovent nebulizers with improvement of her oxygen saturation from 90% to 94%, also on 100% nonrebreather. She was also administered 40 mg of IV Lasix times two with diuresis of approximately one liter. The patient denied any chest pain throughout her entire presentation.

PAST MEDICAL HISTORY:

1. Type II diabetes mellitus.
2. Morbid obesity.
3. Hypertension.
4. Congestive heart failure of unclear etiology with normal [**Name (NI) 20679**] systolic function. Question of left ventricular hypertrophy on prior echocardiogram.
5. Stasis dermatitis in bilateral lower extremities.
6. No history of coronary artery disease.
7. Restrictive lung disease, believed to be secondary to morbid obesity. The patient does have a home O2 requirement of approximately 2.0 to 2.5 liters during the day time.
8. Presumptive obstructive sleep apnea.

ALLERGIES: The patient has no known drug allergies.

ADMITTING MEDICATIONS: 1) Amaryl 2.0 mg po bid, 2) Glucophage 1,000 mg po bid, 3) Singulair 10 mg po q day, 4) Zocor 10 mg po q day, 5) Hyzaar 50/12.5 q day, 6) Atenolol 25 mg po q day, 7) Avandia 8.0 mg po bid.

SOCIAL HISTORY: The patient denies any tobacco use. She lives with her husband, no alcohol use. She is gravida II,

para II.

FAMILY HISTORY: Negative for cancers. Paternal grandmother with diabetes mellitus and maternal aunt with coronary artery disease.

PRIOR STUDIES: Echocardiogram of 12/99 revealed mild left axis deviation, mild mitral regurgitation, and mild pulmonary artery systolic hypertension. Exercise tolerance test MIBI was without angina, no ischemic changes, left ventricular ejection fraction was estimated at 64% with normal wall motion.

PHYSICAL EXAMINATION: Temperature on presentation was 99.1 F, pulse is 84, blood pressure was 116/50, breathing at a rate of 19, 96% on 100% nonrebreather. Weight was approximately 286 pounds. In general, the patient was alert and oriented times three, on 100% nonrebreather, in moderate respiratory distress. Head, eyes, ears, nose, and throat: pupils are equal, round, and reactive to light and accommodation bilaterally, oropharynx is clear. Neck is without lymphadenopathy, there is not any assessable jugular venous pulse. Chest examination reveals diffuse inspiratory and expiratory wheezes and crackles with a prolonged expiratory phase. Cardiovascular examination is of regular rate and rhythm without evidence of murmurs, rubs, or gallops.

Abdomen is obese without tenderness, guarding, or distention,

there are normoactive bowel sounds. There is no suprapubic tenderness, no costovertebral angle tenderness. Extremities reveal trace bilateral upper extremity edema with 2+ to 3+ bilateral lower extremity edema, 1+ bilateral dorsalis pedis pulses, and 2+ bilateral radial pulses with stage I stasis dermatitis of the bilateral ankles. Neurologic examination: there are no focal motor deficits and the patient denies any sensory changes.

ADMISSION LABORATORY DATA: Include a white blood cell count of 8.2, hematocrit of 39.6, platelets are 310,000. Chemistries showed a sodium of 138, potassium of 5.0, chloride 96, bicarbonate is 34, BUN is 17, creatinine 0.6, serum glucose is 231. Urinalysis was negative for blood, nitrates, with 30 protein, greater than 1,000 glucose, negative ketones, and no cells. Troponin on admission was 1.4, CK on admission was 176 with an MB fraction of 2.0. Second CK was 153 with an MB fraction of 3.0. Calcium was 8.3, albumin 3.5, magnesium 4.9, phosphate 1.9.

Chest x-ray on admission showed florid congestive heart failure with no evidence of pleural effusion, but perihilar haziness and more confluent of opacification of the lung bases and retrocardiac region. Electrocardiogram showed a left bundle branch block, stable from comparison electrocardiogram of [**2165-10-30**], with no acute ST-T wave changes indicative of ongoing ischemia.

HOSPITAL COURSE: The patient was admitted and started on a

regimen for treatment of acute pulmonary edema. The patient was aggressively diuresed with 80 mg of IV Lasix [**Hospital1 **] and oxygenated with face mask O2 as needed to keep oxygen saturations greater than 92%. Levaquin 500 mg po q day was also initiated for treatment of presumptive pneumonia. The patient remained initially stable overnight; however, on hospital day two was noted to be increasingly somnolent.

An arterial blood gas was measured at this time which revealed a pH of 7.2, pO2 of 42, pCO2 of 104. The patient was sent for a stat CT scan angiogram to rule out pulmonary embolism. This study, although grossly limited, did not find any major perfusion deficits in the pulmonary vascular system. The patient was continued to be aggressively diuresed. She was also placed on BiPAP, however, the patient did not tolerate the BiPAP apparatus. The patient was transferred to the Medical Intensive Care Unit for closer monitoring and optimization of respiratory status in the setting of hypercarbic respiratory failure of unclear etiology with underlying congestive heart failure and pneumonia, both of which were being treated.

While in the Intensive Care Unit, the patient's oxygenation was maximized with CPAP at bed time at 20 cm of water which the patient intermittently tolerated and five liters of oxygen via nasal cannula during the day. Repeat arterial blood gas prior to discharge from the Medical Intensive Care Unit, was pH of 7.36 with CO2 of 87 and a pO2 of 61. The patient was transferred to [**Hospital Unit Name 196**] team after her Medical

Intensive Care Unit course.

While on the floor, the patient continued to improve on CPAP of 5.0 cm to 10 cm of water at bedtime. She was unable to tolerate any further increase beyond this point. The patient's oxygenation remained stable on four to five liters of oxygen via nasal cannula during the day time. The patient continued to be aggressively diuresed. It was noted that intermittently throughout her hospital course, the patient was experiencing gross hematuria through her Foley catheter. At the time her subcutaneous heparin was discontinued. In addition, this was believed to be secondary to the fact that the patient was intermittently on heparin around the time of admission as empiric therapy for a possible pulmonary embolus.

Upon returning to the Medical Floor, the patient was noted also to have intermittent alarms on telemetry of paroxysmal multi-focal atrial tachycardia and frequent runs of supraventricular tachycardia. The patient's Albuterol nebulizers were believed to be contributing to this and these were placed on a prn basis. In addition, secondary to the patient's persistent wheezing, her beta blocker was stopped and she was switched to Diltiazem. For further characterization of the patient's congestive heart failure, a transthoracic echocardiogram was obtained to assess the patient's systolic function for any further causes for possible diastolic dysfunction.

Echocardiogram windows were severely limited secondary to the patient's body habitus; however, preliminary [**Location (un) 1131**] was of a sustained systolic function. Over the following day of her hospitalization, the patient was evaluated by Physical Therapy, was ambulating well, and was switched to po regimens for her diuretics. Fingerstick blood sugars throughout the hospitalization remained well controlled and the patient was covered with insulin sliding scale.

DISPOSITION: The patient was discharged to a rehabilitation facility in stable condition.

DISCHARGE STATUS: Stable to rehabilitation.

DISCHARGE INSTRUCTIONS: The patient is to follow up with Dr. [**First Name8 (NamePattern2) **] [**Name (STitle) 19512**] in one to two weeks. At this time she will also be scheduled for further outpatient pulmonary follow up for characterization of her restrictive lung disease and for further evaluation of possible obstructive lung disease.

DISCHARGE MEDICATIONS: 1) Lasix 40 mg po bid, 2) potassium chloride 40 mEq po q day, 3) Diltiazem SR 16 mg po bid, 4) Losartan 75 mg po q day, 5) Zocor 10 mg po q day, 6) Levofloxacin 500 mg po q day (discontinue on [**3-2**] after completion of a fourteen day course), 7) Avandia 4.0 mg po bid, 8) Prilosec 20 mg po q day, 9) enteric coated aspirin 325 mg po q day, 10) Glucophage 1,000 mg po bid, 11) Amaryl 2.0 mg po qid, 12) Colace 200 mg po bid, 13) Ocean Spray

nasal spray two to four puffs in each naris q two to four hours prn, 14) Robitussin DM 10 cc to 15 cc po q four hours prn, 15) Lactulose 30 cc q four hours prn, 16) mineral oil 30 cc po bid prn, 17) Fleet's enema one per rectum q other day prn, 17) Dulcolax suppositories 10 mg per rectum q day prn, 18) Tylenol 650 mg po q four to six hours prn, 19) Albuterol metered dose inhaler two to four puffs q four to six hours prn shortness of breath or wheezing.

DISCHARGE DIAGNOSES:

1. Congestive heart failure.
2. Pneumonia.
3. Restrictive lung disease.
4. Presumed to obesity hypoventilation syndrome.
5. Type II diabetes mellitus.
6. Morbid obesity.

[**First Name8 (NamePattern2) **] [**Name8 (MD) **], M.D. [**MD Number(1) 19513**]

Dictated By:[**Name8 (MD) 5469**]

MEDQUIST36

D: [**2167-2-24**] 09:11

T: [**2167-2-24**] 09:27

JOB#: [**Job Number 20680**]

"

"Admission Date: [**2167-11-27**]   Discharge Date: [**2167-12-9**]

Date of Birth: [**2099-5-5**]   Sex: F

HISTORY OF PRESENT ILLNESS: The patient is a 68 year old female with a history of morbid obesity, history of sleep apnea, obesity hypoventilation syndrome, congestive heart failure with diastolic dysfunction, restrictive lung disease, the Emergency Department with a chief complaint of increasing shortness of breath for four to five days. The patient had mild productive cough but no fevers or chills. Prior to her admission on [**2167-11-27**], her O2 saturation dropped from the low-90s which is her baseline, down to 78 to 80% at home with a heart rate in the 130s to 140s.

of 99.8 F.; blood pressure 123/70; heart rate 130 to 140; respirations 30; 02 saturation 80% on room air, up to 95% on four to five liters. She was found to be atrial fibrillation with rapid ventricular response to the 140s and started on heparin and Diltiazem for rate control.

After admission to the Medical Floor on [**2167-11-27**], she required more oxygen to the point of 100% face mask. Arterial blood gas was initially 7.23, 98, 117, 100% non-rebreather mask; 7.25, 95, 58, on 5 liters nasal cannula, to 7.25, 99, 75, on Bi-PAP, then to 7.26, 96, 72, on C-PAP. She was transferred to the Cardiac Care Unit on [**2167-11-28**], for cardiac and respiratory failure.

Her issues in the Cardiac Care Unit included:

1. Pulmonary: Respiratory failure secondary to hypoventilation secondary to morbid obesity in the setting of restrictive lung disease and congestive heart failure. The patient did not require intubation and continued on Bi-PAP and C-PAP. She was started on potassium chloride and progesterone to increase her respiratory drive. On [**2167-12-1**], the patient was started on nasal cannula O2 during the day with continued Bi-PAP at night. Her O2 saturation on nasal cannula of four to five liters was as low as 90%.
2. Cardiovascular: Congestive heart failure; the patient was aggressively diuresed with intravenous Lasix, for a total of nine liters negative while in the Cardiac Care Unit. Paroxysmal atrial fibrillation: Started on anti-coagulation on Diltiazem and digoxin.
3. Gastrointestinal: Constipation; aggressive bowel regimen including Lactulose and GoLYTELY.
4. Decreased mental status: Believed to be secondary to hypoxia and hypercarbia, resolved with improved oxygenation.

PAST MEDICAL HISTORY:

1. Restrictive lung disease with PFTs, FEV of 1.38, 77%, FVC of 1.78, 71%, mild decrease in DLCO, on home O2 two to three liters at night.
2. Morbid obesity.
3. Presumed obstructive sleep apnea.
4. Obesity hypoventilation syndrome.

5. Congestive heart failure with diastolic dysfunction, echocardiogram in [**2166**] very limited, ejection fraction was 67% on stress test in [**2164**]. History of positive stress in 09 of [**2165**]; with reversible defects laterally and inferior laterally which was never worked up.
6. Hypertension.
7. Type 2 diabetes mellitus.
8. Stasis dermatitis.

ALLERGIES: No known drug allergies.

MEDICATIONS at time of transfer to floor

1. Simvastatin 10 mg p.o. q. h.s.
2. Glucophage 1000 mg p.o. twice a day.
3. Avandia 4 mg p.o. twice a day.
4. Provera 5 mg p.o. q. day.
5. Diltiazem 90 mg p.o. four times a day.
6. Digoxin 0.125 mg p.o. q. day.
7. Lasix 60 mg intravenously three times a day.
8. Colace 100 mg p.o. three times a day.
9. Coumadin 2.5 mg p.o. q. h.s.
10. Fleets Enema p.r.n.
11. Atrovent nebulizers p.r.n.
12. Dulcolax p.r.n.
13. Milk of Magnesia p.r.n.
14. Tylenol p.r.n.
15. Ioconasol Powder.

PHYSICAL EXAMINATION: Temperature 98.9 F.; pulse 85 to 112; blood pressure 93/60; respirations 23; O2 saturation 90% on

five liters nasal cannula, 95% on non-rebreather face mask. In general, the patient alert, in no acute distress sitting in a chair. HEENT: Oropharynx is clear. Moist mucous membranes. Neck supple. Unable to assess jugular venous pressure secondary to morbid obesity. Cardiovascular: Irregularly irregular rhythm, normal S1 and S2. Grade II/VI systolic ejection murmur at right upper sternal border. Lungs: Rare crackles bilateral bases. Abdomen obese, soft, nontender, nondistended. Positive bowel sounds. Extremities: Three plus non-pitting edema bilaterally to the thighs. Right upper extremity edema near PICC line. Decreased range of motion of right shoulder secondary to pain. Erythema of bilateral calves but not warm to touch.

LABORATORY: CBC within normal limits. INR 2.8. Sodium 143, chloride 93, potassium 4.4, bicarbonate 41, BUN 12, creatinine 0.4.

Chest x-ray unchanged from previous studies, shows congestive heart failure and bilateral pleural effusions.

HOSPITAL COURSE:

1. Pulmonary: Hypercarbic respiratory failure secondary to morbid obesity/hypoventilatioin and CHF. She was continued on nasal cannula during the day. Her O2 saturations improved to 93 to 97% on 2 liters via nasal cannula. An attempt to continue Bi-PAP at night was tried, however, the patient's O2 saturations dropped to the high 80s on bi-PAP. Instead, she was kept on

her nasal cannula at night. The patient was tried on CPAP but did not tolerate this either. 2. Cardiovascular: Congestive heart failure; the patient continued to be diuresed with intravenous Lasix. Total diuresis to date negative 12 to 15 liters.

Paroxysmal atrial fibrillation/atrial flutter: Cardiology was consulted for a possible transesophageal echocardiogram and cardioversion. They did not recommend cardioversion now as she cannot tolerate TEE due to need to lie flat.Plan to f/u with cardiology as outpatient after several weeks anticoagualtion and consider cardioversion at that time. The patient was continued on Diltiazem and digoxin. Her rate was still poorly controlled. A beta blocker was added. There is a questionable history of beta blocker intolerance with wheezing reported on prior admit however pt's OMR med list indicates that she was on atenolol at the time of admisison. She had no wheezing while on beta blockers here ofr last 2 days of admit.

Coronary artery disease: The patient has a history of positive stress tests with reversible defects. Cardiology was consulted for possible cardiac catheterization. The patient refused cardiac catheterization since she is unable to lie flat. The patient was continued on Statin and aspirin.Repeat TTE was done that showed decraesd EF of 35-40% and multiple regional wall motion abnormalities. beta blocker and ACE-I have been added to help with CAD and CHF managament.

Aortic stenosis murmur on examination with mild AS confirmed on echo this admit.

3. Hematology: The patient on anti-coagulation for paroxysmal atrial fibrillation.

4. Right shoulder pain: Right shoulder films were normal. The patient's pain improved spontaneously without intervention.She appears to have right rotator cuff tendonitis vs bursitis. [**Month (only) 116**] need PT to help increase use and could use tylenol or low dose nsaids for increased pain.

5. GI: severe Constipation; the patient needs to be maintained standing regimen of lactulose and titrate as needed to maintain 1 BM per day

6. Diabetes mellitus: The patient was continued on home medications, Glucophage and Avandia as well as a Regular insulin sliding scale.Her glucotrol and amaryl were added back the day prior to discharge.

Code Status: The patient is ""DO NOT RESUSCITATE"", ""DO NOT INTUBATE"", however, patient is agreeable to Medical Intensive Care Unit transfer for pressors as necessary.

DISCHARGE STATUS: Discharge patient to Rehabilitation.

DISCHARGE CONDITION: Stable.Of note, pt says her breathing is better than it has been in 2 years. She uses home O2.

DISCHARGE MEDICATIONS:

1. Diltiazem 120 mg p.o. four times a day.
2. Digoxin 0.125 mg p.o. q. day.

3. Lasix 120 [**Hospital1 **] PO

4. Colace 100 mg p.o. three times a day.

5. Lactulose 3o cc PO qid

6.Amaryl 2 mg PO bid

7.glucotrol XL 10 mg PO qd

8. Dulcolax 10 mg p.o. prn

9. Aspirin 325 mg p.o. q. day.

10. Simvastatin 10 mg p.o. q. h.s.

11. Provera 5 mg p.o. q. day.

12. Protonix 40 mg p.o. q. day.

13. Avandia 4 mg p.o. twice a day.

14. Glucophage 1000 mg p.o. twice a day.

15. Tylenol 325 mg p.o. q. four to six hours p.r.n.

16. Aldactone 25 mg p.o. [**Hospital1 **]

17. Albuterol MDI two puffs q. two to four hours p.r.n.

18. Coumadin: 1.5 mg po qd- needs to be monitored an dad[**Name (NI) 20681**]

for INR [**1-3**]

19. Lopressor 25 po bid PO

20. O2 2L NP

21. Regular insulin sliding scale.

22. Lisinopril 5 mg po qd

FOLLOW-UP INSTRUCTIONS: The patient has a Cardiology

appointment on [**2168-1-7**], at 4 p.m. at [**Hospital Ward Name 23**] Center, [**Location (un) 20682**], with Dr. [**Last Name (STitle) 20683**].

She also needs f/u with Dr. [**First Name8 (NamePattern2) **] [**Last Name (NamePattern1) 1022**] in [**Company 191**] at [**Hospital1 18**] in [**1-4**]

weeks (Dr. [**First Name (STitle) 1022**] is covering for her PCP- [**Last Name (NamePattern4) **]. [**First Name8 (NamePattern2) **] [**Name (STitle) 19512**] who is

on maternity leave). Pt will also need pulmonary f/u with Dr.

[**First Name4 (NamePattern1) **] [**Last Name (NamePattern1) **] (I think he is her outpatient pulmonary doctor)

DISCHARGE DIAGNOSES:

1. hypercapnic respiratory failure-resolved with crhonic CO2

retention.

2. Obstructive sleep apnea/obesity hypoventialtion syndrome

3. Congestive heart failure

4. Hypertension.

5. Diabetes mellitus, type 2.

6. Restrictive lung disease.

7. Atrial fibrillation/atrial flutter.

8. CAD with echo evidence of prior MI and reduced EF

9. mild AS

10. constipation

[**First Name11 (Name Pattern1) **] [**Last Name (NamePattern4) 3022**], M.D. [**MD Number(1) 3023**]

Dictated By:[**Name8 (MD) 7112**]

MEDQUIST36

D: [**2167-12-7**] 10:29

T: [**2167-12-7**] 11:19

JOB#: [**Job Number 20684**]

"

"Admission Date: [**2170-9-19**] Discharge Date: [**2170-10-12**]

Date of Birth: [**2099-5-5**] Sex: F

Service: [**Hospital Unit Name 196**]

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 9554**]

Chief Complaint:

Weight gain, weakness

Major Surgical or Invasive Procedure:

Colonoscopy-no apparent bleeding lesion.

History of Present Illness:

71 y.o Russian speaking female with extensive PMH including CAD, CHF, afib and chronic anemia. She was recently admitted in [**6-3**] for anemia work-up and found to have a bleeding gastric ectasia on EGD which was removed. Colonoscopy revealed a benign polyp. Pt presents today after feeling increased fatigue at home. Denies CP or increasing SOB. On home O2 at 2L and has not required increased amounts. Pt also notes that she has been unable to walk around her apartment as much, but is limited by weakness vs shortness of breath. She does not feel that her breathig has changed. Her symptoms began approx 3 weeks ago. Denies, cough, cold symptoms, fever, chills, nausea, vomting, change in diet or medication. Pt reports that she was told by her PCP that she had gained a lot of weight due to fluid and needed to come into the hospital for diuresis.

Past Medical History:

CAD

h/o CHF

AFib on coumadin

anemia

Restrictive lung disease

Social History:

married, no alcohol or tobacco

Family History:

non-contributory

Physical Exam:

VS: 97.5, 97/50, 57,16, 95 on 2l NC

GEn: Morbidly obese, pale, pleasant, speaking in full sentences.

HEENT: Ophx clear, MMM, PERRLA, conjinctiva pale, no icterus

CV: distant HS, reg [**Last Name (LF) 20687**], [**First Name3 (LF) **], III/VI SEM radiating to carotids.

Pulm: Distant BS, good inspiratory effort, bibasilar crackles

1/3 up, no rhonchi or wheezing.

Abd: obese, NT, ND, +BS

Ext:4+ woody edema to the knee bilat, warm, erythematous,

non-tender

Neuro: occ resting tremor which is not new. No focal deficits.

A&O x3

Pertinent Results:

ECHO:

Left Atrium - Long Axis Dimension: 3.7 cm (nl <= 4.0 cm)

Aortic Valve - Peak Velocity: *4.1 m/sec (nl <= 2.0 m/sec)

Aortic Valve - Peak Gradient: 64 mm Hg

Aortic Valve - Mean Gradient: 40 mm Hg

Mitral Valve - E Wave: 1.1 m/sec

Mitral Valve - A Wave: 1.2 m/sec

Mitral Valve - E/A Ratio: 0.92

Mitral Valve - E Wave Deceleration Time: 270 msec

LEFT ATRIUM: Normal LA size.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size.

LEFT VENTRICLE: Normal LV cavity size. Overall normal LVEF

(>55%).

RIGHT VENTRICLE: Normal RV chamber size and free wall motion.

AORTA: Normal aortic root diameter.

AORTIC VALVE: Severely thickened/deformed aortic valve leaflets.

Moderate AS.

MITRAL VALVE: Mildly thickened mitral valve leaflets. Moderate

mitral annular

calcification.

PERICARDIUM: No pericardial effusion.

Conclusions:

1. The left ventricular cavity size is normal. Overall left

ventricular

systolic function is very difficult to assess but it may be

normal (LVEF>55%).

2. The aortic valve leaflets are severely thickened/deformed.

There is

moderate aortic valve stenosis.

3. The mitral valve leaflets are mildly thickened.

4. Compared with the findings of the prior study (tape reviewed)

of [**2167-12-7**], LV

function may have improved.

COLONOSCOPY:

(Rectal polyp, polypectomy):

Distorted fragment of benign colonic mucosa with melanosis coli;

no

adenomatous change seen (multiple levels examined).

Brief Hospital Course:

71 yo Russian speaking female with extensive PMH presents with weight gain and increased fatigue over the past 3-4 weeks.

1)Anemia: Pt was recently admitted in [**2170-5-31**] for anemia work-up and found to have a bleeding gastric ectasia on EGD which was removed. Colonoscopy at that time revealed a benign polyp. Pt was found to have Hct of 18 on this admission. Pt was transferred to the CCU for monitoring and received 8 units of PRBC with appropriate increase from 18 to 33. The anemia was thought to be subacute since she was never hemodynamically unstable. GI was consulted. Coumadin was held for suspected GI bleed. Colonoscopy was scheduled but held for persistent high INR which was reversed with vitamin K. Pt was a difficult prep

and required almost 4-5 days of prepping with Golytely and other laxative. Pt finally underwent colonoscopy which revealed no source of bleed. Since pt's Hct was stable 25 34-35, no further diagnostic procedure was done. If pt were to develop another acute/subacute anemia, capsule study was recommended.

2) CHF: Pt has a long hx of CHF per old records. Last echo before admission was from [**2168**] which showed EF of 35-40%. She got an echo on [**9-20**] which showed EF>55%. Pt was initially started on niseritide and lasix for diuresis for suspected CHF exacerbation before her initial Hct of 18 came back. Pt received lasix between transfusions. Lisinopril was held for increased creatinine. Pt's wt was stable and CHF status was stable initially. However, after 5 days of prep for the colonoscopy, pt started to gain weight everyday and was net positive daily. Pt was refractory to standing IV Lasix and Diuril. She got PICC line placed under IR and Natrecor gtt was started with still net positive daily. Lasix gtt was added and was titrated up to 10-15mg/hr which gave some reponse initially but again became refractory to it. Dopamine gtt was tried but showed no improvement in UOP. Pt lost PICC access. However one day, she started to respond extremely well with lasix gtt at 10mg/hr and IV Diuril 250 mg [**Hospital1 **] only (without Natrecor). Pt's admission weight was 130 kg (128 kg in a clinic note) and has gotten up as high as 139 kg. However, she was able to diuresis 1-2L/day and her weight came down to 130kg which is her baseline. The diuretics were changed to po form (Lasix po 120 mg [**Hospital1 **] and Diuril po 125 mg [**Hospital1 **]) and pt continued to diuresis with net negative daily. Pt's CHF was thought to be possibly

from AS. If that is the case, valve replacement could improve her symtoms. Review of the aortic valve orifice and consideration of valve replacement should be discussed as outpatient. Pt needs to follow up with a [**Hospital 1902**] clinic within 1 week.

3) Afib: Pt with hx of atrial fibrillation but now in sinus rhythm. Rate is bradycardic. Pt noted to have pauses on tele up to 2 seconds. Pt was continued on amiodarone 200 mg po qd. Coumadin was held in a setting of GI bleed and also for high INR prior to colonoscopy. Coumadin was restarted with goal INR of [**1-2**]. Pt needs to be seen by her PCP to check her INR level.

4) COPD/restrictive lung dz: Pt was continued on 2 L of oxygen which is her baseline. Pt was getting nebulizer prn for wheezing and SOB. Pt is on home O2.

5) DM: Pt was initially continued on home meds of avandia and glyburide and was cover with RISS. However, avandia was held while she was NPO. She will be discharged with her home regimen.

9) CODE: DNR/ DNI- this was re-discussed with patient and husband to determine if pt still wants to be DNI/DNR as she has been DNR/DNI on prior admissions.

Medications on Admission:
avandia 4 [**Hospital1 **]
amaryl 2 mg prn FS > 250

protonix 50 qd

coumadin 2 qhs- on HOLD

amiodorone 200 qd

lasix 160 qam, 40 qpm

zaroxyln 2.5 qd 30 minute before am lasix

lipitor 40 qd

iron 325 tid- don't give w/ protonix

vit c tid with iron

lisinopril 5 qd

levoxyl 0.050 mg qd

albuterol/atrovent MDI

epogen 3000 units 2x per week.

Discharge Medications:

1. Amiodarone HCl 200 mg Tablet Sig: One (1) Tablet PO QD ().

Disp:*30 Tablet(s)* Refills:*2*

2. Ascorbic Acid 500 mg Tablet Sig: One (1) Tablet PO TID (3

times a day).

Disp:*90 Tablet(s)* Refills:*2*

3. Levothyroxine Sodium 50 mcg Tablet Sig: One (1) Tablet PO QD

().

Disp:*30 Tablet(s)* Refills:*2*

4. Lisinopril 5 mg Tablet Sig: One (1) Tablet PO QD ().

Disp:*30 Tablet(s)* Refills:*2*

5. Epoetin Alfa 4,000 unit/mL Solution Sig: Two (2) Injection

QMOWEFR (Monday -Wednesday-Friday).

Disp:*qs * Refills:*2*

6. Albuterol Sulfate 0.083 % Solution Sig: [**12-1**] Inhalation Q6H

(every 6 hours) as needed.

7. Triamcinolone Acetonide 0.1 % Cream Sig: One (1) Appl Topical HS (at bedtime).

Disp:*1 tube* Refills:*2*

8. Pantoprazole Sodium 40 mg Tablet, Delayed Release (E.C.) Sig: One (1) Tablet, Delayed Release (E.C.) PO Q12H (every 12 hours).

Disp:*60 Tablet, Delayed Release (E.C.)(s)* Refills:*2*

9. Avandia 4 mg Tablet Sig: One (1) Tablet PO twice a day.

Disp:*60 Tablet(s)* Refills:*2*

10. Amaryl 2 mg Tablet Sig: One (1) Tablet PO as needed as needed for FS>200.

Disp:*30 Tablet(s)* Refills:*0*

11. Atorvastatin Calcium 40 mg Tablet Sig: One (1) Tablet PO once a day.

Disp:*30 Tablet(s)* Refills:*2*

12. Iron 325 (65) mg Capsule, Sustained Release Sig: One (1) Capsule, Sustained Release PO three times a day.

Disp:*90 Capsule, Sustained Release(s)* Refills:*2*

13. Metoprolol Succinate 25 mg Tablet Sustained Release 24HR Sig: One (1) Tablet Sustained Release 24HR PO DAILY (Daily).

Disp:*30 Tablet Sustained Release 24HR(s)* Refills:*2*

14. Chlorothiazide 250 mg Tablet Sig: 0.5 Tablet PO BID (2 times a day).

Disp:*60 Tablet(s)* Refills:*2*

15. Furosemide 80 mg Tablet Sig: 1.5 Tablets PO BID (2 times a day).

Disp:*60 Tablet(s)* Refills:*2*

16. Pramoxine-Zinc Oxide in MO 1-12.5 % Ointment Sig: One (1) Appl Rectal Q4-6H (every 4 to 6 hours) as needed.

Disp:*qs qs* Refills:*0*

17. Coumadin 1 mg Tablet Sig: Three (3) Tablet PO once a day.

Disp:*90 Tablet(s)* Refills:*2*

Discharge Disposition:

Home With Service

Facility:

[**Hospital 20688**] Home Health

Discharge Diagnosis:

Acute anemia from GI bleed

CHF

Discharge Condition:

Hemodynamically stable, stable Hct, no chest pain, no symptoms

of dizziness.

Discharge Instructions:

Patient was instructed to take all of the medications as

instructed. Pt was instructed to seek medical attention if shed

develops fatigue, dizziness, SOB, Chest pain, bloody stool,

melena, bloody emesis. Pt should see her PCP [**Last Name (NamePattern4) **] [**12-1**] weeks after

the discharge.

Followup Instructions:

Provider: [**First Name8 (NamePattern2) **] [**Last Name (NamePattern1) **] [**Name8 (MD) **],
MD Where: [**Hospital6 29**]

[**Hospital3 249**] Phone:[**Telephone/Fax (1) 250**] Date/Time:[**2170-10-30**] 1:30

[**First Name8 (NamePattern2) 2064**] [**Last Name (NamePattern1) **] MD [**MD Number(2) 2139**]

Completed by:[**2170-10-12**]"

"Admission Date: [**2172-6-13**] Discharge Date: [**2172-6-22**]

Date of Birth: [**2099-5-5**] Sex: F

Service: MEDICINE

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 8487**]

Chief Complaint:

diarrhea/hypotension

Major Surgical or Invasive Procedure:

None

History of Present Illness:

Pt is a 73 yo female with MMP including CRI, DM, HTN, CHF

requiring admissions, and a recent admission for cellulitis who

presents with seven days of diarrhea and found to be

hypotensive, meeting code sepsis criteria. Pt was recently

admitted to [**Hospital1 **] from [**Date range (3) 20690**] with a left lower extremity

cellulitis treated with unasyn transitioned to augmentin as an outpt. She took the augmentin for 11 days post-discharge with last being ~[**2172-6-9**]. Pt says that for the last seven days she has had profuse diarrhea (two days per husband), last today with 3 episodes. No blood or melena noted. She denies any lightheadedness/ fever/ chills/ nausea/ vomiting or chest pain. She has had decreased PO intake for many days (could not quantify).

In the ED, VS on admission were: T: 99.6; HR: 112; BP 88/42-->70/20; RR: 22; O2: 93% RA. An abdominal CT was done which showed mild diffuse colonic wall thickening without distention. She was given levaquin 500 mg IV and flagyl 500 mg IV x 1. She was also started on norepinephrine gtt prior to transport via ambulance

Past Medical History:

1) Chronic renal insufficiency baseline Cr 2.6 on [**8-4**]
2) Restrictive lung disease presumed to be secondary to obesity

with PFTS in [**2165**]

3) Hyperlipidemia
4) NIDDM x 10 years
5) Obesity
6) HTN
7) CHF, EF >55% with an echo in [**9-2**]
8) Moderate AS (10'[**69**] echo) with AV gradient of 64
9) Chronic atrial fibrillation on coumadin and amiodarone

10) Hypothyroidism TSH 6.7 in [**6-3**]

11) Iron deficiency anemia Hct 34 at baseline 0n [**2171-6-7**] with

gastritis and ectasias on recent EGD/colonoscopy

12) B12 deficiency on supplements

13) Venous insufficiency

14) h/o Left lower extremity cellulitis treated with full course

of Augmentin in [**2171**]

15) Glaucoma; s/p surgery in [**11-3**]

16) h/o left hand cellulitis/gout flare [**10-4**]

Social History:

Lives with her husband in [**Name (NI) 583**]. She denies any smoking or

alcohol use.

Family History:

NC

Physical Exam:

VS: T: 99.5;HR: 75; BP: 103/61; RR: 21; O2: 95 7L; CVP:3

Gen: Speaking in full sentences in mild distress

HEENT: PERRL; EOMI; sclera anicteric; OP clear

Neck: JVD difficult to see [**1-2**] neck girth

CV: RRR S1S2 III/VI crescendo-descrendo murmur at RUSB with

radiation to carotids.

Lungs: scattered crackles 1/3 up without wheezes.

Abd: NABS. Soft, obese, NT, ND

Back: unable to assess

Ext: Brown venous stasis changes ankle--> below knee b/l, L>R.

No open sores, erthema, or warmth. DP 1+. 2+ edema, non-pitting.

Neuro: A&O x 3. MS [**First Name (Titles) 20691**] [**Last Name (Titles) 5235**].

Pertinent Results:

Labs on Admission:

CBC ([**2172-6-13**] 12:10A) WBC-31.6*# RBC-3.88* HGB-11.9* HCT-35.1*

MCV-91 MCH-30.7 MCHC-33.9 RDW-16.4*

NEUTS-88* BANDS-5 LYMPHS-2* MONOS-4 EOS-0 BASOS-0 ATYPS-1*

METAS-0 MYELOS-0

Chemistires ([**2172-6-13**] 12:10AM) GLUCOSE-189* UREA N-94*

CREAT-4.4*# SODIUM-128* POTASSIUM-5.3* CHLORIDE-93* TOTAL

CO2-19* ANION GAP-21*

MAGNESIUM-2.0

Coags: ([**2172-6-13**] 12:56AM) PT-37.0* PTT-33.6 INR(PT)-4.1*

Lactate: ([**2172-6-13**] 12:57AM) LACTATE-3.5*

UA: ([**2172-6-13**] 03:40AM) URINE COLOR-Yellow APPEAR-Clear SP

[**Last Name (un) 155**]-1.012

BLOOD-NEG NITRITE-NEG PROTEIN-NEG GLUCOSE-NEG KETONE-NEG

BILIRUBIN-NEG UROBILNGN-NEG PH-5.0 LEUK-NEG

VBG ([**2172-6-13**] 01:14PM) TYPE-MIX TEMP-37.8 PO2-53* PCO2-47* PH-7.22* TOTAL CO2-20* BASE XS--8 INTUBATED-NOT INTUBA

[**Last Name (un) **] Stim:

[**2172-6-13**] 01:37PM CORTISOL-33.4*

[**2172-6-13**] 02:46PM CORTISOL-46.8*

[**2172-6-13**] 03:25PM CORTISOL-52.1*

Imaging:

CHEST (PORTABLE AP) [**2172-6-13**] 2:04 PM

IMPRESSION:

Compared with earlier the same day, the right IJ central line has been retracted. The tip now overlies the SVC/RA junction. There has been interval progression of left lower lobe collapse and/or consolidation with interval obscuration of left hemidiaphragm. A small left and also a small right pleural effusion cannot be excluded. No pneumothorax is detected.

RADIOLOGY Final Report

CT ABDOMEN W/O CONTRAST [**2172-6-13**] 5:29 AM

IMPRESSION:

1. There is colonic wall thickening extending along the entire course of the colon, with associated pericolonic inflammatory stranding. This appearance is consistent with mild pancolitis, of inflammatory or infectious etiologies. No pericolonic fluid collections or free intraperitoneal air or fluid is identified.

2. Cholelithiasis without evidence of acute cholecystitis.

EKG ([**2172-6-13**])
Sinus rhythm; Borderline first degree A-V block; Left bundle
branch block
Lateral ST-T changes may be due to myocardial ischemia;
Generalized low QRS voltages
No change from previous

Echo ([**2172-6-15**])
IMPRESSION: Suboptimal study. At least moderate (may be severe)
calcific
aortic stenosis. LVH. Normal LVEF. If clincally indicated, a
repeat study with definity contrast may improve spectral doppler
fidelity to assess morte accurately the aortic valve
gradients/area. Compared to the prior report dated [**2170-9-20**], an
aortic valve area change cannot be excluded on the basis of the
current study. LVEF is probably similar.

Brief Hospital Course:
Pt is a 73 yo Ukranian female with MMP who presents with
hypotension, despite fluid resuscitation, and with diarrhea.

She initially required pressors (epinephrine). After more
aggressive IVF use, she was able to be weaned off pressors.
During this time, she was also changed from flagyl to PO
vancomycin (for positive c. diff colitis), given her initial
lack of progress. During this time, her SBPs were in the 90s,

often dropping to the 70s systolic. Her initial acute on chronic renal failure improved over the first few days. After this initial improvement, her course began to worsen again. Her blood pressures again required pressor support (despite IVF), her WBC began to increase (with 14% bands) and her blood gas showed a worsening acidemia. Her urine culture grew enterococcus. Treatment with vanc and flagyl for c. diff and gent/cefepine for UTI were begun. Despite this, she required more pressor support and her respirations became less strong. She expired at 5:59 pm on [**2172-6-22**].

Medications on Admission:

Albuterol prn

Allopurinol 200 mg [**Hospital1 **]

Amiodarone 200 mg qday

Bisacodyl 5 mg qday

Colace 100 mg [**Hospital1 **]

Colchicine 0.6 mg po qod

Glipizide SR 2.5 mg qday

Ipratropium 2 puffs QID

ferrous sulfate 325 one po tid

Levothyroxine 125 mcg qday

Atorvastatin 20 mg qday

Lisinopril 5 mg qday

Pantoprazole 40 mg qday

Cyanocobalamin 1000 mg qday

Furosemide 40 mg po bid

Toprol XL 25 mg qday

Warfarin 1 mg po qhs

Epoetin 6000 units [**Hospital1 **]

Amoxicillin-Claulanate 500-125 mg q12--ENDED [**2172-6-9**]

Discharge Medications:

None

Discharge Disposition:

Expired

Discharge Diagnosis:

Primary:

Sepsis

C. Diff Colitis

UTI

Cardiopulmonary arrest

Secondary:

Diabetes Mellitus

CHF

CRI

Discharge Condition:

Expired

Discharge Instructions:

None

Followup Instructions:

None

"

"PATIENT/TEST INFORMATION:

Indication: Aortic valve disease. Shortness of breath.

Height: (in) 63

Weight (lb): 290

BSA (m2): 2.27 m2

BP (mm Hg): 130/70

Status: Inpatient

Date/Time: [**2167-12-7**] at 13:21

Test: TTE(Complete)

Doppler: Complete pulse and color flow

Contrast: None

Technical Quality: Adequate

INTERPRETATION:

Findings:

LEFT VENTRICLE: Left ventricular wall thicknesses are normal. The left ventricular cavity size is normal. Overall left ventricular systolic function is moderately depressed.

LV WALL MOTION: The following resting regional left ventricular wall motion abnormalities are seen: basal anterior - hypokinetic; mid anterior - hypokinetic; basal anteroseptal - hypokinetic; mid anteroseptal - hypokinetic; anterior apex - hypokinetic; septal apex - hypokinetic;

AORTIC VALVE: There is mild aortic valve stenosis.

MITRAL VALVE: The mitral valve leaflets are mildly thickened. There is moderate mitral annular calcification. Physiologic mitral regurgitation is seen (within normal limits).

TRICUSPID VALVE: Physiologic tricuspid regurgitation is seen. There is borderline pulmonary artery systolic hypertension.

PERICARDIUM: There is no pericardial effusion.

GENERAL COMMENTS: Suboptimal image quality due to body habitus.

Conclusions:
Left ventricular wall thicknesses are normal. The left ventricular cavity size is normal. Overall left ventricular systolic function is hard to assess but is probably moderately depressed. Resting regional wall motion abnormalities include mid and distal septal hypokinesis to akinesis. There is mild aortic valve stenosis. The mitral valve leaflets are mildly thickened. There is borderline pulmonary artery systolic hypertension. There is no pericardial effusion.

Compared to the previous study of [**1-29**], there is a marked decrease in LV

function present.

"

"PATIENT/TEST INFORMATION:

Indication: Congestive heart failure.

Height: (in) 65

Weight (lb): 280

BSA (m2): 2.28 m2

BP (mm Hg): 132/76

Status: Inpatient

Date/Time: [**2167-2-20**] at 15:19

Test: Portable TTE(Complete)

Doppler: Complete pulse and color flow

Contrast: None

Technical Quality: Suboptimal

INTERPRETATION:

Findings:

LEFT VENTRICLE: The left ventricle is not well seen.

RIGHT VENTRICLE: The right ventricle is not well seen.

AORTIC VALVE: The aortic valve leaflets are mildly thickened.

MITRAL VALVE: The mitral valve leaflets are mildly thickened. There is mild

mitral annular calcification.

PERICARDIUM: There is no pericardial effusion.

GENERAL COMMENTS: Suboptimal image quality due to poor echo windows.

Conclusions:
Study was extremely limited. The left ventricle is not well seen but systolic function appears grossly normal. The aortic valve leaflets are mildly thickened. The mitral valve leaflets are mildly thickened. There is no pericardial effusion.

"

"PATIENT/TEST INFORMATION:

Indication: h/o AS. Hypotensive.

Height: (in) 62

Weight (lb): 258

BSA (m2): 2.13 m2

BP (mm Hg): 108/41

HR (bpm): 83

Status: Inpatient

Date/Time: [**2172-6-15**] at 15:14

Test: Portable TTE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Suboptimal

INTERPRETATION:

Findings:

LEFT ATRIUM: Mild LA enlargement.

LEFT VENTRICLE: Mild symmetric LVH with normal cavity size and systolic function (LVEF>55%). Suboptimal technical quality, a focal LV wall motion abnormality cannot be fully excluded.

RIGHT VENTRICLE: Paradoxic septal motion consistent with conduction abnormality/ventricular pacing.

AORTA: Normal aortic root diameter. Mildly dilated ascending aorta.

AORTIC VALVE: Severely thickened/deformed aortic valve leaflets. Moderate AS.

MITRAL VALVE: Mildly thickened mitral valve leaflets. No MVP. Mild mitral annular calcification. Mild thickening of mitral valve chordae.

TRICUSPID VALVE: Borderline PA systolic hypertension.

PERICARDIUM: Small pericardial effusion. No echocardiographic signs of tamponade.

GENERAL COMMENTS: Suboptimal image quality - poor echo windows.

Conclusions:
The left atrium is mildly dilated. There is mild symmetric left ventricular

hypertrophy with normal cavity size and systolic function (LVEF>55%). Due to suboptimal technical quality, a focal wall motion abnormality cannot be fully excluded. The ascending aorta is mildly dilated. The aortic valve leaflets are severely thickened/deformed. There is at least moderate aortic valve stenosis (severe aortic stenosis may be present but cannot be excluded by this study). The mitral valve leaflets are mildly thickened. There is no mitral valve prolapse. There is borderline pulmonary artery systolic hypertension. There is a small pericardial effusion. There are no echocardiographic signs of tamponade.

IMPRESSIOn: Suboptimal study. At least moderate (may be severe) calcific aortic stenosis. LVH. Normal LVEF. If clincally indicated, a repeat study with definity contrast may improve spectral doppler fidelity to assess morte accurately the aortic valve gradients/area. Compared to the prior report dated [**2170-9-20**], an aortic valve area change cannot be excluded on the basis of the current study. LVEF is probably similar.

"

"PATIENT/TEST INFORMATION:
Indication: Aortic valve disease. Congestive heart failure. Left ventricular function.
Height: (in) 63
Weight (lb): 299
BSA (m2): 2.30 m2
BP (mm Hg): 101/41
HR (bpm): 90
Status: Inpatient
Date/Time: [**2170-9-20**] at 15:34
Test: Portable TTE (Complete)

Doppler: Full doppler and color doppler

Contrast: Definity

Technical Quality: Adequate

INTERPRETATION:

Findings:

LEFT ATRIUM: Normal LA size.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size.

LEFT VENTRICLE: Normal LV cavity size. Overall normal LVEF (>55%).

RIGHT VENTRICLE: Normal RV chamber size and free wall motion.

AORTA: Normal aortic root diameter.

AORTIC VALVE: Severely thickened/deformed aortic valve leaflets. Moderate AS.

MITRAL VALVE: Mildly thickened mitral valve leaflets. Moderate mitral annular calcification.

PERICARDIUM: No pericardial effusion.

Conclusions:

1. The left ventricular cavity size is normal. Overall left ventricular systolic function is very difficult to assess but it may be normal (LVEF>55%).

2. The aortic valve leaflets are severely thickened/deformed. There is
moderate aortic valve stenosis.
3. The mitral valve leaflets are mildly thickened.
4. Compared with the findings of the prior study (tape reviewed) of [**2167-12-7**], LV
function may have improved.

"

"Atrial fibrillation with a controlled ventricular response. Left bundle-branch
block. Ventricular ectopy. Compared to the previous tracing of [**2167-12-3**]
ventricular ectopy is now present.
TRACING #2

"

"Atrial fibrillation with a controlled ventricular response. Left bundle-branch
block. Compared to the previous tracing of [**2167-11-27**] the ventricular rate is now
controlled.
TRACING #1

"

"Atrial fibrillation with rapid ventricular response
Left bundle branch block
Lateral ST elevation, consider recent infarction
Inferior T wave changes are nonspecific
Repolarization changes may be partly due to rate/rhythm
Low QRS voltages in limb leads
Since last ECG, [**2167-2-25**], rate, rhythm change

"

"Sinus rhythm with atrial ectopy. Left bundle-branch block. Compared to the previous tracing of [**2167-2-24**] no diagnostic interval change.

"

"Sinus rhythm with atrial ectopy. Left bundle-branch block. Compared to the previous tracing of [**2167-2-23**] there is now atrial ectopy.

"

"Sinus rhythm. Left bundle-branch block. No diagnostic change compared to the previous tracing of [**2167-2-22**].

"

"Sinus rhythm with atrial ectopy. Left bundle-branch block. No diagnostic change compared to the previous tracing of [**2167-2-20**].
TRACING #2

"

"Sinus rhythm with atrial ectopy. Left bundle-branch block. No diagnostic change compared to the previous tracing of [**2167-2-17**].
TRACING #1

"

"Sinus rhythm. Left bundle-branch block. No diagnostic change compared to the tracing of [**2167-2-16**].
TRACING #2

"

"Sinus rhythm
Borderline first degree A-V delay

Left bundle branch block

Since previous tracing of [**2172-6-21**], lateral T wave changes now inverted

"

"Sinus tachycardia

Left atrial abnormality

Left bundle branch block

Lateral T waves are upright could be in part primary - clinical correlation is

suggested

Since previous tracing of [**2172-6-20**], sinus tachycardia present

"

"Sinus rhythm

Left atrial abnormality

Left bundle branch block

Lateral T waves are upright - could be in part primary - clinical correlation

is suggested

Since previous tracing of [**2172-6-13**], T waves now upright

"

"Sinus rhythm

Borderline first degree A-V block

Left bundle branch block

Lateral ST-T changes may be due to myocardial ischemia

Generalized low QRS voltages

No change from previous

"

"Sinus rhythm

Left bundle branch block

Since last ECG, faster rate

"

"Sinus rhythm. Left bundle-branch block. Since the previous tracing of [**2170-10-3**] no significant change.

"

"Sinus rhythm

Left bundle branch block

Generalized low QRS voltages

Since previous tracing of [**2170-9-21**], no significant change

"

"Baseline artifact. Sinus rhythm. Left bundle-branch block. Consider repeat tracing for interpretation of ST segments and T waves. Compared to the previous tracing of [**2165-11-25**], no diagnostic interval change.

TRACING #1

"

"Sinus bradycardia. Left bundle-branch block. Compared to the previous tracing of [**2170-6-12**] bradycardia is present.

"

"Sinus rhythm

Left bunch branch block

Since previous tracing of [**2170-5-15**], no significant change

"

"Sinus bradycardia. Left bundle-branch block. Compared to the previous tracing of [**2168-3-2**] the rate has slowed. Otherwise, no diagnostic interim change.

"

"Normal sinus rhythm. Left bundle-branch block. Compared to tracing #1, atrial fibrillation is no longer present.

TRACING #2

"

"Atrial fibrillation with a moderate ventricular response. Underlying left bundle-branch block. Borderline low limb lead voltage. Compared to the previous tracing of [**2167-12-4**], no diagnostic interval change.

TRACING #1

"

"[**2167-2-17**] 10:09 AM

CT CHEST W/CONT+RECONSTRUCTION; CT 100CC NON IONIC CONTRAST Clip # [**Clip Number (Radiology) 67832**]

Reason: r/o pe

Contrast: OPTIRAY Amt: 100

[**Hospital 2**] MEDICAL CONDITION:

67 year old woman with hypoxia, chf, please r/o pe

REASON FOR THIS EXAMINATION:

r/o pe

FINAL REPORT

HISTORY: Hypoxia, CHF, rule out PE.

TECHNIQUE: Axial images of the chest after the administration of 100 cc of Optiray per fast bolus technique.

Multiplanar re-formations were performed.

Comparison with prior CT from [**1-/2166**].

CT OF THE CHEST WITH IV CONTRAST: There is suboptimal opacification of the pulmonary arteries due to suboptimal timing of the contrast bolus. There is no evidence of discrete filling defects within the main branches of the pulmonary arteries. Again seen is prominence of the pulmonary artery measuring 3.2 cm, Again seen are several small mediastinal and hilar lymph nodes, some of which appear tatty replaced and others appear calcified. They are stable in size and number compared to a yeare ago. Also noted is mediastinal lipomatosis. There are tiny bilateral pleural effusions. Also noted is increased septal line thickening throughout both lungs, clearly increased compared to prior examination. The images are slightly degraded due to motion, but there appears to be bilateral subtle ground glass opacity.

The previously noted prominent bronchi are unchanged. The upper abdominal structures appear unremarkable.

IMPRESSION:

1. Suboptimal CT pulmonary angiogram without evidence of definite filling defects within the main or major branches of the pulmonary artery. The studcannot exclude emboli in the segmental divisons..

2. Stable multiple mediastinal lymph nodes, unchanged compared to one year previously.

(Over)

[**2167-2-17**] 10:09 AM

CT CHEST W/CONT+RECONSTRUCTION; CT 100CC NON IONIC CONTRAST Clip # [**Clip Number (Radiology) 67832**]

Reason: r/o pe

Contrast: OPTIRAY Amt: 100

FINAL REPORT

(Cont)

"

"[**2167-2-17**] 9:09 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92134**]

Reason: comment on resolution of CHF, ? of infiltrative process

---

[**Hospital 3**] MEDICAL CONDITION:

67 year old woman with CHF, COPD, ? pneumonia, s/p agressive diuresis, ? of

infiltrate.

REASON FOR THIS EXAMINATION:

comment on resolution of CHF, ? of infiltrative process

FINAL REPORT

INDICATION: SHORTNESS OF BREATH, CHF, COPD, POSSIBLE PNEUMONIA.

Comparison is made to a portable AP chest radiograph on [**2167-2-16**].

There is left ventricular enlargement with slight upper zone redistribution of
the pulmonary vascularity. There is minor atelectasis at the bases
bilaterally. No pleural effusions are present.

IMPRESSSION: Slight improvement of CHF.

"

"[**2167-2-16**] 11:10 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92133**]

Reason: sob, r/o infiltrate, r/o chf

[**Hospital 3**] MEDICAL CONDITION:

67 year old woman with diabetes. hx of chf

REASON FOR THIS EXAMINATION:

sob, r/o infiltrate, r/o chf

FINAL REPORT

INDICATION: Shortness of breath.

The cardiac silhouette appears enlarged, there is vascular engorgement,
perihilar haziness and more confluent areas of opacification in the lung bases
and the retrocardiac region. No definite pleural effusion is evident, but the
left costophrenic angle has been excluded from the study, precluding
assessment of this region.

IMPRESSION: Findings consistent with congestive heart failure. Follow up radiographs after diuresis may be helpful to exclude other underlying process.

"

"[**2167-2-21**] 11:29 AM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 92177**]

Reason: comment on CHF

[**Hospital 3**] MEDICAL CONDITION:

67 year old woman with CHF, COPD, ? pneumonia, s/p agressive diuresis, ? of infiltrate.

REASON FOR THIS EXAMINATION:

comment on CHF

FINAL REPORT

HISTORY: SOB with CHF and COPD. Assess diuresis.

PA and lateral chest. The heart is enlarged with central vascular plethora. Equivocal interstitial edema. I doubt the presence of effusions. It is difficult to compare this exam with less satisfactory bedside study of [**2167-2-17**] but the fluid overload/CHF has probably improved.

IMPRESSION: Minimal CHF with interval improvement.

"

"[**2167-3-31**] 3:03 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 92178**]

Reason: f/u chf

[**Hospital 3**] MEDICAL CONDITION:

67 year old woman with CHF, COPD, ? pneumonia, s/p agressive diuresis, ? of infiltrate.

REASON FOR THIS EXAMINATION:

f/u chf

FINAL REPORT

HISTORY: Follow-up CHF.

PA AND LATERAL VIEWS OF THE CHEST: The size of the cardiac silhouette is moderately enlarged. There is slight upper zone redistribution and pulmonary vascular engorgement. No pleural effusion is identified. Compared to [**2167-2-21**], there is no significant change.

IMPRESSION: Minimal CHF with no significant change.

"

"[**2167-12-2**] 7:07 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92324**]

Reason: eval for change in pulm edema.

[**Hospital 3**] MEDICAL CONDITION:

68 year old woman with new onset rapid afib, chf, dm, being diuresed.

REASON FOR THIS EXAMINATION:

eval for change in pulm edema.

FINAL REPORT

INDICATION:

CHF.

COMPARISON:

[**2167-12-1**].

PORTABLE AP CHEST:

Cardiac silhouette is enlarged but stable. There are bilateral pleural

effusions, upper zone vascular redistribution and blurring of the vascular

consistent with congestive failure, not significantly changed.

IMPRESSION:

No significant change in congestive heart failure.

"

"[**2167-11-27**] 3:54 PM

ABDOMEN (SUPINE & ERECT) Clip # [**Clip Number (Radiology) 67834**]

Reason: r/o intraabdominal process... pt with 10 days of no BM with

---

[**Hospital 2**] MEDICAL CONDITION:

68 year old woman with See above

REASON FOR THIS EXAMINATION:

r/o intraabdominal process... pt with 10 days of no BM with distended, tense

abdomen. Nontender. Pt also with CHF/Shortness of breath and tachycardia

requiring O2 on Nonrebreather. Pt morbidly obese.

If you think a portable is a better option, this is fine as well.

Thanks,

[**First Name8 (NamePattern2) 10**] [**Last Name (NamePattern1) **]

[**Numeric Identifier 31340**]

FINAL REPORT

INDICATION: Abdominal pain and distention, no bowel movement for 2 days, r/o obstruction.

ABDOMEN, TWO VIEWS: This is exam is markedly limited due to patient's body habitus. On the supine film there appeared to be a few dilated loops of small bowel in the mid abdomen. This exam is nondiagnostic due to its technical limitations. The upright film of the abdomen is nondiagnostic due to technique and patient's body habitus.

IMPRESSION: Nondiagnostic exam. There may be dilated loops of small bowel in the mid abdomen.

"

"[**2167-12-1**] 3:14 PM

CHEST (SINGLE VIEW) PORT Clip # [**Clip Number (Radiology) 67835**]

Reason: please confirm picc tip placement to right arm; unable to fu

---

[**Hospital 2**] MEDICAL CONDITION:

68 year old woman with chf/a fib requiring improved access for poor access

REASON FOR THIS EXAMINATION:

please confirm picc tip placement to right arm; unable to further advance; page [**8-/2609**] with results. thanks

---

FINAL REPORT

AP CHEST [**2167-12-1**].

INDICATION: PICC line placement.

COMPARISON: AP chest dated [**2167-11-30**].

AP CHEST: The right-sided PICC line extends no further than the proximal right axillary vein. The heart is stably enlarged. Bilateral pleural effusions are unchanged from the prior study. There is slightly increased left midlung linear atelectasis. Bilateral hilar vascular prominence is not significantly changed from the prior study.

IMPRESSION:

1. PICC line extends no further than the right proximal axillary vein.

2. Stable CHF and bilateral pleural effusions. Findings were communicated to the Vascular Access Team.

"

"[**2167-11-30**] 8:17 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 68045**]

Reason: eval for resolution/progression of pulm edema.

[**Hospital 2**] MEDICAL CONDITION:

68 year old woman with new onset rapid afib, chf, romi, being diuresed.

REASON FOR THIS EXAMINATION:

eval for resolution/progression of pulm edema.

FINAL REPORT

INDICATIONS: 68 y/o female with CHF, being diuresed.

COMPARISONS: [**2167-11-28**].

PORTABLE AP CHEST: the heart is enlarged but assessment is difficult due to bilateral effusions which appear stable. Lung volumes have slightly increased but there is persistent upper zone vascular redistribution and indistinctness of the vasculature.

IMPRESSION:

Slightly improved congestive failure.

"

"[**2167-11-28**] 3:31 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67973**]

Reason: Acute sob with o2 desat

[**Hospital 2**] MEDICAL CONDITION:

68 year old woman with new onset rapid afib, chf, romi

REASON FOR THIS EXAMINATION:

Acute sob with o2 desat

FINAL REPORT

INDICATION: Acute shortness of breath.

CHEST, SINGLE VIEW, TIME 3:42: Evaluation of the study is extremely limited due to patient motion, body habitus, and low lung volumes. Taking this into

account, the bilateral effusions have probably increased since [**2167-11-27**] time 10:22. The central pulmonary vessels remain hazy and indistinct.

IMPRESSION: Taking into account the limitations of this study, as described above, the degree of failure is probably worsened since [**2167-11-27**]. Bilateral effusions have also increased.

"

"[**2167-11-27**] 9:52 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92069**]

Reason: fever and sob, r/o infil

[**Hospital 3**] MEDICAL CONDITION:

68 year old woman with

REASON FOR THIS EXAMINATION:

fever and sob

r/o infil

FINAL REPORT

INDICATION: Fever and shortness of breath r/o infiltrate.

PORTABLE AP CHEST RADIOGRAPH dated [**2167-11-27**] is compared to [**MD Number(3) 14176**] radiograph dated [**2167-3-31**]. The patient has a large amount of overlying soft tissue in the lordotic position. This slightly limits the portion of visualized lung. There is a large cardiac silhouette. There is fluid in the minor fissure with bilateral diffuse infiltrates and upper zone redistribution. The bases of the lung cannot be assessed due to the patient's positioning so effusions cannot be excluded. Compared to the prior study, there has been interval increase in

the bilateral diffuse infiltrates.

IMPRESSION: Limited exam, however, fluid in the minor fissure. Large cardiac silhouette and diffuse infiltrates likely represent pulmonary edema. No focal consolidation is noted to suggest pneumonia.

"

"[**2167-12-3**] 10:49 AM

SHOULDER [**1-3**] VIEWS NON TRAUMA RIGHT Clip # [**Clip Number (Radiology) 68093**]

Reason: Please r/o degenerative changes of the right shoulder

---

[**Hospital 2**] MEDICAL CONDITION:

68 year old woman with several weeks of right shoulder pain

REASON FOR THIS EXAMINATION:

Please r/o degenerative changes of the right shoulder

FINAL REPORT

INDICATION: Several weeks of right shoulder pain.

SHOULDER, RIGHT, 4 VIEWS: This is a limited exam of the right shoulder without true neutral views of this joint. No fracture and no dislocation is identified.

IMPRESSION: Limited but unremarkable examination of the right shoulder.

"

"[**2170-9-21**] 10:53 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 68094**]

Reason: Please r/o obstruction.

Admitting Diagnosis: CONGESTIVE HEART FAILURE

[**Hospital 2**] MEDICAL CONDITION:

71 year old woman with CHF and GIB now not passing gas

REASON FOR THIS EXAMINATION:

Please r/o obstruction.

FINAL REPORT

ABDOMEN SINGLE FILM:

HISTORY: GI bleed and absence of residual flatus.

Gas and fecal residue are present in the colon and rectum and there is no evidence for intestinal obstruction. No obvious soft tissue masses or other diagnostic abnormality. No upright or decubitus films.

"

"[**2171-2-5**] 1:34 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92506**]

Reason: r/o infiltrate

[**Hospital 3**] MEDICAL CONDITION:

71 year old woman with decreased hct

REASON FOR THIS EXAMINATION:

r/o infiltrate

FINAL REPORT

HISTORY: Decreased hematocrit.

COMPARISON: [**2170-9-30**].

UPRIGHT AP VIEW OF THE CHEST: There is stable cardiomegaly. The aorta is unfolded. There is perihilar haziness, upper zone vascular redistribution, and vascular indistinctness; findings all consistent with mild congestive heart failure. Left lower lobe patchy opacity is present, likely representing atelectasis. No definite focal consolidations, pleural effusions, or pneumothorax is demonstrated. Osseous structures appear unchanged.

IMPRESSION: Mild congestive heart failure with left lower lobe atelectasis.

DFDdp

"

"[**2170-9-30**] 10:14 AM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 92417**]

Reason: Pt difficult to diurese, volume overloaded, please ck for fa

Admitting Diagnosis: CONGESTIVE HEART FAILURE

[**Hospital 3**] MEDICAL CONDITION:

71 year old woman with CHF exacerbation.

REASON FOR THIS EXAMINATION:

Pt difficult to diurese, volume overloaded, please ck for failure, heart size

---

FINAL REPORT

HISTORY: CHF exacerbation.

CHEST, TWO VIEWS:

There is moderately severe cardiomegaly. There is upper zone redistribution and diffuse vascular spurring consistent with interstitial edema. There is bibasilar atelectasis. Pleural thickening along both lateral chest walls and biapical pleural thickening, but no blunting of the costophrenic angles to suggest large effusions. No frank consolidation or effusion is seen.

IMPRESSION: Cardiomegaly and CHF with interstitial edema. No infiltrate or effusion.

"

"[**2170-10-1**] 3:17 PM

PICC LINE PLACMENT SCH Clip # [**Clip Number (Radiology) 92073**]

Reason: Placement of PICC

Admitting Diagnosis: CONGESTIVE HEART FAILURE

********** CPT Codes **********

* [**Numeric Identifier 413**] PICC W/O [**Numeric Identifier 414**] FLUOR GUID PLCT/REPLCT/REMOVE *

* C1751 CATH [**Last Name (LF) 415**],[**First Name3 (LF) **]/CENT/MID(NOT D *

****

[**Hospital 3**] MEDICAL CONDITION:

71 year old woman with CHF, needs Dopamine plus diuretics. Could not get bedside PICC.

REASON FOR THIS EXAMINATION:

Placement of PICC

FINAL REPORT

INDICATION: CHF, chronic renal insufficiency, need for IV dopamine and diuretics. Could not get bedside PICC.

PROCEDURE/FINDINGS: The procedure was performed by Drs. [**Last Name (STitle) 2581**] and [**Name5 (PTitle) 179**], the staff radiologist who was present and supervising. The left upper arm was prepped and draped in the standard sterile fashion. Since no suitable superficial veins were visible, ultrasound was used for localization for a suitable vein. The left basilic vein was patent and compressible. After local anesthesia with 3 cc of 1% lidocaine, the basilic vein was entered under ultrasonographic guidance with a 21 gauge micropuncture needle. A 0.018 guidewire was advanced under fluoroscopy into the superior vena cava. Based on the markers on the guidewire, it was determined that a length of 44 cm will be suitable. The PICC line was trimmed to length and advanced over a 4 FR introducer sheath under fluoroscopic guidance into the superior vena cava. The sheath was removed. The catheter was flushed. A final chest x-ray was obtained. The film demonstrates the tip to be in the superior vena cava just above the atrium. The line is ready for use. A Statlock was applied and the line heplocked.

IMPRESSION:

Successful placement of a 44 cm total length dual lumen PICC line with the tip in the superior vena cava ready for use.

"

"[**2170-10-1**] 9:10 AM

RENAL U.S. Clip # [**Clip Number (Radiology) 92441**]

Reason: please assess renal size, hydronephrosis

Admitting Diagnosis: CONGESTIVE HEART FAILURE

[**Hospital 3**] MEDICAL CONDITION:

71 year old woman with acute on chronic renal failure

REASON FOR THIS EXAMINATION:

please assess renal size, hydronephrosis

FINAL REPORT

CLINICAL INDICATION: Acute on chronic renal failure.

The right kidney is normal in size and appearance measuring 10.2 cm in length. There is no evidence of stones, masses or hydronephrosis. The left kidney is also normal in appearance measuring 11.4 cm in length and again without evidence of stones masses or hydronephrosis. The bladder is empty with a Foley catheter in place.

CONCLUSION: Normal appearance of the kidneys bilaterally.

"

"[**2170-9-21**] 8:34 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92072**]

Reason: please evaluate for volume overload

Admitting Diagnosis: CONGESTIVE HEART FAILURE

[**Hospital 3**] MEDICAL CONDITION:

71 year old woman with CHF and GIB

REASON FOR THIS EXAMINATION:

please evaluate for volume overload

FINAL REPORT

INDICATION: 71-year-old woman with CHF, GI bleeding.

TECHNIQUE: Portable AP chest radiograph.

The comparison is made with the prior chest radiograph dated [**2167-12-2**].

FINDINGS: Again note is made of marked cardiomegaly with widened superior mediastinum. Again note is made of increased vasculature as well as increased interstitial markings, representing CHF. Bilateral pleural effusion and left lower lobe atelectasis are also noted. The study is somewhat limited due to patient's body habitus.

IMPRESSION: Cardiomegaly. Congestive heart failure with left lower lobe atelectasis.

"

"[**2171-6-7**] 12:33 PM

ANKLE/FOOT (AP, LAT & OBL) LEFT Clip # [**Clip Number (Radiology) 92075**]

Reason: r/o osteo

[**Hospital 3**] MEDICAL CONDITION:

72 year old woman with diabetic foot,cellulitis in left ankle with pain.swelling-especially medial malleous

REASON FOR THIS EXAMINATION:

r/o osteo

FINAL REPORT

Left ankle and left foot AP, lateral and oblique.

INDICATION: Diabetic foot, cellulitis in left ankle with pain, swelling especially medial malleolus, evaluate for osteoarthritis.

FINDINGS: AP, oblique and lateral view of the left ankle demonstrate diffuse soft tissue swelling but absence of any acute skeletal trauma. The position of the talus in the mortise is anatomic. No significant degenerative changes can be identified, however, the soft tissue swelling surrounding the ankle joint makes detail assessment difficult.

The lateral view confirms the edematous soft tissue swelling and discloses the presence of rather advanced arterial wall calcifications both in dorsalis pedis and posterior tibial artery area. There exists a half cm planter heel spur and mild contour irregularities in the dorsal aspect of the foot consistent with some osteoarthritis. The major joint spaces, however, appear preserved. AP, oblique and lateral view of the left foot also exclude the presence of an acute skeletal injury. Degenerative changes in the form of joint distance reduction exists in the first metatarsophalangeal joint area with contour irregularities of the joint surfaces and increased sclerosis in the adjacent skeletal structures. No significant hallux valgus deformity is present. Moderate degree of hammer toe deformities are seen in the distal phalanges most marked in the third, fourth and fifth toe. The tarsophalangeal joint and internal tarsal joints appear quite well preserved with only minor degenerative changes.

There exists no prior similar study in our records available for comparison.

Edematous soft tissue swelling surrounding the ankle joint, but no significant degenerative changes and no evidence of acute skeletal trauma.

"

"[**2171-10-3**] 1:58 PM

HAND (AP, LAT & OBLIQUE) LEFT Clip # [**Clip Number (Radiology) 67839**]

Reason: Foreign body? Fracture? Osteomyelitis?

[**Hospital 2**] MEDICAL CONDITION:

72 year old woman with L finger swelling, redness, and unclear trauma to the hand w/ knife vs. sharp meat bone

REASON FOR THIS EXAMINATION:

Foreign body? Fracture? Osteomyelitis?

FINAL REPORT

HISTORY: Left finger swelling and redness. Unclear trauma to the hand with a knife Vs. sharp meat bone. Evaluate for foreign body, fracture, or osteomyelitis.

COMPARISON: No previous studies.

FINDINGS: AP, oblique and lateral views of the left hand. The bones are diffusely demineralized. There is no fracture or malalignment. There is no radiopaque foreign body. There is no osseous erosion or periosteal reaction. The visualized soft tissues appear diffusely swollen.

IMPRESSION:

1. No radiopaque foreign body detected.

2. No fracture identified.

3. Diffuse soft tissue swelling. No radiographic evidence of osteomyelitis.

DFDkq

"

"[**2172-1-7**] 5:26 PM

HAND (AP, LAT & OBLIQUE) RIGHT Clip # [**Clip Number (Radiology) 68320**]

Reason: Please evaluate the hand and wrist.

[**Hospital 2**] MEDICAL CONDITION:

72yF with right hand cellulitis vs gout flair.

REASON FOR THIS EXAMINATION:

Please evaluate the hand and wrist.

FINAL REPORT

INDICATION: Right hand cellulitis versus gout flare.

COMPARISON: None.

THREE VIEWS OF THE RIGHT HAND: There is diffuse demineralization. No fractures are seen. The joint spaces appear preserved. No periarticular erosions are seen. No soft tissue calcifications are seen.

IMPRESSION: Diffuse osseous demineralization. No specific radiographic evidence of gout.

"

"[**2172-5-27**] 6:51 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 67598**]

Reason: atelectasis ? CHF?

Admitting Diagnosis: CELLULITIS

[**Hospital 2**] MEDICAL CONDITION:

73 year old woman with lower extrememity cellulitis, chf.

REASON FOR THIS EXAMINATION:

atelectasis ? CHF?

FINAL REPORT

INDICATION: Cellulitis, atelectasis, CHF.

PA AND LATERAL RADIOGRAPHS OF THE CHEST: There is stable cardiomegaly compared to [**2171-2-5**]. The aorta is unfolded. The hilar contours are stable. No discrete consolidations are seen. There are no pleural effusions. There is a linear opacity in the left lung base which may represent atelectasis.

IMPRESSION: Left basilar plate-like atelectasis. No evidence of pneumonia.

"

"[**2172-6-22**] 9:15 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92135**]

Reason: check for line placement, eval lung fields

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis, s/p NGT placement and L SC placement, now with acute hypoxia.

REASON FOR THIS EXAMINATION:

check for line placement, eval lung fields

FINAL REPORT

PORTABLE CHEST of [**2172-6-22**].

COMPARISON: [**2172-6-21**].

INDICATION: Line placement.

A left subclavian vascular catheter remains in place, terminating in the left brachiocephalic vein, in an approximately midline location. Nasogastric tube continues to terminate below the diaphragm. There is stable cardiomegaly, vascular engorgement and perihilar haziness. Bibasilar areas of atelectasis are again demonstrated, with interval worsening on the left. There are probable small bilateral pleural effusions, left greater than right.

"

"[**2172-6-20**] 11:31 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 92006**]

Reason: Please eval R SC placement; pulm edema

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis, s/p NGT placement

REASON FOR THIS EXAMINATION:

Please eval R SC placement; pulm edema

FINAL REPORT

CLINICAL HISTORY: Placement of new line, check position.

The tip of the left subclavian line lies in the right ventricle. A nasogastric tube is present but the position of its tip cannot be determined as the film is somewhat underpenetrated.

Some loss of the left hemidiaphragm is present suggesting probable effusion with some associated atelectasis of the left lower lobe.

IMPRESSION: Tip of left subclavian line in right ventricle.

"

"[**2172-6-14**] 12:10 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 91971**]

Reason: interval change

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis fluid overload

REASON FOR THIS EXAMINATION:

interval change

FINAL REPORT

HISTORY: Sepsis, fluid overload, assess interval change.

CHEST, SINGLE AP PORTABLE VIEW.

Compared with one day earlier, the right IJ central line tip is now seen to overlie the right atrium. No pneumothorax is detected. Otherwise, no significant interval change is detected. Increased retrocardiac density and blunting of both costophrenic angles remains. Pleural thickening is present on the right, unchanged. There is blurring throughout the image due to patient motion.

"

"[**2172-6-13**] 2:04 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 1**] # [**Clip Number (Radiology) 92706**]

Reason: line position

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis, s/p RIJ pulled back.

REASON FOR THIS EXAMINATION:

line position

FINAL REPORT

HISTORY: Sepsis, right IJ pulled back, check line position.

CHEST, SINGLE AP PORTABLE VIEW.

Compared with earlier the same day, the right IJ central line has been retracted. The tip now overlies the SVC/RA junction. There has been interval

progression of left lower lobe collapse and/or consolidation with interval obscuration of left hemidiaphragm. A small left and also a small right pleural effusion cannot be excluded. No pneumothorax is detected.

"

"[**2172-6-13**] 5:29 AM

CT ABDOMEN W/O CONTRAST; CT PELVIS W/O CONTRAST Clip # [**0-0-**]

Reason: PO CONTRAST ONLY! colitis? obstruction? abscess?

Field of view: 50

[**Hospital 2**] MEDICAL CONDITION:

73 year old woman with suspected c. diff?

REASON FOR THIS EXAMINATION:

PO CONTRAST ONLY! colitis? obstruction? abscess?

CONTRAINDICATIONS for IV CONTRAST:

renal failure

WET READ: MAlb SAT [**2172-6-13**] 9:19 AM

There is mild diffuse colonic wall thickening without distention with mild pericolonic inflammatory stranding along the entire colon. No free air or fluid. Differential includes inflammatory or infectious etiologies.

FINAL REPORT

INDICATION: 73-year-old woman with suspected C. diff, evaluate for colitis, obstruction, or masses.

COMPARISON: None.

TECHNIQUE: MDCT-acquired contiguous axial images were obtained from the lung bases to the pubic symphysis. Multiplanar reconstructions were performed.

CONTRAST: Oral contrast only was administered. No intravenous contrast was given.

CT OF THE ABDOMEN: No pulmonary nodules or parenchymal consolidation is seen. There are some calcified lymph nodes within the right inferior hilar region, which may represent changes from prior granulomatous disease. There are calcifications within the coronary arteries noted.

There is limited evaluation of solid organs without intravenous contrast, however, the liver, kidneys, spleen, and pancreas are within normal limits. The pancreas is slightly atrophic. Calcification is seen within the gallbladder, likely reflecting gallstones, without any evidence of pericholecystic fluid or inflammatory stranding. No pathologically retroperitoneal or mesenteric lymphadenopathy is seen. The small bowel is normal in appearance, without any evidence of bowel wall thickening or dilatation. No free air or free fluid is seen.

There is diffuse mild colonic wall thickening, extending from the rectum to the cecum. There is some associated pericolonic inflammatory stranding along the entire colon. The colon is not distended. There are no pericolonic fluid collections or foci of air.

CT OF THE PELVIS WITH IV CONTRAST: A Foley catheter is seen within the bladder, which is decompressed. Uterus is normal in appearance. There is some proliferation of perirectal fat noted.

BONE WINDOWS: Degenerative changes are seen in the lower thoracic spine,

(Over)

[**2172-6-13**] 5:29 AM

CT ABDOMEN W/O CONTRAST; CT PELVIS W/O CONTRAST Clip # [**0-0-**]

Reason: PO CONTRAST ONLY! colitis? obstruction? abscess?

Field of view: 50

FINAL REPORT

(Cont)

without any evidence of lytic or sclerotic lesions.

CT RECONSTRUCTIONS: Multiplanar reconstructions were essential in delineating the anatomy and pathology.

IMPRESSION:

1. There is colonic wall thickening extending along the entire course of the colon, with associated pericolonic inflammatory stranding. This appearance is consistent with mild pancolitis, of inflammatory or infectious etiologies. No pericolonic fluid collections or free intraperitoneal air or fluid is identified.
2. Cholelithiasis without evidence of acute cholecystitis.

"

"[**2172-6-21**] 12:48 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 92078**]

Reason: Please eval placement of L SC central line, pulled back ~5 c

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis, s/p NGT placement and L SC placement.

REASON FOR THIS EXAMINATION:

Please eval placement of L SC central line, pulled back ~5 cm.

FINAL REPORT

CLINICAL HISTORY: nasogastric tube placed, subclavian line placed, check position.

CHEST: Film is under penetrated. It is likely that the portable machine does not have the output to obtain a good film on this patient. The tip of the nasogastric tube appears to lie below the diaphragm. The tip of the left subclavian line lies at the junction of the SVC and left innominate. There is probably some failure present though this is difficult to evaluate in a patient in supine position of this size.

IMPRESSION: Both lines appear to be in satisfactory position.

"

"[**2172-6-18**] 6:00 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 92179**]

Reason: Assess interval change.

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis, AS, status post fluid resuscitation.

REASON FOR THIS EXAMINATION:

Assess interval change.

FINAL REPORT

REASON FOR EXAMINATION: Interval changes in the patient with sepsis after fluid resuscitation.

Portable AP chest radiograph compared to [**2172-6-14**].

The heart size is enlarged but stable. The mediastinal contours are unchanged. There is bilateral vascular prominence in the perihilar areas with upper lung zone redistribution suggesting vascular congestion/mild pulmonary edema. There is left lower lobe consolidation most probably due to basilar atelectasis.

The tip of the right internal jugular line is 1 cm below the cavoatrial junction.

IMPRESSION: Mild pulmonary edema. Stable moderate-to-severe cardiomegaly. Discoid left lower lobe atelectasis.

"

"[**2172-6-21**] 2:30 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 92325**]

Reason: eval for ICH, mass effect

Admitting Diagnosis: SEPSIS

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with C diff now hypotensive, somnolent, difficult to arouse without having obtained sedating medications

REASON FOR THIS EXAMINATION:

eval for ICH, mass effect

CONTRAINDICATIONS for IV CONTRAST:

cri

FINAL REPORT

INDICATION: 73-year-old female with C. diff, now hypotensive and somnolent.

COMPARISON: [**2165-12-17**].

TECHNIQUE: Non-contrast head CT scan.

FINDINGS: There is no hemorrhage, mass effect, shift of the normally midline structures or major vascular territorial infarct. The [**Doctor Last Name **]-white matter differentiation is preserved. There is no hydrocephalus. The osseous structures are unremarkable. There is mucosal thickening of the ethmoid and sphenoid sinuses as well as air-fluid levels seen in the sphenoid sinuses and mastoid air cells.

IMPRESSION:

1. No hemorrhage or mass effect.

2. Mucosal thickening and air-fluid levels in the paranasal sinuses and mastoid air cells. Acute sinusitis cannot be excluded.

"

"[**2172-6-21**] 2:31 PM

CT ABDOMEN W/O CONTRAST; CT PELVIS W/O CONTRAST Clip # [**Clip Number (Radiology) 68095**]

Reason: eval for fluid collection, dilated bowel

Admitting Diagnosis: SEPSIS

[**Hospital 2**] MEDICAL CONDITION:

73 year old woman with c diff, on vanc/flagyl now increased abdominal distension and hypotension

REASON FOR THIS EXAMINATION:

eval for fluid collection, dilated bowel

CONTRAINDICATIONS for IV CONTRAST:

cri

FINAL REPORT

INDICATION: 73-year-old female with C. diff colitis, now on antibiotics with increasing abdominal distention and hypotension, evaluate for dilated bowel and fluid collection.

COMPARISON: [**2172-6-13**].

TECHNIQUE: MDCT axial images of the abdomen and pelvis were obtained without IV contrast. Multiplanar reformatted images were also obtained.

CT ABDOMEN WITHOUT IV CONTRAST: There are increasing small bilateral pleural effusions with associated atelectasis. There is limited evaluation of the solid organs without IV contrast, however, the liver, spleen, adrenal glands, kidneys, and pancreas are within normal limits. The liver is mildly

hypderdense. The gallbladder is hyperdense which may be secondary to vicarious excretion. Again seen are two small gallstones. There is a small amount of perihepatic fluid as well as a small amount of fluid extending down the left paracolic gutter. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes. The stomach and small bowel are unremarkable.

There has been mild interval improvement in the diffuse colonic wall thickening which now involves portions of the ascending, descending and sigmoid colon. The colon is not distended.

CT PELVIS WITHOUT IV CONTRAST: There is a Foley catheter within the bladder. The uterus is normal in appearance.

The soft tissues reveal mild anasarca.

Osseous windows demonstrate no suspicious lytic or sclerotic foci.

Multiplanar reformatted images confirm the above findings.

IMPRESSION:

1. Mild improvement in colonic wall thickening, now predominantly involving the ascending, descending and sigmoid colon. The appearance is consistent with resolving colitis.

2. Mild amount of perihepatic ascites and fluid within the left paracolic

(Over)

CT ABDOMEN W/O CONTRAST; CT PELVIS W/O CONTRAST Clip # [**Clip Number (Radiology) 68095**]

Reason: eval for fluid collection, dilated bowel

Admitting Diagnosis: SEPSIS

FINAL REPORT

(Cont)

gutter.

3. Increasing small bilateral pleural effusions.

4. Cholelithiasis without evidence of acute cholecystitis.

"

"[**2172-6-13**] 1:45 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 92077**]

Reason: R IJ placement

[**Hospital 3**] MEDICAL CONDITION:

73 year old woman with sepsis

REASON FOR THIS EXAMINATION:

R IJ placement

FINAL REPORT

INDICATION: 73-year-old female with sepsis and right IJ placement.

COMPARISON: [**2172-5-27**].

AP UPRIGHT CHEST: Tip of a right internal jugular catheter terminates in the right atrium. There is stable mild cardiomegaly. The aorta is unfolded. There is perihilar haziness, upper zone vascular redistribution and vascular indistinctness, findings consistent with mild congestive heart failure. Left lower lobe patchy opacity likely reflects atelectasis. No pleural effusions or pneumothoraces are demonstrated. Osseous structures appear unchanged.

IMPRESSION:

1. Right IJ malpositioned in the right atrium.
2. Mild congestive heart failure with left lower lobe atelectasis.

Findings were discussed with the ER staff caring for the patient at the time of dictation.

"

"[**2172-1-27**] 2:39 PM

DIG SCREENING BILAT; CAD SCREENING Clip # [**Clip Number (Radiology) 92561**]

Reason: ROUTINE 1ST [**Last Name (un) 570**]

FINAL REPORT

INDICATION: Screening.

[**Doctor Last Name **] DIGITAL SCREENING MAMMOGRAM WITH ICAD COMPUTER-AIDED DETECTION

SOFTWARE VERSION 7.0: This is the patient's baseline study. The breasts are largely fatty, with minimal scattered fibroglandular densities bilaterally.

There is no evidence of dominant or spiculated mass, architectural distortion, or suspicious clustered microcalcifications. There are coarse loosely grouped benign appearing microcalcifications in the anterior breasts bilaterally.

IMPRESSION: Baseline mammogram. No evidence of malignancy.

Recommend follow up screening mammogram in one year.

[**Hospital1 **]-RADS 2 - benign findings.

"

"MICU/SICU NPN HD #4

Events: arterial line placed last PM to confirm hypotension and titrate pressors, remains on modest dose of norepinepherine

S: ""Bathroom""

O:

Neuro: pt is A&Ox3, converses well in English, MAE, [**Doctor First Name **] pain but has difficulty getting comfortable

Pulm: SRR 20's, LS gross expiratory wheezes in upper lobes, very diminshed at bases, O2 titrated to keep SpO2 > 90, SpO2 91-97%

CV: HR 87-99 SR with 1st AVB and occasional PVC's, BP 79-99/32-41 on Levophed totrated to keep MAP > 60, CVP 8-13, please see flowsheet for data

Integ: cellulitis in RLE, LLE has vascular discoloration, [**1-3**]+ edema BLE, otherwise C/D/I

GI/GU: abd is grossly obese, soft, NT/ND, BS are present, tolerating consitent carb diet, multiple soft stools, Foley is patent for small amts clear yellow urine

Access: right IJ TLCL day #4, left radial art line day #1

A:

altered breathing r/t chronic pulmonary disease, body habitus

risk for impaired skin integrity

risk for injury, cardio/cerebrovascular r/t hypotension

risk for infection r/t invasive lines, indwelling catheter

P:

continue to monitor hemdynamic/respriatory status, continue abx as ordered and follow microdata, continue pressors and wean as tolerated

"

"NPN

Neuro: Pt is awake and alert, she has had periods of aggitation and asking/insisting to get out of bed. After talking with her I explained to her that her BP was too low and getting out of bed could make her BP lower.

CV: She remains on levo, she is now down to .04mcg/min. Her Aline has been dampening, she now has a NBP on as well and when the aline is working the pressures are similar. She was given a 250cc bolus in hopes of getting her off of the levo.

Pulm: LS diminished at the bases, 02 SATs drop to the low 90s on RA, she is in the upper 90s on 3 L NC.

GI: Eating small amounts of her meals, decreased BM.

GU: U/O ~ 20-30cc/hr

"

"MICU NPN:

NEURO: A&Ox3 but has periods of confusion/agitation. Follows commands consistently and MAE in bed, although very weak. Complaining of pain in back from lying in bed and given tylenol prn.

CV: Tmax 99.4. HR 80s-100s 1st degree AV block. Hypotensive requiring levophed and titrating to goal MAP >60 (see carevue). Skin warm and dry with generalized 2+ edema. R IJ presept cath line intact with ecchymosis noted around site- patent.

RESP: Continues on 3L NC with O2 Sat >92%. LS clear and diminished at bases. Non-productive cough.

GI/GU: Abd. obese, soft with positive bowel sounds. No BM overnight although asking to go on bedpain q2-3hrs. On regular diet although pt. refusing dinner. States she has no appetite. Foley draining amber urine with sediment.

SKIN: Very small opening on coccyx with scant amts of pus draining- area cleaned and OTA- MDs aware. RLE cellulitus. Both [**Name Prefix (Prefixes) **] [**Last Name (Prefixes) 7965**]. L radial a-line intact.

"

"NPN 7P-7A

SEE CAREVIEW FOR ALL OBJECTIVE DATA.

NEURO: PT. VERY PLEASANT AND COOPERATIVE. REMAINS A+OX3. MAE. ASSISTS WITH TURNS. NO NEURO DEFICITS/PAIN ISSUES AT THIS TIME.

RESP: PT. REMAINS ON 6L NC WITH SATS >94%. BREATH SOUNDS CLEAR. DIMINISHED IN BASES. SOME CRACKLES NOTED IN BASES AT START OF SHIFT. NO SOB OR COUGH NOTED [**Company **] HIS TIME.

CV: PT. REMAINS IN FIRST DEGREE AV BLOCK WITH RATE 70'S TO 90'S. PT. REMAINS ON LEVOPHED GTT. NO CHANGES IN RATE MADE THIS SHIFT. R SC PRECEP CATH REMAINS IN WITH CVP MONITORING. 500CC NS BOLUS GIVEN OVER 2 HOURS FOR CVP OF 6. + PULSES. GENERALIZED EDEMA NOTED.

GI: PT. CONTINUES TO REFUSE TO EAT/DRINK ANYTHING FOR FEAR OF HAVING TO STOOL. HER ABD. REMAINS LG./SOFT. BS+. PT. HAD SMALL SMEAR OF BM. (NOT ENOUGH TO SEND SAMPLE) PT. COMPLAINING OF SOME CRAMPING.

GU: FOLEY CATH REMAINS IN PLACE WITH YELLOW URINE. APPROX. 20-40CC OUT PER HOUR.

ENDO: PT. REMAINS ON INSULIN GTT AT THIS TIME.

PLAN: AT THIS TIME CONT. WITH CURRENT POC. WEAN LEVOPHED AS TOLERATED TO MAINTAIN SBP >100. ? D/C INSULIN GTT IF SUGARS REMAIN WNL AND GAP CLOSES. (AM LABS PENDING) PT REMAINS DNR/DNI. NO CONTACT WITH FAMILY MEMBERS THIS SHIFT.

"

"NPN

Neuro: Pt is awake, alert, oriented, able to assist with her care. She hepls to turn herself in the bed, she is able to feed herself.

CV: Conts on levo, I am very slowly weaning it down, she is currently on .09mcg/kg/min with a SBP ~ 100, team is following her sytolic and will tolerat a SBP >90. Her CVP has been [**8-9**] today, she has not received any fluid boluses. She had a cardiac echo. She is in a 1st degree AV block, we are still holding her coumadin, she was restarted on her SQ hep since her coags have normalized.

Resp: Conts to have rales at the bases, this afternoon she had exp wheezes - she conts on her atrovent inhaler. Her 02 SAT is in the upper 90s on 6 L NC. She conts to take her 02 on and off as she feels fit.

GI: Less stooling today, her flagyl was changed to PO and her prilosec was d/ced. She has a better appitite today and has eaten both breakfast and lunch. She does not feel the urge to have a BM right after she eats.

GU: U/O 30-40cc/hr, her urine is now somewhat cloudy - to be sent for clx.

Soc: Her husband was in to see her.

Endo: She remains on 1.5 units/hr of insulin and her BS have been in the 90s.

"

"MICU EAST NPN 0700-1900

Please see flowsheet for further details...

A%&O per husband. Pt speaks some English. Somewhat withdrawn. Napping when undisturbed.

Levophed gtt remains between 0.02-0.08. Unable to wean despite 250cc IVB. Currently receiving 250ccIVB over ~3hrs. Remains in 1st degree AVB.

Stable O2sats on 3L n/c. Tol fluid boluses at present.

Afebrile. Flagyl changed to PO Vanco. Passed 1 med loose stool. L rad arterial line site appears very red/inflammed. Wave form occ dampened.

UO adequate. She is ~300cc + since midnight. PO intake poor.

Husband visited x2 today. Updated by pulmonary Fellow.

"

"MICU NPN 7P-7A

NEURO: ALERT AND ORIENTED X2, UNCLEAR OF WHERE SHE IS. DIFFICULT TO UNDERSTAND @TIMES [**1-2**] LANGUAGE AND OTHER TIMES TALKING WHILE SHE IS CRYING. PATIENT WEEPING/CRYING ASKING ""WHY?WHY?"", MOANING. ON CALL LIGHT ALL NIGHT FOR FREQUENT REPOSITIONING, ON/OFF BEDPAN. ASKING IF SHE CAN GET UP OR STAND. EXPLAINED TO HER THAT IT WOULD NOT BE SAFE AT THIS TIME TO GET HER OOB. C/O BACK PAIN AND ABDOMINAL CRAMPING, REFUSED TYLENOL

WHEN OFFERED. DENIED PAIN THIS MORNING. MOVING ALL EXTREMITIES AND FOLLOWING COMMANDS APPROPIATELY. GIVEN 5MG AMBIEN FOR SLEEP WITH LITTLE EFFECT.

CARDIAC: HR 87-93 BORDERLINE 1ST DEGREE AV BLOCK. NO ECTOPY. RECEIVED ON 0.02MCG OF LEVOPHED. USED FLUID BOLUSES AND WEANED OFF LEVO DURING THE NIGHT. BP 87-108/39-47 AND MAINTAINING MAPS >60. ART LINE POSITIONAL. HCT 31.9 DOWN FROM 33.9 MOST LIKELY DILUTIONAL FROM FLUID BOLUSES. NO SIGNS OF BLEEDING.

RESP: ON 2.5L N/C WITH RR 17-26 AND SATS 91-96%. FREQUENTLY REMOVING OXYGEN ABD WILL DROP SATS TO THE HIGH 80'S. LS CLEAR WITH DIMINISHED BASES. OCCSIONAL CONG NONPRODUCTIVE COUGH.

GI/GU: ABD OBESE WITH +BS. STOOL X2 BROWN AND LOOSE. UOP 35-60CC/HR AMBER AND CLEAR. CREAT 2.7 THIS AM, PATIENT'S BASELINE.

FEN: CVP 8-10. +7.6L LOS WITH ANASARCA. RECEIVED 250CC FLUID BOLUS X3. GIVEN GENTLY WITH H/O MODERATE AS. TOLERATED WELL WITH NO SIGNS OF RESP COMPROMISE. LYTES PER CARE, K+ 5.1, MD AWARE, WILL MONITOR. FS 6HRS WITH SS HUMALOG. PATIENT C/O THIRST. TOLERATING FLUIDS DURING THE NIGHT.

ID: TMAX 98 WITH WBC 19.1 DOWN FROM 24.5. ON CONTACT PRECAUTIONS FOR CDIFF. NOW ON PO VANCO.

SKIN: LLE WITH RESOLVING CELLULITIS. NO OPEN AREA APPRECIATED ON COOCYX, BARRIER CREAM APPLIED.

ACCESS: LEFT ART LINE (REDDENED) AND RIJ PSC (ECCHYMOTIC).

SOCIAL/DISPO: DNR/DNI. NO CALL FROM FAMILY. PLAN TO USE GENTLE FLUID BOLUSES FOR LOW BP WITH GOAL CVP 8-10. MONITOR UOP. NEEDS PIV/PICC SO CVL CAN BE D/C'D.

"

"CCU NSG PROGRESS NOTE-MICU BORDER.

O:PULM=O2 VIA SHOVEL MASK-50% @ 12L/MIN W SATS 91-96%. WO BIPAP. BREATH SOUNDS=DEMINISHED THROUGHOUT. UP TO CHAIR @ APPROX 0000- REMAINED IN CHAIR THROUGHOUT SHIFT.

CV=AF W CONTROLLED VENT RESPONSE-DILT 90MG PO QID. HEPARIN @ 1300U W AM PTT PENDING.

GU=LASIX @ 0200 W EXCELLENT RESPONSE. NEG 3L @ 2300 & 1.2L @ 0600.

ACCESS=MID LINE FUNCTIONING. ABLE TO DRAW LABS OFF.

SOCIAL=HUSBAND PRESENT TILL APROX 2100.

A:ADEQ SATS ON 50% SHOVEL MASK WO BIPAP. EXCELLENT RESPONSE TO IV LASIX-REMAINS VOLUME OVERLOADED, BUR RESP STATUS IMPROVING.

P:WEAN O2 AS TOLERATED-BIPAP AS NEEDED. [**Name (NI) 1720**] [**Name (NI) **] PTT. CONTIN PO DILT. CONTIN TID LASIX-FOLLOW BUN/CREAT. SUPPORT AS NEEDED.

"

"CCU NSG D/C SUMMARY: RESP FAILURE

ADMITTING DIAGNOSIS: RESP FAIURE

ALLERGIES: NKDA

TRANSFERING EVENT: Pt was initially admitted to floor [**11-26**] with 4-5 day history of increasing SOB and 10 days without bowel movement. She was in a-fib with rapid response to 140s. She R/O, has fair cardiac fuctioning, was rate controlled and diuresed. She had numerous enemas, laxatives, etc with no results, though x-ray showed massive amt stool in bowel. On [**11-27**] she became acutely short of breath with her CO2 up to 98 and pH down to 7.23. She was transfered to unit,further diuresed and placed on bi-pap. By [**11-28**] she was able to wean to 40% neb with sats in the low 90s.

PMH: NIDDM, HTN, CHF with nl EF- last admission [**1-29**]. Restrictive lung disease and probable sleep apnea. On home 02. Chronic constipation with QD enemas. Bilaterat lower extremitiy venous insufficiencey with chronic cellulitis.Morbid obesity.

REVIEW OF SYSTEMS:

ID: Pt has been afebrile with nl white ct.

RESP: Pts sats have continued to improve on 40% shovel mask with sats up to 97%. She will quickly de-sat to the low 80s when mask is off. She continue to rales up 1/2 on R and [**12-3**] on L. Episodes of sleep apnea, with transiently low sats have been noted at night when she if off bi-pap. She is now to receive bi-pap every night. Plan is for sleep study prior to D/c.

CV: Pt remains in a-fib. Rate in 80-90s, though she did go up to 1-teens prior to her dilt 90mg. She is also on digoxin. BP has been stable in 100-140/50s. She has been started on coumadin and as INR is 2.8 today heparin was shut off and coumadin dose decreased.

RENAL: Pt continues to be aggressively diuresed with lasix 60mg IV being given tid. She is about 10 liters neg LOS and over 2 liters thus far for today. Creatinine is one and has not bumped with diuresis.

GI: Pt was finally given [**Last Name (un) **] and magcitrate and has had numerous liquid stools. She is somewhat more comfortable. Last stool [**12-2**] at 6am G-.

ENDO: Pt on glucophage and ss reg insulin. Sugars have been mostly in 150s.

MS/SOCIAL: Pt alert and oriented. She is primarily Russian speaking, but has some English. She spends most of her time in the chair as she is better able to breath there. She is able to get up and move from bed to chair with minimal assistance. She is married and her spouse is very loving and supportive.

PLAN: Resp failure: continue aggressive diuresis. Bi-pap at night or with SOB. Keep careful I & O.

Alt in Bowel: Continue with laxatives and enemal prn.

D/C planning: Pt need sleep test before d/c and may need bi-pap at home.

"

"CCU NPN 1900-0700

Pleasant, cooperative Lithuanian lady admitted for CHF, GIB.

NEURO: A&Ox3, able to ID needs, denies pain. SMAE, c/o pain in lower ext on eves, relieved by sitting up in chair for a few hours. Ambulated with minimal assist to chair.

RESP: Pt is on home 02 2L, currently on 3L r/t some DOE with moving to and from chair. Denies SOB. No cough noted. Breath sounds clear anteriorly, with some bibasilar crackles.

CV: SB-NSR with occasional PVC's. Low BP 80s-100/20s-40s, but is mentating well and has adequate UOP. PO Lopressor held on eves. Hct on admit was 18, after 2 units PRBCs was 23, now after 2 more units PRBCs, Hct is 26.5. Pt also received 40mg lasix x2 doses. Pt has #20g PIV LAC capped with + blood return. Skin warm, dry with brisk cap refill.

ID: Afebrile, WBC 7.6.

GI: NPO except meds for possible endoscopy today. Obese abdomen with + bowel sounds. No BM this shift. Blood sugars 60s, pt drank some OJ and was asymptomatic. Team aware.

GU: Foley patent with clear yellow UOP with sediment at times. Diuresed with blood products, remains + 400 cc for LOS, - 400 since midnight.

DERM: Bilat LE with 4+ tight edema from knees down. + palpable pulses. Skin is reddened, tough but no broken down areas seen.

PLAN: Possible endoscopy today. Plan to DC diabetes meds, hold beta-blockers for SBP<100.

"

"CCU NPN: please see flowsheet for objective data

Cardiac: HR 58-70 SB-SR no VEA,BP 89-109/36-42 lopressor and lisinopril held. K 3.9 repleted with 20po.

GU/Volume: good urine output 120-300/hr then given 40mg lasix prior to first unit of blood,currently negative 1400cc. last BUN/Creat 101/3.2

Resp: lungs clear,diminished at bases. on 3l NP with good sats 97-100

GI: to have colonoscopy on Monday,just to have clear liquids over the weekend. protonix now IV. had duculax supp and has had two dark small stools,OB-. improved BS.

Heme: HCT 26.5 this am,goal is to have HCT greater than 30. just finished first of two more units of blood.

Endocrine: blood sugars have been low,ranging from 50-84. all diabetes meds have been d/ced and did not receive any today. on nites received [**12-1**] amp D50,during the day drank some warm apple juice.

Neuro: alert and oriented x3,very pleasant and cooperative

A/P: transfuse second unit of blood and then check HCT

follow lytes and replete as needed

cont to closely follow bloood sugars

"

"NPN

Neuro: Pt is alert and oriented, able to understand most of the things said to her - she is russian speaking. This morning she briefly became very aggitated, wanted to stand up, able to calm her by talking with her. She has been very cooperative this afternoon, helping to turn and reposition.

CV: She remains on the levo, I have been able to wean her by ~ 25%. She remains in a 1st decree AV block. She conts on amiodorone. CVP 12-15, she has not received any fluid boluses.

Resp: She still has rales ~ 1/2 up from the bases, remains on 6 L NC with 02 SATs in the mid 90s, she occationally takes her 02 off but she will put it back on when asked to do so. She denies resp distress.

GI: Cdif came back possitive this morning from the lab, she is on IV flagyl, she does c/o some abd pain occationally but it goes away without intervention. Her WBC is 45 today up from 41, she has been afebrile. She has been on the bedpan 2-3 times today for a small amount of greenish stool. She ate a late breakfast, didn't want to eat lunch, is afraid that eating will make her go to the bathroom.

GU: U/O 20-25cc/hr, no fluid boluses were given today.

Endo: Blood sugars elevated, she was started on an insulin gtt, last FS was 125.

Skin: She has a small opening on her coccyx, it is draining yellow/green pus - clx sent. It felt like she had crepitis around the area as well and up into her back but on further palpation I didn't feel it. The opening was seen by the team.

Soc: Her husband and daughter were in.

"

"RESPIRATORY CARE:

Following pt for nocturnal BIPAP. Pt placed on mask ventilation at 10pm- Insp press=10. Exp press=5 FiO2=30%. Pt maintained good SaO2's while on support, though removed bipap in the middle of the noc. See flowsheet for further pt data.

Plan: Follow at noc. for bipap.

"

"MICU NPN (IN CCU)

S- C/O SOB

O- AFEBRILE. CV- HR 90S-116 AF, SHORT BURSTS TO 140 WITH ACTIVITY. BP 100-120S/. RE'D 60MEQ KCL PO AND REPEAT K 4.4 THIS PM, MG 2.0. HEPARIN CONT. AT 1300UNITS/HR.

RESP- ON 45% COOL NEB/FACE TENT ALT. WITH 4L N/C, GOAL SAT 87-92. SATS HIGHER WITH NEB. SOB WITH ACTIVITY. ALSO BIPAP TONOCT AS TOL. DIURESED WELL TO AM LASIX AND REPEATED AT 6PM. L/S DIM, OCC WHEEZES WHICH RESPOND WELL TO ATROVENT NEBS PER RT. CONT. WITH FOLEY.

GI- APP. GOOD. BS 140, 148, 162, NO COVERAGE. PO DM MEDS GIVEN.

MS- A+O X3.

SOCIAL- FX IN, SUPPORTIVE.

ACTIVITY- OOB CHAIR X2, BREATHS BETTER IN CHAIR. SOB GETTING BACK TO BED.

ACCESS- VERY DIFFICULT- IV TEAM TO PLACE PICC TOMORROW.

"

"CCU NPN

S:""NOT GOOD...(TALKING ABOUT HER STOMACH)."

O: SEE VS/OBJECTIVE DATA PER CARE VUE.

ID: AFEBRILE

CV: HR BETTER CONTROLLED TONIGHT, RANGING HIGH 70-90'S AFIB WHILE ASLEEP INCREASING TO 100-110'S WHEN AWAKE. BP STABLE 90-110'S. FINISHED DIG LOAD AND CONTS ON DILT. HEPARIN CONTS AT 1300U/HR.

RESP: O2 AT 40% COOL NEB WITH SATS 88-91%, BECOMES SOB WITH ANY MOVEMENT. ATTEMPTED TO PLACE ON 4LNP BUT SATS IN LOW 80'S. LUNGS WITH CRACKLES 1/2 UP BILAT, INCREASED LASIX TO 60MG TID. ATTEMPTED BIPAP BUT TOLERATED ONLY 1 1/2 HOURS THEN BACK TO FACE MASK BUT SATS DECREASED TO LOW 80'S UPPER 70'S THEREFORE BIPAP REINSTITUTED WITH IMPROVED SATS. NO COUGH OR SPUTUM.

GI/GU: TAKING SIPS OF WATER. OOB TO COMMODE FOR LIQUID BROWN BM APPROX 200CC THAT WAS GUIAC NEG. C/O STOMACH ""RUMBLING"". PT REQUESTING TO SIT UP IN CHAIR TO AID WITH STOMACH.

MS: APPROPRIATE. HUSBAND IN TO VISIT TONIGHT. ABLE TO GET OOB TO CHAIR WITH ONE ASSIST, STABLE ON FEET.

"

"micu npn (in ccu)

o- afebrile. cv- hr 80s-113 afib. bp 109-133/. k-3.9 this pm, replaced with 60meq po x1. hct 29.1. cont. on heparin 1300units/hr, ptt 58 this pm but heparin had been off for about 1hr for line placement, ho aware.

resp- on 45% cool face tent alt. with 4l n/c for meals. required face tent most day. sats 87-94, down to 79 x1 while asleep. l/s with cxs lower [**12-2**]. cxr done. lasix 60mg iv tid with good diuresis. soe, must stop between each phase of activity (such as going back to bed) to catch her breath.

gi- app. good earlier in day, refused dinner. no bm, colace increased and drank 1 bottle mag citrate this pm.

dm- no coverage needed.

ms- a+o x3, anxious at times. c/o r shoulder pain, ho aware. dinamap moved to opposite arm, med. with tylenol this am with effect. c/o again this pm and refused tylenol.

access- iv midline placed this pm by iv team. position readjusted per cxr by iv rn. midline is drawing blood back.

social- husband in most day, supportive. other visitors in also.

"

"npn 7p-7a continued:

social:

pt w/ supportive husband; grandson also in to see pt yesterday during the day;

husband acknowledges DNR/DNI;

PLAN:

1) notify husband for changes in pt status, or decrease

(intern plans to call him at 07:00 this a.m.)

2) vasopressor for adequate b/p

3) insulin gtt for normal blood glucose

4) IV Abx as ordered

5) will check tube feed resid again at 6a

6) hrly FS's for insulin gtt

7) contact precautions

8) careful re turning pt on side

9) bite block/airway in use to prevent tongue occlusion of airway

"

"AFINARD 4 ICU NPN 0700-1900

Sats dropped to 55% on 6L NP when tlited on R side for repositioning. Placed back in supin position with HOB 35 degrees with no improvement. Hi-flow mask added with sats to 100%. Suctioned mouth for tan secretions- ? TFVBG this afternoon 102/132/6.81/24/-18. Did not tol mask ventilation due to breathing pattern.

Levophed increased to 0.3. BP now in the low 70's with HR 59-62 1st degree heart block. No VEA noted. K 5.7. Unable to give K-exalate via NGT 2/2high residuals, asp risk or PR [**1-2**] being unable to turn pt due to tenueous resp status. Team aware. Nail beds & finger tips becoming bluish color.

Unresponsive to deep pain. No spont movement. Wrist restraints d/d'd.

[**Name (NI) 15**] husband in to visit most of the shift. He has been updated throughout the shift by this nurse as well as house staff. Dtr in this afternoon from N.Y. Updated on pt's condition as well. Remains DNR/DNI. Resident states family declining morphine sulfate gtt at htis time. SS to touch bases with family.

Cont with min UO.

Afeb. On antibiotics

TF off d/t high residuals

Insulin gtt currently at 5u hr. BS 102-220.

A/P: Unresponsive with resp failure, hypercarbic resp failure now hypotessive on max levo.

Family aware of grim prognosis. Support to family.

"

"[**Hospital Ward Name 363**] 4 ICU NPN ADDENDUM

Pt becoming progressively more hypoptensive with subsequent asystole. Family at bedside.

"

"CCU NPN 1900-0700

S/O:

TM 98.8po. HR 58-60's NSR. no VEA. BP 87-121/30's-50's.

RR 12-19, unlabored. LS diminished. sats 94-99% on 3lnc.

pt. developed nose bleed during night resolving with pressure. O2 changed to face tent 50%. pt. states that she gets nose bleeds at home.

transfusion completed at 2300. post transfusion HCT 30 . K+ 4.4/cr down to 2.7. AM labs pnd at 0600.

u/o 60-100cc/hr. negative 1.8L for [**9-21**].

drinking clear liqs- water/g-ale. no stool.

OOB to chair with one assist ~ 0400.

FS 69-86. no coverage.

A/P: follow HCT's, lytes. clear liqs only. ? start bowel prep today. face tent prn for nose bleed.

"

"Nursing Admit Note

This is a 73 yo female with a past med hx of CRI, (baseline 2.7) DM, HTN, CHF - takes 40mg lasix [**Hospital1 26**], restrictive lung dz secondary to obesity, hyperlipidemia, moderate AS, afib on coumadin and amiodorone, hypothyroidism, iron def anemia, B12 def, venous insufficiency, LLE and L hand cellulitis, glaucoma, who was recently d/ced from here after being treated with antibiotics for a cellulitis. She came to the EW after 7 days of diarrhea and a decreased PO intake. She was hypotensive in the EW, given 5 liters of IVF, starte on levo, code sepsis called. CT of abd showed diffuse colonic wall thickening, CHX showed mild CHF. blood, urine, stool specs sent. In the MICU she is awake, oriented x3, on and off bed pan with stoolx1 - black in color but guiac neg. Remains on the levo at .13, CVP 12-20, [**Last Name (un) 879**] stim done, SV02 79. He hosband was in to visit.

All: NKDA

Neuro: Alert and oriented, feels tired.

CV: SBP 90s-100s, levo remains on .13, CVP 13-20, IVF stopped, conts on abx. Precep cath with a SV02 of 79%.

Resp: LS diminished in the bases, 02 SAT on 6 L is in the upper 90s.

GI: On the bedpan numerous times but had stool once, on IVF, she will need 2 more stool specs for cdif.

GU: her urine is light in color, u/o ~50cc/hr, she is presently off on her [**Hospital1 26**] lasix, Na is 128, creat 3.7

Endo: BS in the 200 range, she is on QID FS with coverage.

Soc: Her husband was in to visit.

"

"CCU NURSING ADMISSION NOTE

68 YO RUSSIAN SPEAKING WOMAN ADMITTED FROM PACU S/P RESP FAILURE ON FLOOR (NO MICU BEDS).

PMH: NIDDM, HTN, CHF WITH NL EF LAST EPISODE [**2-7**], MORBID OBESITY, RESTRICTIVE LUNG DISEASE, GERD. CHRONIC O2 AT HOME. CHRONIC CONSTIPATION WITH WITH QD ENEMAS AT HOME. HX BILAT LE VENOUS INSUFFICINCY WITH CELLULITIS.

HPI: SOB X4-5 DAYS AT HOME WITH COUGH, HR AT HOME INC TO 130'S WHEN NORMALLY. PT ALSO HAD NOT HAD A BM IN 10 DAYS WITH INC ABD DISCOMFORT.

PT ADMITTED TO FLOOR [**11-27**] AND R/O'D, DIURESED, HEP BEGUN, AND DILT STARTED FOR RAPID AF. AT 0800 [**11-28**], PT BECAME ACUTELY SOB WITH CO2 TO 98 AND PH 7.23. PT DIURESED FURTHER, PLACED ON CPAP 12 AND TRANSFERRED TO PACU. PT IMPROVED OVER COURSE OF DAY AND WEANED TO 40% NEB DURING DAY WHEN SHE IS UP IN CHAIR. ON IV DILT BRIEFLY FOR RATE CONTROL. REC'D SS ENEMAS X3, DULCOLAX, LACTULOSE AND MOM WITH NO RESULTS. ENEMAS REVEALED NO STOOL IN RECTUM.

CV: AF, RATE 70'S-90'S WITH LEFT BUNDLE. WANT K 4.0 OR MORE TO INC BLOOD ACIDITY. DILT AT 60 MG QID. HEP AT 1300U/HR, PTT THERAPEUTIC.

RESP: CURRENTLY ON 40% NEB WITH SATS IN LOW 90'S. LUNGS WITH CRACKLES 1/3 UP BILAT. RR IN 20'S, NON-LABORED. PT STATES SHE IS COMFORTABLE.

OCC WHEEZING.

ID: AFEB, WBC 11.

GI: NO STOOL TODAY, AWAITING GOLYTELY FROM PHARMACY. PT DRINKING CLEAR LIQS TODAY. HCT 30.

GU: FOLEY IN, 2L NEG FOR TODAY.

ENDO: COVERED WITH SS REG INSULIN, ON GLUCOPHAGE AT HOME.

MS: A AND O, DAUGHTER TRANSLATES FOR PT. PT LIKES TO SIT IN CHAIR, CANNOT LIE FLAT. PT HAS EXPRESSED HER DESIRE THAT SHE NOT BE INTUBATED IN THE PAST. LIVES AT HOME WITH HUSBAND.

A/P: START GOLYTELY WHEN AVAILABLE. FOLLOW RESP STATUS CLOSELY. DNI. KEEP K >4. WANT PT AT LEAST 1 LITER NEGATIVE TODAY. CPAP WHEN PT GETS INTO BED TONIGHT.

"

"CCU NPN

S: RUSSIAN SPEAKING

O: SEE VS/OBJECTIVE DATA PER CARE VUE.

ID: AFEBRILE

CV: INITIALLY WITH ELEVATED HR RANGING 100-120'S REC'D TOTAL OF DILT 10MG IV X 2 AND ADDITIONAL 30MG PO DILT WITH DECREASE IN RATE TO 80-90'S. INCREASED 12AM DOSE OF DILT TO 90MG WITH GOOD EFFECT, HR MAINTAINED HIGH 80'S TO LOW 100'S. AT TIME OF ELEVATED HR SHE DID C/O FEELING HER HEART POUND IN HER CHEST. BP STABLE. HEPARIN CONTS AT 1300U/HR AND SHE REC'D HER COUMADIN.

RESP: INITIALLY ON 40% NEB WITH SATS 89-93%. CHANGED TO BIPAP AT 10:30PM FOR SLEEP. SHE TOOK IT OFF A FEW TIMES BUT WAS AMENABLE TO HAVING IT PLACED BACK ON. SHE TOLERATED THIS UNTIL APPROX 4AM THEN WANTED IT OFF. LUNG SOUNDS ARE DIMINISHED THROUGHOUT. HAD A GOOD DIURESIS TO LASIX THAT WAS GIVEN AT 6PM, BUT WAS TAKING GOLYTELY SO NOT AS NEGATIVE AS SHE SHOULD BE.

GI/GU: NO BM. HAD ANOTHER 400-500CC OF GOLYTELY. BLOOD SUGAR 311 AND WAS COVERED BY SS INSULIN.

MS: SLEPT ON/OFF THROUGH NIGHT. SHE IS ABLE TO UNDERSTAND BITS AND PIECES AND IS ABLE TO GET WHAT SHE WANTS ACROSS TO YOU. HER FAMILY IS VERY SUPPORTIVE OF HER AND VISITED UNTIL 8PM. SHE GOT OUT OF BED TO CHAIR AFTER HER BIPAP WAS OFF, SHE NEEDED ONE ASSIST.

A: CONT WITH BOUTS OF RAPID AFIB THAT IS CONTROLLED WITH DILT

DIURESED WELL WITH LASIX

NO BM

P: CONT WITH DILT, ? INCREASE TO 120MG

CONT WITH DIURESIS DUE TO LARGE INTAKE WITH GOLYTELY

CONT BOWEL PREP

"

"RESP: UNABLE TO ASSESS BS'S THIS AM D/T THE PATIENT SNORING. DID ATTEMPT TO NASALLY SUCTION, WITH SOME BLOODTINGED SECRETIONS. O2 SATS DID IMPROVE HOWEVER. O2 NP 4L.

GI: ABD CT DONE- C-DIFF COLITIS IMPROVED. BLADDER PRESSURE 32. TO BE STARTED ON NEPRO TF'INGS AT 10CC/HR.

ENDOC: K+ 6.3 THIS AM. GIVEN K-EXYLATE WITH NO STOOL. LATER GIVEN 10U INSULIN IVP AND 50GM DEXTROSE AND 2AMPS CA+ GLU. LAST K+ 5.9. TO GET ANOTHER DOSE OF K-EXYLATE WHEN IT COMES FROM THE PHARMACY.

RENAL: VERY POOR U/O'S. PT. IN ATN. GIVEN 1X BOLUS OF NS AT 500CC. WITH NO EFFECT. CREAT 3.5. BUN 80.

CV: LEVOPHED CONT. AND NEEDED TO BE INCREASED. BP DID IMPROVE.

NEURO: PT. WAS MEDICATED ON NIGHTS WITH VERSED. SLEEPY THIS AM, BUT FAILED TO WAKE UP. GIVEN FLUMENZIL WITHOUT EFFECT TO REVERSE THE VERSED. PT. EVENTUALLY OPENED HER EYES ON COMMAND, BUT DIDN'T REMAIN OPEN. HEAD CT NEG. UNRESPONSIVENESS ? D/T ATN. VS SEPSIS.

ID: URINE CX-POSITIVE. STARTED ON LEVOQUIN. FEBRILE TO 100.8AX THIS AM , BUT TEMP BACK TO 98.8AX AT 16PM WITHOUT TYLENOL. BLOOD CX'S SENT THIS AM.

SOCIAL: HUSBAND AND GRANDSON INTO VISIT.

ATTENDING SPOKE WITH THE HUSBAND RE: PT'S CONDITION AND PROGNOSIS.

PLAN: NEED TO RECHECK LYTES IF PT. STOOLS, OR THIS EVENING.

RECHECK BLADDER PRESSURES.

INCREASE TF'INGS AS ORDERED.

FLUID BOLUSES AS NEEDED.

ABG'S TO BE DRAWN BY HO.

"

"npn 7p-7a (see also carevue flownotes for objective data)

dx: c-diff colitis--sepsis pt DNR/DNI

73 yo fe admitted [**6-13**] for diarrhea,fevers,hypotension;

had recently been treated at [**Hospital1 95**] for cellulitis and sent home;

significant problem has been pt's continual progressive renal failure, w/ hi elevating K+, elevating phos--husband/MD's state pt will not be put on dialysis;

neuro:

pt a/o when better after admission, though lethargic; however over past few days w/ progressive renal failure, pt has had decrease in LOC, is barely responsive--mostly to noxious stimuli now;

c-v:

pt remains on levophed at 0.074 mcg/k/min, no change overnight;

pt did not respond to NS 500 cc fluid boluses previous 24 hrs;

this a.m. pt ordered for LR 500 cc bolus d/t pt's acidosis and continued low urine output and need for vasopressor;

resp:

pt remains on [**3-5**] l nc O2, with O2 sats 94-95; pt's respirations shallow;

g-i/blood sugars;

pt started on tube feeds, tolerating so far--resid 15 cc's at approx 02:00;

blood sugars elevated despite ss coverage--therefore pt ordered for insulin gtt, started when available from pharmacy (04:45);

no stool this night;

g-u:

0-5 cc/hr urine output d/t renal failure;

pt receiving 500 cc LR IVF bolus as stated above (at 04:45);

GNR in urine, started on new abx (cefepime, gentamycin x1 (hi dose noted);

access:

pt received new left subclav [**First Name9 (NamePattern2) **] [**Last Name (un) **] cvl [**6-20**], being used for vasopressor, insulin gtt, and IVF's/IV abx;

skin:

cvl site oozes a small bit--pt w/ resolving elevated INR:

bottocks/peri-area cleansed, barrier cream appplied;

back care given;

**pt did not tolerated being on side for back/skin care, had ectopy, face became grey/ashen--pt returned to back/supine position

tbc

"

"RESP: O2 SATS ADEQUATE. PRESENTLY ON 4L NP. BS'S ESS. CLEAR WHEN ABLE TO TAKE DEEP BREATHS.

GI: TAKING SMALL AMTS OF BROTH FROM HOME. LIKES HER DRINKS WARM NGT PLACED FOR K-EXYLATE. SHOULD REMAIN IN FOR MEDICATIONS. PH 3 GUAIAC NEG. INCONT. 1X OF LARGE AMT OF LIQUID STOOL.

RENAL; POOR U/O'S ALL DAY. GIVEN SEVERAL FLUID BOLUSES. WITH POOR RESULTS.

ACCESS: TRIPLE LUMEN PLACED. UNABLE TO PLACE ANOTHER PERIPH. BLEEDING FROM SUBCL. SITE.

CV: BP RESPONDING TO FLUID BOLUSES, BUT PT THIRD SPACING. CVP 8-11. PROBABLY NEEDS MORE FLUID OR PRESSORS TO MAINTAIN AN ADEQUATE BP.

NEURO: VERY AGITATED THIS AM. MOANING AND SCREAMING. UNABLE TO COMMUNICATE WELL, TIL HUSBAND [**Name (NI) 1495**]. GIVEN 1.5MG VERSED FOR LINE PLACEMENT AND PT. SLEPT SEVERAL HOURS AFTER THAT.

ID: TEMP 100. THIS AFTERNOON. PRESENTLY APPEARS TO HAVE CHILLS-TEMP 99.8 AX. RESTARTED ON VANCO THROUGHT NGT.

ENDOC: REQUIRING SSI FOR BS'S. REPEAT K+ SLIGHTLY HEMOLYZED WAS 5.5. WOULD RECHECK LYTES THIS EVENING. CA+ REPLETED WITH 1 GM CA+ GLUC.

SOCIAL: HUSBAND IN MOST OF THE DAY.

S

"

"MICU EAST NPN 0700-1900

Please see flowsheet for further details.

Listless and withdrawn at times. Occ moaning but refusing pain med. C/O of foot pain and pneumo boots taken off with improvement.

INR continues to rise to 6.2. S.C. Heparin dc'd. No noted bleeding. MD [**First Name (Titles) **] [**Last Name (Titles) **] central line. PO Vitamin K given x1.

BP stable off Levophed.

Afebrile but w/bandemia. Though she did take her po Vanco this am it was changed to IV Flagyl. BC x1 from R IJ and U/A C/S sent. Plan to dc central line and send tip for culture. Has 2 PIVs in place. MD will place central line only if needed.

Apetite poor though taking liquids fairly well. Loose stool x2...sm-med amt.

Husband visited x2 and spoke w/RN Case [**Name6 (MD) **] and MD. Plan to keep pt in ICU for now d/t her new bandemia.

"

"MICU NURSING PROGRESS NOTE. 1900-0700

PLEASE SEE CAREVIEW FOR OBJECTIVE DATA.

Events: No significant changes o/n. Appears to have increased confusion this a.m.

Neuro: Alert and appeared oriented at start of shift. Able to follow commands, calm and cooperative. Medicated for shoulder/le discomfort with 5 mg oxycodone with good effect, was able to sleep for several hours. Awoke this a.m. during care and appears more confused, calling out "" why why why why"". Is unable to clarify needs or if she is uncomfortable. Medicated with 325 mg tylenol po with warm water. Spit out other tylenol.

Respiratory: Lung sounds are coarse in upper fields, bilat, diminished in lower fields bilat. Rr 12-28, tachypneic with agitation. O2 saturation 92-97% on 2l nc. Occn drops in o2 due to removing n.c. Occn congested but non productive cough.

CV: First degree a/v block with ventricular ectopy, rate 70's to 90's. Nbp high 80's to low 110's systolic. 2 peripheral iv's intact.

Team aware of occn bp drops that are remedied by arousing pt.

GI/GU: Abdomen obese with hypoactive bs. Able to take small sips and swallow pills. No bm as of this time. Foley catheter patent and draining yellow urine with sediment in decreasing amts.

Social: No social contacts o/n.

ID: Continues on flagyl iv.

Plan: Probable call out to the floor today. Monitor bp and tx as required. Micu dnr/dni

"

"npn 7p-7a (see carevue flownotes for objective data)

pt w/ recurring hypotension yesterday; [**6-20**] a.m. labs suggested pt intravascularly dry; pt received NS 500 cc IV bolus over 60-90 minutes x 5 over past 24 hrs (given over 60-90 minutes d/t pt's AS); urine ouput and b/p remained low, therefore pt started on IV levophed; also notable is pt w/ poor to no po food intake for several days, 1 week ago serum albumin already low, discussed w/ MD team, serum albumin ordered to be drawn w/ a.m. labs; low albumin could contribute to 3rd spacing of body fluids and hypotension; discussed possiblity of starting nutrition--MD [**First Name (Titles) 237**] [**Last Name (Titles) 7968**] for a.m. rounds to address plan for nutrition;

pt receiving abx as ordered; afebrile overnight;

new lft subclav [**First Name9 (NamePattern2) **] [**Last Name (un) **] cvl pulled back by MD team, re-dressed; stat p-cxr done to check placement, MD team stated placement/tip position confirmed; additional oozing of bloody drainage at cvl insertion site noted--pt also w/ current issue of elevated INR (coumadin on hold, pt has received vit K0;

pt's husband present at beginning of this 12 hr shift;

pt had small amt brown diarrhea at approx 03:00;

PLAN:

1) check results a.m. labs

2) note serum albumin and K+

3) team to address nutrition issue(s)

4) abx as ordered

5) skin care

6) coping support to husband

7) follow resp exam re IVF boluses

8) pt DNR/DNI

"

"NPN 7P-7A

SEE CAREVIEW FOR OBJECTIVE DATA.

NEURO: PT. IS RUSSIAN SPEAKING, HOWEVER DOES UNDERSTAND AND SPEAK SOME ENGLISH. A+OX3. ASSISTS WITH TURNS. NO PAIN ISSUES AT THIS TIME. PT. SLEPT THROUGHOUT MOST OF SHIFT.

RESP: PT. REMAINS ON 6L NASAL CANNULA WITH SATS REMAINING >95%. SHE DOES TAKE OXYGEN OFF AT TIMES AND IMMEDIATELY DESATS TO HIGH 80'S. BREATH SOUNDS CLEAR. DIMINISHED IN BASES. NO COUGH NOTED. SOME SOB PRESENT WITH ACTIVITY.

CV: PT. REMAINS IN FIRST DEGREE AV BLOCK WITH RATE 70'S TO 80'S. PT. REMAINS ON LEVOPHED AT THIS TIME. HER BP HAS RANGED FROM HIGH 60'S TO LOW 120'S. HER HYPOTENSION DID NOT RESPOND TO 500CC NS BOLUS GIVEN. ALSO, WITH THE LOW BP, UO APPEARS TO DECREASE, HOWEVER, MENTAL STATUS DOES NOT CHANGE. LEVOPHED TITRATED TO ATTEMPT MAINTAIN SBP AROUND 100. GOAL IS NO LONGER TO MAINTAIN MAP>60 D/T LOW DIASTOLIC PRESSURES. CVP HAS REMAINED AROUND [**11-13**]. SVO2 RANGING FROM 79-89. + PULSES. AFEBRILE

GI: ABD. OBESE. BOWEL SOUNDS DISTANT. PT. REFUSING TO EAT OR DRINK THIS SHIFT STATING ""I WANT TO SLEEP"". PT. PLACED ON BEDPAN MULTIPLE TIMES BUT NO BM.

GU: FOLEY IN PLACE. APPROX. 30-40CC OUT PER HOUR.

SKIN: INTACT

ACCESS: R SC PRECEP CATH. BRUISING NOTED AROUND SITE.

R HAND 18G PIV

PLAN: CONTINUE WITH CURRENT POC. CONTINUE TO WEAN LEVOPHED AS TOLERATED. MONITOR RESP./CV STATUS CLOSELY. AM LABS PENDING AT THIS TIME. COLLECT STOOL FOR [**Name (NI) 5270**] IF PT. HAS BM. (2 MORE SAMPLES NEEDED). PT.'S HUSBAND CALLED LAST NIGHT AND HE WAS UPDATED ON HER CONDITION. WILL BE IN THIS AM TO VISIT. PT. REMAINS DNR/DNI.

"

"ADDENDUM TO NPN 7P-7A

PT.'S PT/PTT/INR REDRAWN TWICE ALL WITH ABNORMAL RESULTS. 5MG VIT K IVP GIVEN FOR INR OF 12.2. CONT. TO MONITOR CLOSELY.

"

"Mrs [**Known lastname 7966**] is a 73 year old Russian speaking patient admitted of sepsis; upon admission she had diarrhea, hypotensive, lactate 3.5. on C-diff precaution. History of Anemia, CHF, DM, Hypertension. Recently hospitalized because of cellulitis.

neuro: patient oriented x 2, had been crying most of the day. often times would deny any pain, needs encouragement to take meds and food. cries and yells during turning, asks for bedpan often. can speak and understand English. transfered out of bed using [**Doctor Last Name 43**] lift. stayed only for 10 mins, patient has to use bedpan.

cardio: BP @ high 80's - low 100's, 1st degree AV block, edema of extremities continues, elevated with pillow. arterial line dc'd, with new peripheral line @ Left LFA. RIJ patent + hematoma.

respi: O2sats @ >95% @ 2.5 lpm, denies shortness of breath. lung sounds clear, diminished @ bases.

GI/GU: contact [**Name (NI) **] maintained, small bowel movement x 2, greenish, mucoid foul smelling. very poor appetite, refused fluids.

F/E: received 250 cc fluid bolus x 1 for low BP and urine output of 20cc, = 194 for 24 hr period. BUN 73, creatinine 2.7

Social: husband at bedside most of the day, updated of latest plan of care. interpreter in this am, helps in communicating needs of patient and assessment of patient's orientation.

plan:

maintain on contact precaution

monitor for signs &symptoms of hypo/hyperglycemia

for transfer out of MICU once there will be an available bed

monitor hemodynamic status

PICC line insertion and take out RIJ IVline

"

"addendum:

patient continues on Vancomycin oral liquid, afebrile the whole shift. Levofloxacin dc'd today. PRN oxycodone for pain made. Still on Humalog sliding scale, coverage changed. latest fingerstick 130. had fair appetite @ dinner, finished the mashed potato served and took good amount of fluids. calm and cooperative, denies any pain. patient call out status dc'd @ this time, for monitoring.

"

"NPN 7P-7A

SEE CAREVIEW FOR OBJECTIVE DATA.

PT. WAS INITIALLY CALLED OUT TO FLOOR YESTERDAY BUT WAS CALLED BACK IN D/T LOW BP AND DECREASED UO.

NEURO: PT. ALERT AND ORIENTED X2. SHE CONTINUES TO MOAN AND CRY WITH TREATMENTS AND TURNING YET REFUSES ANY PAIN MEDICATION.

RESP: PT. ON 2L NASAL CANNULA WITH SATS MID 90'S. BREATH SOUNDS CLEAR/DIMINISHED IN BASES. DENIES ANY SOB. NO COUGH NOTED.

CV: PT. REMAINS IN FIRST DEGREE AV BLOCK. SBP HAS RANGED FROM HIGH 70'S TO LOW 100'S. WITH HYPOTENSION UO DECREASES. THREE 250CC NS BOLUSES GIVEN THROUGHOUT SHIFT WITH LITTLE

EFFECT. WILL CONSIDER RESTARTING LEVOPHED IF HYPOTENSION CONTINUES. [**2-1**]+ EDEMA IN ALL EXTREMITIES. R IJ PATENT. + HEMATOMA AT SITE.

GI: PT. ON DIET, HOWEVER HAS BEEN REFUSING TO EAT X2 DAYS. PT. ALSO REFUSING TO TAKE PILLS. ABD. OBESE. + BS. PT. HAD LARGE BM THIS SHIFT. ON CONTACT PRECAUTIONS FOR C-DIFF.

GU: FOLEY DRAINING 10-40CC PER HOUR. MDS AWARE.

SKIN: SMALL OPEN AREA ON COCCYX

PLAN: CONTINUE TO MONITOR BP AND UO. RESTART LEVOPHED IF NEEDED. ? START [**Name (NI) 7967**] IF PT. CONTINUES TO REFUSE FOOD. PT. REMAINS DNR/DNI

"