"Admission Date: [**2122-7-14**] Discharge Date: [**2122-7-29**]

Date of Birth: [**2044-10-22**] Sex: F

Service: CARDIOTHORACIC

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 1505**]

Chief Complaint:

Type A Aortic Dissection

Major Surgical or Invasive Procedure:

[**2122-7-14**] - Emergent repair of aortic dissection

History of Present Illness:

77 year old female found to have a type A aortic dissection at [**Hospital3 **], Her pain started the night prior to admission and was localized to her chest with radiation to her back. A CT scan at [**Hospital1 **] revealed a type A dissection and she was transported to the [**Hospital1 18**] for emergent surgical management.

Past Medical History:

HTN

Aortic aneurysm

DM

CRI

Social History:

Lives with Husband

Family History:

N/C

Physical Exam:

110 186/110 157cm 120lbs

GEN: WDWN in NAD

SKIN: Warm, dry, no clubbing or cyanosis.

HEENT: PERRL, Anicteric sclera, OP Benign

NECK: Supple, no JVD, FROM.

LUNGS: CTA bilaterally

HEART: ST, no M/R/G

ABD: Soft, ND/NT/NABS

EXT:warm, 1+ DP/PT pulses, no bruits, no varicosities.

NEURO: No focal deficits.

Pertinent Results:

[**2122-7-29**] 02:19AM BLOOD WBC-12.6* RBC-3.20* Hgb-9.5* Hct-29.9*

MCV-94 MCH-29.7 MCHC-31.8 RDW-16.2* Plt Ct-518*

[**2122-7-28**] 03:28AM BLOOD WBC-14.6* RBC-3.31* Hgb-10.0* Hct-31.0*

MCV-94 MCH-30.3 MCHC-32.4 RDW-16.1* Plt Ct-531*

[**2122-7-27**] 03:06AM BLOOD WBC-13.3* RBC-3.16* Hgb-9.4* Hct-29.3*

MCV-93 MCH-29.7 MCHC-32.0 RDW-16.1* Plt Ct-472*

[**2122-7-26**] 12:51AM BLOOD WBC-14.0* RBC-3.31* Hgb-9.9* Hct-30.8*

MCV-93 MCH-30.0 MCHC-32.2 RDW-15.7* Plt Ct-461*

[**2122-7-26**] 12:51AM BLOOD PT-12.9 PTT-39.9* INR(PT)-1.1

[**2122-7-29**] 02:19AM BLOOD Glucose-145* UreaN-36* Creat-1.1 Na-147*

Cl-116* HCO3-25

[**2122-7-28**] 04:00PM BLOOD K-3.8

[**2122-7-28**] 03:28AM BLOOD Glucose-107* UreaN-36* Creat-1.2* Na-148*

K-3.6 Cl-113* HCO3-24 AnGap-15

[**2122-7-27**] 03:06AM BLOOD Glucose-193* UreaN-38* Creat-1.1 Na-145

K-3.6 Cl-113* HCO3-27 AnGap-9

[**2122-7-26**] 12:51AM BLOOD Glucose-147* UreaN-43* Creat-1.3* Na-144

K-4.0 Cl-113* HCO3-24 AnGap-11

[**2122-7-25**] 01:42AM BLOOD Glucose-111* UreaN-46* Creat-1.3* Na-146*

K-4.4 Cl-113* HCO3-27 AnGap-10

[**2122-7-24**] 02:06AM BLOOD Glucose-147* UreaN-50* Creat-1.5* Na-145

K-3.8 Cl-109* HCO3-27 AnGap-13

[**2122-7-17**] 01:51AM BLOOD ALT-5 AST-34 LD(LDH)-230 AlkPhos-115

Amylase-132* TotBili-0.6

[**2122-7-29**] 02:19AM BLOOD Phenyto-9.3*

[**2122-7-28**] 03:28AM BLOOD Phenyto-7.9*

[**2122-7-27**] 03:06AM BLOOD Phenyto-8.9*

[**2122-7-26**] 12:51AM BLOOD Phenyto-11.7

[**2122-7-25**] 01:42AM BLOOD Phenyto-15.1

[**2122-7-24**] 04:38PM BLOOD Phenyto-16.6

[**2122-7-15**] ECHO

PRE-CPB:1. No atrial septal defect is seen by 2D or color

Doppler.

2. There is moderate symmetric left ventricular hypertrophy. The

left ventricular cavity size is normal. Overall left ventricular

systolic function is normal (LVEF>55%).

3. Right ventricular chamber size and free wall motion are normal.
4. The aortic root is mildly dilated at the sinus level. There are simple atheroma in the aortic root. The ascending aorta is markedly dilated There are simple atheroma in the ascending aorta. There is a dissection flap that originates around the right coronary and extends into the arch. The aortic arch is moderately dilated. There are complex (>4mm) atheroma in the aortic arch. There is intramural thrombus present in the descending aorta. There is spontaneous echo contrast in the descending thoracic aorta. The descending thoracic aorta is mildly dilated. There are complex (>4mm) atheroma in the descending thoracic aorta.
5. There are three aortic valve leaflets. The aortic valve leaflets are mildly thickened. There is no aortic valve stenosis. Mild (1+) aortic regurgitation is seen.
6. The mitral valve leaflets are mildly thickened. The mitral valve leaflets are not well seen. Mitral regurgitation is present but cannot be quantified.
7. There is a moderate sized pericardial effusion.
Dr. [**Last Name (STitle) **] was notified in person of the results.

POST-CPB: On infusions of nitroglycerine. Well-seated synthetic graft in the aortic position from the sinotubular junction. No apparent leak. There is residual intramural thromus at the level of right coronary cusp. Coronary flow is visible in both the RCA and LMCA. The descending aorta is unchanged post decannulation. There is a small right pleural effusion. The pericardial effusion is small..

[**Known lastname **],[**Known firstname **] [**Medical Record Number 78526**] F 77 [**2044-10-22**]

Radiology Report CT HEAD W/O CONTRAST Study Date of [**2122-7-20**]

10:07 AM

[**Last Name (LF) **],[**First Name3 (LF) **] R. CSURG CSRU [**2122-7-20**] SCHED

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 78527**]

Reason: ischemic event/bleed

[**Hospital 93**] MEDICAL CONDITION:

77 year old woman s/p emergent AAA

REASON FOR THIS EXAMINATION:

ischemic event/bleed

CONTRAINDICATIONS FOR IV CONTRAST:

None.

Provisional Findings Impression: RSRc MON [**2122-7-20**] 2:08 PM

Evolution of multiple subacute infarctions throughout right

frontal, parietal,

temporal, bilateral occipital, and cerebellar lobes. No

hemorrhage, mass
effect, or midline shift.

Final Report
HISTORY: 77-year-old female with emergent AAA repair several
days prior.
Please evaluate for ischemic event or hemorrhage.

COMPARISON: CTA head four days prior.

TECHNIQUE: Contiguous axial imaging was performed from the
cranial vertex to
the foramen magnum without IV contrast.

HEAD CT WITHOUT IV CONTRAST: Multifocal cortical and subcortical

hypodensities involving the frontal, parietal, and occipital
lobes as well as
the cerebellum bilaterally are more well defined, indicative of
evolving
ischemic infarction. There is no hemorrhage, edema, mass effect,
or shift of
normally midline structures. The visualized paranasal sinuses
are
unremarkable. The mastoid air cells are clear. Mild
periventricular
hypodensity is indicative of chronic small vessel ischemic
disease.

IMPRESSION: Multiple bilateral hypodensities consistent with

evolving

subacute infarction.

The study and the report were reviewed by the staff radiologist.

DR. [**First Name (STitle) **] [**Doctor Last Name 3900**]

DR. [**First Name11 (Name Pattern1) **] [**Initial (NamePattern1) **]. [**Last Name (NamePattern1) 7415**]

Approved: MON [**2122-7-20**] 4:31 PM

Imaging Lab

Radiology Report CHEST (PORTABLE AP) Study Date of [**2122-7-27**] 1:47

PM

[**Last Name (LF) **],[**First Name3 (LF) **] R. CSURG CSRU [**2122-7-27**] SCHED

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 78528**]

Reason: ptx

[**Hospital 93**] MEDICAL CONDITION:

77 year old woman s/p trach/bronch

REASON FOR THIS EXAMINATION:

ptx

Final Report

INDICATION: 77-year-old female status post trach and
bronchoscopy.

COMPARISON: [**2122-7-24**]..

FRONTAL CHEST RADIOGRAPH: Over the interval, the patient has
undergone
tracheostomy which is appropriately positioned. A right internal
jugular
central venous line has been removed and there is no
pneumothorax. The left-
sided PICC line tip resides within the proximal SVC. The
Dobbhoff tube has
been removed. There is a persistent left retrocardiac opacity
and small left-
sided pleural effusion. There is a small right-sided pleural
effusion as
well.

Radiology Report PORTABLE ABDOMEN Study Date of [**2122-7-27**] 1:47 PM

[**Last Name (LF) **],[**First Name3 (LF) **] R. CSURG CSRU [**2122-7-27**] SCHED
PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 78529**]
Reason: free air

[**Hospital 93**] MEDICAL CONDITION:

77 year old woman s/p PEG

REASON FOR THIS EXAMINATION:

free air

Provisional Findings Impression: CXWc TUE [**2122-7-28**] 1:15 PM

New PEG tube overlies the left mid abdomen. No evidence of free intraperitoneal air. Stool and gas to the rectum.

Final Report

INDICATION: 77-year-old woman status post PEG, evaluate for free air.

COMPARISON: [**2122-7-20**].

SINGLE SUPINE VIEW OF THE ABDOMEN AT 2:00 P.M.: There has been interval placement of a PEG tube, overlying the left mid abdomen. There is no gross evidence of free intraperitoneal air. Stool and gas present in the colon, extending from the cecum to the rectum.

Other findings are unchanged. Skin staples overlie the mid upper

abdomen.

Phleboliths are present in the pelvis. Degenerative changes are

present at

the hips bilaterally and the lower lumbar spine, where there is

mild convex

leftward scoliosis.

IMPRESSION: No gross evidence of intraperitoneal air.

Brief Hospital Course:

Mrs. [**Known lastname 56811**] was admitted to the [**Hospital1 18**] on [**2122-7-14**] for emergent

surgical management of her type A dissection. She was taken to

the operating room where she underwent replacement of her

ascending aorta and hemiarch using a 38mm gelweave graft.

Postoperatively she was taken to the cardiac surgical intensive

care unit for monitoring. She received multiple blood products.

Her sedation was weaned to off but she remained unresponsive to

pain without pupillary reflex, head CT showed Subacute

infarction involving the cerebellum, frontal, parietal, and

occipital lobes bilaterally as well as chronic infarction in the

right temporal lobe. She began having seizures and was loaded

with and started on dilantin. She was followed closely by

neurology. Dobhoff tube was placed and she was started on tube

feeds.

She remained unresponsive. Repeat head ct showed Multiple

bilateral hypodensities consistent with evolving subacute

infarction. She was started on cipro and zosyn for gram negative bacteria in sputum and UTI. General surgery consulted to plan for trach/PEG placement. Her neuro exam improved very slightly and she opened her eyes to noxious stim. Repeat EEG showed mild to moderate encephalopathy but no evidence of seizures. Neurological prognosis remained poor. Tracheostomy and PEG tube were placed on [**7-27**]. Dilantin level should be maintained at 15-20. Tube feeds were restarted, and she tolerated 8 hours of trach collar. PICC line became totally occluded seconadry to IV dilantin and her dilantin was changed to PO. BUE U/S for edema showed right axillary DVT but none on left. PICC line was changed to a single lumen. She was raedy for discharge to rehab on [**7-29**].

Medications on Admission:
Prednisone 2mg QD
Vytorin 10/10 QD
HCTZ 25mg QD
Metformin 500mg QD
Detrol 4mg QD
Timolol eye drops
Labetolol 100mg QD
Nifedipine 90mg QD

Discharge Medications:
1. Chlorhexidine Gluconate 0.12 % Mouthwash Sig: One (1) ML Mucous membrane [**Hospital1 **] (2 times a day).
2. Acetaminophen 325 mg Tablet Sig: Two (2) Tablet PO Q4H (every

4 hours) as needed for temperature >38.0.

3. Aspirin 81 mg Tablet, Chewable Sig: One (1) Tablet, Chewable
PO DAILY (Daily).

4. Docusate Sodium 50 mg/5 mL Liquid Sig: [**1-28**] PO BID (2 times a
day).

5. Atorvastatin 10 mg Tablet Sig: One (1) Tablet PO DAILY
(Daily).

6. Artificial Tear with Lanolin 0.1-0.1 % Ointment Sig: One (1)
Appl Ophthalmic PRN (as needed).

7. Polyvinyl Alcohol-Povidone 1.4-0.6 % Dropperette Sig: [**1-28**]
Drops Ophthalmic PRN (as needed).

8. Ipratropium-Albuterol 18-103 mcg/Actuation Aerosol Sig: Two
(2) Puff Inhalation Q4H (every 4 hours).

9. Timolol Maleate 0.25 % Drops Sig: One (1) Drop Ophthalmic [**Hospital1 **]
(2 times a day).

10. HydrALAzine 10 mg IV Q6H:PRN sbp > 160

11. Heparin Flush (10 units/ml) 2 mL IV PRN line flush
PICC, heparin dependent: Flush with 10mL Normal Saline followed
by Heparin as above daily and PRN per lumen.

12. Bisacodyl 5 mg Tablet, Delayed Release (E.C.) Sig: Two (2)
Tablet, Delayed Release (E.C.) PO DAILY (Daily).

13. Heparin (Porcine) 5,000 unit/mL Solution Sig: One (1)
Injection TID (3 times a day).

14. Metoprolol Tartrate 25 mg Tablet Sig: 1.5 Tablets PO BID (2
times a day).

15. Phenytoin 125 mg/5 mL Suspension Sig: Two [**Age over 90 1230**]y
(250) mg PO BID (2 times a day).

16. Ranitidine HCl 15 mg/mL Syrup Sig: One [**Age over 90 1230**]y (150)
mg PO DAILY (Daily).

17. Furosemide 10 mg/mL Solution Sig: Twenty (20) mg Injection [**Hospital1 **] (2 times a day).

18. Potassium Chloride 20 mEq Tab Sust.Rel. Particle/Crystal Sig: One (1) Tab Sust.Rel. Particle/Crystal PO BID (2 times a day): while on lasix

.

Discharge Disposition:

Extended Care

Facility:

[**Hospital1 700**] - [**Location (un) 701**]

Discharge Diagnosis:

Aortic dissection s/p repair

intra-op CVA

right axillary DVT

HTN

CVA

CRI

DM

Aortic Aneurysm

Discharge Condition:

Stable

Discharge Instructions:

1) Monitor wounds for signs of infection. These include
redness, drainage or increased pain. In the event that you have
drainage from your sternal wound, please contact the [**Name2 (NI) 5059**] at
([**Telephone/Fax (1) 1504**].

2) Report any fever greater then 100.5.

3) Report any weight gain of 2 pounds in 24 hours or 5 pounds
in 1 week.

4) No lotions, creams or powders to incision until it has
healed. You may shower and wash incision. Gently pat the wound
dry. Please shower daily. No bathing or swimming for 1 month.
Use sunscreen on incision if exposed to sun.

5) No lifting greater then 10 pounds for 10 weeks.

6) No driving for 1 month.

7) Call with any questions or concerns.

Followup Instructions:

Follow-up with Dr. [**Last Name (STitle) **] in 1 month. ([**Telephone/Fax (1) 11763**]

Follow-up with Dr. [**First Name (STitle) **] after discharge from rehab.
[**Telephone/Fax (1) 4475**]

Completed by:[**2122-7-29**]"

"PATIENT/TEST INFORMATION:

Indication: Abnormal ECG. Aortic dissection. Aortic valve disease. Chest pain. Hypertension.

Status: Inpatient

Date/Time: [**2122-7-15**] at 01:09

Test: TEE (Complete)

Doppler: Full Doppler and color Doppler

Contrast: None

Technical Quality: Suboptimal

INTERPRETATION:

Findings:

LEFT ATRIUM: LA not well visualized.

RIGHT ATRIUM/INTERATRIAL SEPTUM: Normal RA size. A catheter or pacing wire is seen in the RA and extending into the RV. No ASD by 2D or color Doppler.

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

LV WALL MOTION: basal anterior - normal; mid anterior - normal; basal anteroseptal - normal; mid anteroseptal - normal; basal inferoseptal - normal; mid inferoseptal - normal; basal inferior - normal; mid inferior - normal; basal inferolateral - normal; mid inferolateral - normal; basal anterolateral - normal; mid anterolateral - normal; anterior apex - normal; septal apex - normal; inferior apex - normal; lateral apex - normal; apex - normal;

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

AORTA: Mildly dilated aortic sinus. Simple atheroma in aortic root. Markedly dilated ascending aorta. Simple atheroma in ascending aorta. Moderately dilated aortic arch. Complex (>4mm) atheroma in the aortic arch. Mildly

dilated descending aorta. Complex (>4mm) atheroma in the descending thoracic aorta. Focal calcifications in descending aorta.

AORTIC VALVE: Three aortic valve leaflets. Mildly thickened aortic valve leaflets. No AS. Mild (1+) AR.

MITRAL VALVE: Mildly thickened mitral valve leaflets. Mitral valve leaflets not well seen. No MS. MR present but cannot be quantified.

TRICUSPID VALVE: Normal tricuspid valve leaflets with trivial TR.

PULMONIC VALVE/PULMONARY ARTERY: Pulmonic valve not well seen.

PERICARDIUM: Moderate pericardial effusion.

GENERAL COMMENTS: A TEE was performed in the location listed above. I certify I was present in compliance with HCFA regulations. The patient was under general anesthesia throughout the procedure. The patient received antibiotic prophylaxis. The TEE probe was passed with assistance from the anesthesioology staff using a laryngoscope. No TEE related complications. Results were personally reviewed with the MD caring for the patient.

Conclusions:
PRE-CPB:1. No atrial septal defect is seen by 2D or color Doppler.
2. There is moderate symmetric left ventricular hypertrophy. The left ventricular cavity size is normal. Overall left ventricular systolic function is normal (LVEF>55%).
3. Right ventricular chamber size and free wall motion are normal.
4. The aortic root is mildly dilated at the sinus level. There are simple

atheroma in the aortic root. The ascending aorta is markedly dilated There are simple atheroma in the ascending aorta. There is a dissection flap that originates around the right coronary and extends into the arch. The aortic arch is moderately dilated. There are complex (>4mm) atheroma in the aortic arch. There is intramural thrombus present in the descending aorta. There is spontaneous echo contrast in the descending thoracic aorta. The descending thoracic aorta is mildly dilated. There are complex (>4mm) atheroma in the descending thoracic aorta.

5. There are three aortic valve leaflets. The aortic valve leaflets are mildly thickened. There is no aortic valve stenosis. Mild (1+) aortic regurgitation is seen.

6. The mitral valve leaflets are mildly thickened. The mitral valve leaflets are not well seen. Mitral regurgitation is present but cannot be quantified.

7. There is a moderate sized pericardial effusion.

Dr. [**Last Name (STitle) 32**] was notified in person of the results.

POST-CPB: On infusions of nitroglycerine. Well-seated synthetic graft in the aortic position from the sinotubular junction. No apparent leak. There is residual intramural thromus at the level of right coronary cusp. Coronary flow is visible in both the RCA and LMCA. The descending aorta is unchanged post decannulation. There is a small right pleural effusion. The pericardial effusion is small..

"

"Sinus rhythm. Borderline prolongation of P-R interval. Inferior and lateral ST-T wave changes suggest possible myocardial injury. Clinical correlation is suggested. Compared to the previous tracing of [**2122-7-18**] the lateral ST-T wave changes have resolved to normal and atrial premature beats are no longer seen.

"

"Baseline artifact. Sinus rhythm. Atrial ectopy. Diffuse ST segment elevation with PR segment depression consistent with pericardial disease. Non-specific ST-T wave changes. Compared to the previous tracing ST segment elevation is more extensive.

"

"Normal sinus rhythm with A-V conduction delay. ST segment elevations in the anterior leads V2-V4 with Q waves in leads V1-V2 consistent with acute anterior myocardial infarction. No diagnostic change from tracing #1.
TRACING #2

"

"Normal sinus rhythm. ST segment elevations in leads V2-V3 with Q waves in leads V1-V2 consistent with acute myocardial infarction. Compared to the previous tracing of [**2122-7-15**] the Q waves in leads V1-V2 are new. Clinical correlation is suggested.
TRACING #1

"

"Baseline artifact. Since the previous tracing the Q-T interval is longer. ST-T wave abnormalities are more prominent. Axis is less leftward and inferior R waves are more prominent. Clinical correlation is suggested.
TRACING #2

"

"Sinus rhythm. Borderline P-R interval prolongation. Left axis deviation. Consider left anterior fascicular block and/or inferior myocardial infarction.

Late R wave progression. Consider anteroseptal myocardial infarction.

ST-T wave abnormalities. No previous tracing available for comparison.

TRACING #1

"

"[**2122-7-15**] 7:22 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 28950**]

Reason: ptx

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p Replacement of Asc Aorta

REASON FOR THIS EXAMINATION:

ptx

FINAL REPORT

REASON FOR EXAMINATION: Followup of a patient after replacement of ascending aorta.

Portable AP chest radiograph was reviewed with no prior studies available for comparison.

The ET tube tip is about 6 cm above the carina. The NG tube intrathoracic portion is displaced to the left from its expected location, most likely in the stomach , due to leftward mediastinal shift and left lower lobe atelectasis. Mediastinal widening especially in its upper portion is demonstrated, most likely related to the recent surgery. The Swan- Ganz catheter tip is at the level of right ventricle outflow tract. Left and right chest tubes are in expected location. The lungs are clear. There is a small

amount of bilateral pleural effusion but no evidence of pneumothorax.

"

"[**2122-7-16**] 6:39 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 28952**]

Reason: acute desat

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

acute desat

WET READ: [**First Name9 (NamePattern2) 5210**] [**Doctor First Name 141**] [**2122-7-16**] 7:34 PM

Swan-Ganz catheter removed, R IJ sheath remains in place. Unchanged

retrocardiac opacity. No PTX.

FINAL REPORT

AP CHEST 6:49 [**Initials (NamePattern4) **] [**7-16**]

HISTORY: Swan-Ganz catheter removed, IJ sheath still in place. Evaluate left

lower lobe atelectasis.

IMPRESSION: AP chest compared to [**7-15**] through [**7-16**] at 11:26 a.m.:

Left lower lobe collapse unchanged. Mild cardiomegaly stable. Right lung and

left upper lung clear. ET tube and right internal jugular sheath are in

standard placements. Bilateral pleural effusion is small. No pneumothorax.
ET tube in standard placement. Nasogastric tube should be advanced 4 cm to
move all the side ports into the stomach.

"

"[**2122-7-16**] 10:58 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 28832**]

Reason: evaluate rll

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p aortic repair

REASON FOR THIS EXAMINATION:

evaluate rll

FINAL REPORT

STUDY: Single portable AP chest radiograph.

INDICATION: Status post aortic repair. Evaluate effusion.

COMPARISON: [**2122-7-15**].

FINDINGS: NG tube, ET tube and Swan-Ganz catheter remain in standard
unchanged position. Left lower lobe atelectasis and effusion remain
unchanged. The left upper lobe and right lung remain clear.

IMPRESSION: No significant change from previous with left lower lobe
atelectasis and effusion.

"

"[**2122-7-17**] 7:10 AM

BILAT LOWER EXT VEINS PORT Clip # [**Clip Number (Radiology) 29580**]

Reason: PROLONGED BEDREST EVALUATE FOR DVT

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

r/o DVT

PROVISIONAL FINDINGS IMPRESSION (PFI): [**Last Name (un) 13**] FRI [**2122-7-17**] 2:52 PM

No evidence of DVT in either leg.

FINAL REPORT

INDICATION: 77-year-old female with prolonged bed rest. Rule out DVT.

COMPARISON: No previous exams for comparison.

FINDINGS: Grayscale, color and Doppler son[**Name (NI) 14**] of bilateral common femoral, superficial femoral, popliteal and tibial veins were performed. There is normal flow, compression and augmentation seen in all of the vessels.

IMPRESSION: No evidence of deep vein thrombosis in either leg.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-17**] 7:10 AM

BILAT LOWER EXT VEINS PORT Clip # [**Clip Number (Radiology) 29580**]

Reason: PROLONGED BEDREST EVALUATE FOR DVT

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

r/o DVT

PFI REPORT

No evidence of DVT in either leg.

"

"[**2122-7-16**] 9:30 AM

CTA HEAD W&W/O C & RECONS; CTA NECK W&W/OC & RECONS Clip # [**Clip Number (Radiology) 28833**]

Reason: r/o bleed s/o aortic repair non responsive

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p aortic repair

REASON FOR THIS EXAMINATION:

r/o bleed s/o aortic repair non responsive

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): [**First Name9 (NamePattern2) 5203**] [**Doctor First Name 141**] [**2122-7-16**] 10:49 AM

infarcts of R cerebellum, b/l occital, frontal, and parietal lobes likely subacute. Old infarct of R temporal lobe.

Long severe atherosclerotic changes of L subclavian and axillary arteries

awaiting reformats

FINAL REPORT

HISTORY: 77-year-old female status post aortic repair. Please evaluate for hemorrhage.

COMPARISON: None available.

TECHNIQUE: Contiguous axial images were obtained through the brain without contrast. Subsequently, rapid axial imaging was performed from the aortic arch through the brain during infusion of Omnipaque IV contrast. Images were processed on a separate workstation with display of curved reformats, volume rendered images, maximum intensity projection images.

HEAD CT WITHOUT IV CONTRAST: The right temporal lobe demonstrates a well-defined focus of hypoattenuation indicative of encephalomalacia, likely from prior infarction (2:16). Additional less well-defined hypodensities in the frontal lobes, the parietal lobes, occipital lobes, and the cerebellum bilaterally are consistent with edema due to subacute infarction. Periventricular hypoattenuation is consistent with chronic small vessel ischemic disease. The visualized paranasal sinuses are clear. The mastoid air cells are clear. There is no fracture. The patient is intubated.

HEAD AND NECK CTA: There is severe atheromatous disease involving the aorta

and the common carotid arteries bilaterally. The left subclavian demonstrates a long segment of severe atherosclerotic change. There is an approximately 33% stenosis of the proximal right ICA at the right carotid bifurcation. There is a 1.2-cm segment of the distal cervical left internal carotid artery which demonstrates a fenestration or possible dissection (3:187). The left vertebral artery demonstrates an approximately 65% stenosis at its origin ([**Numeric Identifier 28951**]:25, 695). The major intracranial vessels are patent, with no evidence of aneurysm formation.

There is a 3.4 x 3.1 cm hypoattenuating left thyroid nodule (3:72). There is a large left pleural effusion.

(Over)

[**2122-7-16**] 9:30 AM

CTA HEAD W&W/O C & RECONS; CTA NECK W&W/OC & RECONS Clip # [**Clip Number (Radiology) 28833**]

Reason: r/o bleed s/o aortic repair non responsive

Admitting Diagnosis: AORTIC DISSECTION

FINAL REPORT

(Cont)

IMPRESSION:

1. Subacute infarction involving the cerebellum, frontal, parietal, and occipital lobes bilaterally; chronic infarction in the right temporal lobe.

2. Long segment atheromatous disease of the aorta, both common carotid arteries, and left subclavian artery without flow-limiting stenosis.

3. Right ICA proximal 33% stenosis.

4. Fenestrated segment or dissection of the distal left cervical ICA.

5. Approximately 65% stenosis of the left vertebral artery at its origin.

6. Large left pleural effusion.

7. Large left hypoattenuating thyroid nodule.

"

"[**2122-7-17**] 1:20 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 29578**]

Reason: RSC IJ rewire: check placementCheck placement of Dobhoff fee

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

RSC IJ rewire: check placementCheck placement of Dobhoff feeding tubbe

---

PROVISIONAL FINDINGS IMPRESSION (PFI): MEz FRI [**2122-7-17**] 4:02 PM

PROCEDURE: Chest portable AP.

Evaluate lines. The right internal jugular line terminates in the atrium and

needs to be retracted by at least 3 cm.

FINAL REPORT

PROCEDURE: Chest portable AP on [**2122-7-17**].

COMPARISON: [**2122-7-15**] at 07:58.

HISTORY: 77-year-old woman with placement of line right IJ, Dobbhoff.

IMPRESSION:

Right internal jugular line is low lying and needs to be retracted by at least

3 cm.

Dobbhoff tip is out of view on this examination.

Recent surgical repair of the ascending aorta with postsurgical changes at

that level.

Improving left lower lobe atelectasis with a small stable left pleural

effusion.

The findings were communicated to [**First Name8 (NamePattern2) 238**] [**Last Name (NamePattern1) **].

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-17**] 1:20 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 29578**]

Reason: RSC IJ rewire: check placementCheck placement of Dobhoff fee

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

RSC IJ rewire: check placementCheck placement of Dobhoff feeding tubbe

---

PFI REPORT

PROCEDURE: Chest portable AP.

Evaluate lines. The right internal jugular line terminates in the atrium and

needs to be retracted by at least 3 cm.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-16**] 9:30 AM

CTA HEAD W&W/O C & RECONS; CTA NECK W&W/OC & RECONS Clip # [**Clip Number (Radiology) 28833**]

Reason: r/o bleed s/o aortic repair non responsive

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p aortic repair

REASON FOR THIS EXAMINATION:

r/o bleed s/o aortic repair non responsive

No contraindications for IV contrast

PFI REPORT

infarcts of R cerebellum, b/l occital, frontal, and parietal lobes likely

subacute. Old infarct of R temporal lobe.

Long severe atherosclerotic changes of L subclavian and axillary arteries

awaiting reformats

"

"[**2122-7-24**] 8:53 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 29583**]

Reason: left PICC 53 cm please check placement thanks [**Doctor First Name 798**] [**9-/2556**]

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

left PICC 53 cm please check placement thanks [**Doctor First Name 798**] [**9-/2556**]

PROVISIONAL FINDINGS IMPRESSION (PFI): JWK FRI [**2122-7-24**] 10:59 AM

Right-sided PICC line appropriately positioned.

FINAL REPORT

INDICATION: 77-year-old female with left-sided PICC line placement.

COMPARISON: [**2122-7-22**].

UPRIGHT CHEST RADIOGRAPH: A left-sided PICC line tip terminates in the cavoatrial junction. Right internal jugular central venous line terminates in the proximal SVC. An endotracheal tube and Dobbhoff tube are appropriately positioned. Mild cardiomegaly persists. A small left-sided pleural effusion and left retrocardiac opacity likely representing atelectasis are unchanged. There is a small right-sided pleural effusion.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-20**] 10:07 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 28834**]

Reason: ischemic event/bleed

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p emergent AAA

REASON FOR THIS EXAMINATION:

ischemic event/bleed

No contraindications for IV contrast

PFI REPORT

Evolution of multiple subacute infarctions throughout right frontal, parietal, temporal, bilateral occipital, and cerebellar lobes. No hemorrhage, mass effect, or midline shift.

"

"[**2122-7-20**] 7:10 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 29579**]

Reason: effusion

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p acsending aotic replacement

REASON FOR THIS EXAMINATION:

effusion

FINAL REPORT

INDICATION: 77-year-old female status post ascending aorta replacement.

COMPARISON: [**2122-7-17**].

SUPINE CHEST RADIOGRAPH: The right internal jugular central venous line has been retracted and the tip now resides in the proximal SVC. Endotracheal tube and feeding tube are in unchanged positions. Cardiomediastinal silhouette is stable. There is mild increase in size of the small left-sided pleural effusion with associated atelectasis. There is a new moderate-sized right-sided pleural effusion with basilar atelectasis. There is no pneumothorax or focal consolidation.

IMPRESSION:

1. New moderate-sized layering right-sided pleural effusion with associated basilar atelectasis.
2. Mild increase in size of small left-sided pleural effusion with associated atelectasis.

"

"[**2122-7-20**] 10:07 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 28834**]

Reason: ischemic event/bleed

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p emergent AAA

REASON FOR THIS EXAMINATION:

ischemic event/bleed

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): RSRc MON [**2122-7-20**] 2:08 PM

Evolution of multiple subacute infarctions throughout right frontal, parietal, temporal, bilateral occipital, and cerebellar lobes. No hemorrhage, mass effect, or midline shift.

FINAL REPORT

HISTORY: 77-year-old female with emergent AAA repair several days prior. Please evaluate for ischemic event or hemorrhage.

COMPARISON: CTA head four days prior.

TECHNIQUE: Contiguous axial imaging was performed from the cranial vertex to the foramen magnum without IV contrast.

HEAD CT WITHOUT IV CONTRAST: Multifocal cortical and subcortical hypodensities involving the frontal, parietal, and occipital lobes as well as the cerebellum bilaterally are more well defined, indicative of evolving ischemic infarction. There is no hemorrhage, edema, mass effect, or shift of normally midline structures. The visualized paranasal sinuses are unremarkable. The mastoid air cells are clear. Mild periventricular hypodensity is indicative of chronic small vessel ischemic disease.

IMPRESSION: Multiple bilateral hypodensities consistent with evolving

subacute infarction.

"

"[**2122-7-29**] 12:36 PM

PICC LINE PLACMENT SCH Clip # [**Clip Number (Radiology) 28836**]

Reason: please change from current dual lumen - one port clotted onl

Admitting Diagnosis: AORTIC DISSECTION

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

* [**Numeric Identifier 1323**] EXCH PERPHERAL W/O [**Numeric Identifier 1324**] FLUORO GUID PLCT/REPLCT/REMOVE *

****

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p asc aorta replacement

REASON FOR THIS EXAMINATION:

please change from current dual lumen - one port clotted only needs single

lumen

FINAL REPORT

PICC LINE PLACEMENT, [**2122-7-29**].

INDICATION: 77 year-old female with clotted left PICC.

RADIOLOGIST: Dr. [**First Name (STitle) 5473**] and Dr. [**Last Name (STitle) 5549**] performed the procedure. The

Attending Radiologist, Dr. [**First Name (STitle) 5473**], was present and supervising throughout.

TECHNIQUE: Using sterile technique and local anesthesia, a 0.018 guidewire was

advanced through the indwelling left arm double lumen PICC line. The wire

could not be advanced through the catheter due to blockage at its mid portion and a 0.018 glidewire was also ineffective at traversing the obstructed portion through either lumen. Therefore, a close-fitting 4 Fr peel- away sheath was then advanced over the old PICC to secure access. The old PICC line and the wire were then removed. A single lumen catheter measuring 55 cm in length with 51.5 cm inside of the patient was then placed through the peel-away sheath with its tip positioned at the brachiocephalic junction under fluoroscopic guidance. (Tip postion was pulled back from SVC as catheter tip preferentially abutted right lateral wall of SVC) Position of the catheter was confirmed by a fluoroscopic spot film of the chest. The peel- away sheath and guidewire were then removed. The catheter was secured to the skin, flushed, and a sterile dressing applied. The sleeping patient tolerated the procedure well. There were no immediate complications.

IMPRESSION:: Uncomplicated fluoroscopically guided left single lumen PICC line exchange. Final internal length is 51.5 cm (3.5 cm outside of the patient) with the tip positioned at the brachiocephalic junction. The line is ready to use

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-27**] 1:47 PM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 29581**]

Reason: free air

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p PEG

REASON FOR THIS EXAMINATION:

free air

PFI REPORT

New PEG tube overlies the left mid abdomen. No evidence of free intraperitoneal air. Stool and gas to the rectum.

"

"[**2122-7-21**] 7:25 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 28835**]

Reason: pl.eff

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p emergent AAA repair

REASON FOR THIS EXAMINATION:

pl.eff

PROVISIONAL FINDINGS IMPRESSION (PFI): PSS TUE [**2122-7-21**] 4:17 PM

Left lower lobe atelectasis. Moderate left pleural effusion. Widened mediastinum unchanged. Small right pleural effusion decreased.

FINAL REPORT

AP CHEST 8:14 [**Initials (NamePattern4) **] [**7-21**]:

HISTORY: Emergency AAA repair. Pleural effusion.

IMPRESSION: AP chest compared to [**7-16**] through [**7-20**]:

Left lower lobe remains collapsed. Small to moderate left pleural effusion is stable. Small right pleural effusion has decreased. Mild cardiomegaly and widening of the upper mediastinum is stable postoperatively. ET tube is in standard placement. Right jugular line ends in the SVC and a feeding tube passes into the stomach and out of view. No pneumothorax.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-21**] 7:25 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 28835**]

Reason: pl.eff

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p emergent AAA repair

REASON FOR THIS EXAMINATION:

pl.eff

PFI REPORT

Left lower lobe atelectasis. Moderate left pleural effusion. Widened mediastinum unchanged. Small right pleural effusion decreased.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-21**] 1:25 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 28953**]

Reason: r/o ptx

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p bronch

REASON FOR THIS EXAMINATION:

r/o ptx

PFI REPORT

No pneumothorax status post bronchoscopy.

"

"[**2122-7-20**] 9:41 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 30141**]

Reason: assess dophoff placement

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p Asc Ao replacement

REASON FOR THIS EXAMINATION:

assess dophoff placement

FINAL REPORT

INDICATION: 77-year-old woman here to assess Dobbhoff placement.

COMPARISON: None.

FINDINGS: One view of the abdomen shows the Dobbhoff tube in the region of

the gastric antrum or first part of the duodenum. There is an unremarkable bowel gas pattern with no evidence of bowel obstruction.

IMPRESSION: Dobbhoff tube in region of gastric antrum or first part of the duodenum with no evidence of obstruction.

"

"[**2122-7-29**] 9:27 AM

BILAT UP EXT VEINS US Clip # [**Clip Number (Radiology) 29694**]

Reason: r/o dvt edema

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with s/p asc aorta replacement

REASON FOR THIS EXAMINATION:

r/o dvt edema

FINAL REPORT

INDICATION: Critically ill patient with ascending aorta replacement. Upper extremity edema. Assess for DVT.

There are no prior studies for comparison.

BILATERAL UPPER EXTREMITY ULTRASOUND: [**Doctor Last Name **] scale and Doppler son[**Name (NI) **] of the internal jugular, subclavian, axillary, brachial, basilic and cephalic veins was performed. The right axillary vein is expanded with hypoechoic material and is noncompressible, consistent with acute thrombosis. The other

named venous structures of the upper extremities are patent and compressible

with appropriate flow and waveforms. A PICC line is seen in the left basilic

and axillary veins which are patent.

IMPRESSION: Acute thrombus of the right axillary vein.

The finding was discussed with [**First Name8 (NamePattern2) 238**] [**Last Name (NamePattern1) **] at the immediate conclusion of

the exam.

"

"[**Last Name (LF) **],[**First Name3 (LF) 3675**] R. CSURG CSRU [**2122-7-24**] 8:53 AM

CHEST PORT. LINE PLACEMENT Clip # [**Clip Number (Radiology) 29583**]

Reason: left PICC 53 cm please check placement thanks [**Doctor First Name 798**] [**9-/2556**]

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman with

REASON FOR THIS EXAMINATION:

left PICC 53 cm please check placement thanks [**Doctor First Name 798**] [**9-/2556**]

PFI REPORT

Right-sided PICC line appropriately positioned.

"

"[**2122-7-27**] 1:47 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 29695**]

Reason: ptx

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p trach/bronch

REASON FOR THIS EXAMINATION:

ptx

FINAL REPORT

INDICATION: 77-year-old female status post trach and bronchoscopy.

COMPARISON: [**2122-7-24**]..

FRONTAL CHEST RADIOGRAPH: Over the interval, the patient has undergone tracheostomy which is appropriately positioned. A right internal jugular central venous line has been removed and there is no pneumothorax. The left-sided PICC line tip resides within the proximal SVC. The Dobbhoff tube has been removed. There is a persistent left retrocardiac opacity and small left-sided pleural effusion. There is a small right-sided pleural effusion as well.

"

"[**2122-7-22**] 6:40 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 29582**]

Reason: effusion

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman ws/p asc aota and hemiarch replacement

REASON FOR THIS EXAMINATION:

effusion

FINAL REPORT

INDICATION: Status post ascending aorta and hemiarch replacement.

COMPARISON: [**2122-7-21**].

FRONTAL CHEST RADIOGRAPH: All lines and tubes are in unchanged position. The cardiomediastinal silhouette is unchanged. There is an increased small layering right-sided pleural effusion and a stable left-sided pleural effusion. A retrocardiac opacity likely represents atelectasis. There is no pneumothorax.

IMPRESSION:

1. Increased layering small right-sided pleural effusion.
2. Stable small left-sided pleural effusion and retrocardiac opacity likely representing atelectasis.

"

"[**2122-7-27**] 1:47 PM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 29581**]

Reason: free air

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p PEG

REASON FOR THIS EXAMINATION:

free air

PROVISIONAL FINDINGS IMPRESSION (PFI): CXWc TUE [**2122-7-28**] 1:15 PM

New PEG tube overlies the left mid abdomen. No evidence of free intraperitoneal air. Stool and gas to the rectum.

FINAL REPORT

INDICATION: 77-year-old woman status post PEG, evaluate for free air.

COMPARISON: [**2122-7-20**].

SINGLE SUPINE VIEW OF THE ABDOMEN AT 2:00 P.M.: There has been interval placement of a PEG tube, overlying the left mid abdomen. There is no gross evidence of free intraperitoneal air. Stool and gas present in the colon, extending from the cecum to the rectum.

Other findings are unchanged. Skin staples overlie the mid upper abdomen. Phleboliths are present in the pelvis. Degenerative changes are present at the hips bilaterally and the lower lumbar spine, where there is mild convex leftward scoliosis.

IMPRESSION: No gross evidence of intraperitoneal air.

"

"[**2122-7-21**] 1:25 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 28953**]

Reason: r/o ptx

Admitting Diagnosis: AORTIC DISSECTION

[**Hospital 2**] MEDICAL CONDITION:

77 year old woman s/p bronch

REASON FOR THIS EXAMINATION:

r/o ptx

PROVISIONAL FINDINGS IMPRESSION (PFI): SP TUE [**2122-7-21**] 2:54 PM

No pneumothorax status post bronchoscopy.

FINAL REPORT

TYPE OF EXAMINATION: Chest AP portable single view.

INDICATION: Status post bronchoscopy. Evaluate for pneumothorax.

FINDINGS: AP single view of the chest with patient in sitting semi-upright position is analyzed in direct comparison with a preceding similar study obtained five hours earlier during the same day. Position of previously described ETT, right internal jugular approach central venous line and Dobbhoff catheter are all unchanged. No pneumothorax is identified. Chest findings that include status post sternotomy and ascending aorta replacement as well as the presence of an atelectatic area in retrocardiac position remain unchanged. No new pulmonary abnormalities are identified.

IMPRESSION: No pneumothorax or any other significant interval change status post bronchoscopy.

"

"CVICU NPN 1900-0700

Neuro: remains unchanged. withdrawls BLE to nailbed pressure. Pupils non reactive. (+) cough/gag. Does not appear to be in pain. No seizure activity noted overnight.

CV: SR/ST up to 105. Dr. [**First Name (STitle) 979**] notified, no intervention done. SBP 140-150 via cuff. Given 10 mg IV hydralazine for SBP > 170 with good effect. Natrecor gtt continues at 0.02 mcg/kg/min. K+/Ca2+ repleted overnight. Tmax 100.8, then down to 99.9 at 0400. PICC eval done, should be inserted today in IR.

Resp: Received on MMV and changed to AC overnight to rest d/t increased WOB. O2 sats 97% and greater on current vent settings. LS coarse at times then clear and diminished at bases. ?Trach/peg in future?

GI/GU: abd soft, NT, ND. (+) BS, (+) small loose liquid BM. TF continue at goal via dobhoff, minimal residuals. Foley with clear yellow adequate HUO. Good response to 40 mg IV lasix. BUN 50, Creat 1.5 this AM.

Endo: FS q4h humalog insulin per pt specific sliding scale.

Skin: sternal/mediastinal dsgs changed and CDI. DTI to sacrum unchanged and skin intact.

Social: no calls from family overnight. ? family meeting prior to trach/peg? see neuro note in chart. Parking stickers affixed to marker board in pt room.

Plan: Monitor cardiopulmonary and neuro status. To IR for PICC. Goal 1L negative in diuresis, cont natrecor gtt.

"

"Respiratory Care:

Patient switched to A/C due to increased periods of apnea with ^ BP. Latest abg results determied a very mild metabolic alkalemia with very good oxygenation.

RSBI = 138 on 0-PEEP and 5 cm PSV (FAILED RSBI).

"

"See [**Month (only) **] and carevue for detailed documentation

Neuro: Patient unresponsive. PERL, very sluggish. No movement noted, eye opening occassionally with coughing, turning, no response to nail bed pressure. Patient blinks to eye stim/ gtts. Gaze upward with pupil exam. Strong cough and gag with turning, intermittent reponse with oral care.

Resp: BS clear, diminished in bases. Suctioned for minimla amounts secretions from ETT, large amount from mouth. Continues on A/C due to hx of apnea.

CV: In NSR, 90's. PAC noted, potassium repleted with improvement. BP slightly elevated in am, rec'd lopressor with improvement. Again >160, rec'd hydralazine IV x1 with slight improvement with BP to 150's. Dr. [**Last Name (STitle) **] aware. Low grade temp. Initially with weak, palpable pulses, now found with doppler. Incision sited CDI.

GI/Endo: Continues on nutren 2.0, tol well. No BM despite colace, supp. Humalog sliding scale per individual scale, lantus given in am.

GU: Foley to gravity with 20-100ml/ hour urine output. Continues with generalized edema.

Skin: Purple area over coccyx unchanged. Tissue intact. Skin barrier applied thru day. Continues on KinAir bed.

Social: Husband into visit. Appears to be aware of poor prognosis, remains hopeful. Discussed difficulty with extended family, does not want their involvement. Parking vouches given, Plan for social service contact on [**Name (NI) **].

Plan: Continue cardiopulmonary monitoring. Follow neuro exam. Continue vent support due to hx of apnea. Continue feeds.

"

"Neuro: tmax 100; pupils 3mm & sluggish; 0 movement noted BUE, moves toes on bil feet spont. and when bottom of foot scraped; + gag, cough, & corneal reflex; opens eyes to noxious stimuli (turning, sx); 500mg dilantin given for prior seizure activity, none noted this shift;

CV: SR-ST 87-105 w/ occ. PVC's; sb/p 113-151 (goal sb/p <150), Lopressor [**Hospital1 **] w/ good effect; Rt 3+/Lt 2+ pulses; 2+ pitting edema bil hands; M Boots and SCD's on;

Resp: #7.5 ETT taped 21 @ lip; resp [**1-20**]; Sat 98-100%; sx thick, white, small secretions via in-line sx cath; ph 7.48/pco2 35/ p02 97; AC 10/Fio2 40%/TV 450/Peep 5, remains on AC for hx of apnea on PS; rhonchi bil., dim. bases;

GI: Lt nare DHT w/ 2.0 Nutren @ goal 30ml/hr; + bowel sounds; 0 BM, + gas when coughing; abd. soft, distended; Colace [**Hospital1 **] & Bisocodyl scheduled;

GU: foley to gravity w/ clear, yellow drainage; 25-60ml/hr UOP;

IV: Lt UA PICC; IVF @ KVO;

Lab: Q4 hr finger sticks w/ Humalog SS; am scheduled Lantus;

Skin: sternotomy w/ staples - dsg D&I; Rt groin w/ steri-strips - D&I; coccyx area purple w/ skin intact, criticaid applied; on kinair bed;

Plan: social services to speak w/ husband [**Name (NI) **]???; keep sb/p <150, prn hydralazine if needed; monitor for seizure activity; trach & peg this week???; tx labs as needed; comfort & support;

"

"Nursing 7p-7a

Neuro: Opening eyes to voice when name called. Does not follow commands. No spontaneous movement. Does flex bilat feet to stimuli and nailbed pressure. No movement of upper extremeties. Strong cough reflex, entire body spasms during coughs. Cont on po dilantin. No seizure activity noted.

CV: NSR w/rare pvcs. SBP <150, on po lopressor. No prn hydralazine required. Pulses per flowsheet, L weaker than R- team aware. Both LE warm.

Resp: No vent changes per team, abg to be drawn in am. Rhonchorous lung sounds. CPT done. Suctioning min white thick secretions. Awaiting tracheostomy.

Gi: TFs at goal, tol well. Lg amt mucous, vs melted dulcolax supp, excreted. +flatus. No stool. No abd distention.

Endo: Hypoglycemic requiring D50. MD [**Doctor Last Name 979**] made aware, lantus dose decreased.

Gu: Min-adequate HUO via foley.

Skin: See flowsheet for incisions/impairments.

Social: No contact overnight.

Plan: Awaiting tracheostomy & PEG insertion. Rehab screen once trach & peg placed. Monitor blood sugars, dilantin level. SW to meet w/husband today.

"

"Respiratory Care:

Pt remain orally intubated & sedated on full/assist ventilatory support. No vent changes done. Bs are dim & claer bil. We are sxtn for small amt of thick whitish secretions from ETT. Plan: awaiting Tracheotomy & peg & rehab placement. See [** 66**] for further details.

"

"7-10am

PROB: PRE-OP FOR TRACH AND PEG

TUBE FEEDINGS OFF, MEDS GIVEN BY FEEDING TUBE. GLARGINE INSULIN HELD, AND D/[**Name (NI) **], PT TO BE TREATED WITH S/S. SUCTIONED FOR THIN WHITE. COUGHING, GAGGING WITH TURNING, ACTIVITY, SUCTIONED FOR MOD TO LARGE AMOUNT THIN WHITE. LUNGS COARSE/RHONCHI THROUGHOUT. O2 SATS ADEQUATE. DILANTIN TO BE CHANGED BACK TO IV D/T VARIABLE DRUG LEVEL.

"

"resp care - Pt was trached this shift with #8Portex Perfit. Pt is now on PSV 10/5 with Vt in 400s with RR of 15-18. ABG is WNL. A copious amount of thin, bloody secretions were suctioned Q 2-4 post procedure. BS are coarse t/o. Pt received MDI as ordered. Plan is to continue weaning as tolerated.

"

"7A->7P

Neuro- Opens eyes, ? purposeful or not. With drawls to pain, moving toes but not to command. PERRLA 3mm->2mm OU. Neuro in to assess after procedures.

CV- SR->ST, 80's-110, some PVC's this afternoon. HTN at times, Hydralazine given per order. Remains on Lopressor at 25mg po. UOP decreased at times and Diamox started x 2 doses, 500mg IV.

Resp- Lungs coarse throughout, diminished bibasular. Suctioned for thick white sec in small amounts, no has Trach, # 8 portex. Placed at 12n, Suctioning thick, bloody sec in mod amonunts. Vent weaned to CPAP 10/5 this afternoon. Sats in high 90's on 40%. CXR done. Bronch done

GI/GU-GT placed today at bedside. NPO for procedure except meds. Placed at 1230 today and to gravity drainage. Draining bilious drainage. Meds only, per tube tonight. No stool. Foley to gravity with a drop in UOP this afternoon, Diamox IV x 2 doses ordered and started. UOP picked up after. KUB done. UGI done.

ID- afebrile, Kefzol 2 gm x 1 for procedure.

[**Name (NI) **] Husband in for visit and update. Was supose to meet with SW, but could not wait. She can call him or leave a # where he can call her. No family meeting today?

Plan- Monitor rhythm, SBP, resp status during wean. NPO except meds per new GT. Watch UOP and notify team if it's below 30cc/hr.

"

"N: pt opens eyes spontaneously, PERRL, 3/brisk, grimaces to pain in upper extrem. and withdraws from BLE stimulation. No FC. Unable to adeq. assess pain, pt appears to be comfortable and is not medicated, VSS. pt continues on dilantin IV.

C: NSR - ST early in shift, occas. PVC's, tol. lopressor, BP stable, BUE pulses palpable, BLE dopplerable.

R: #8 portex trach intact with small amt bleeding, inner cannula replaced. O2 sats >93% on CPAP 40% 5/10. ABG's sent 0500. BBS clear.

GI/GU: abd. softly distended, BS+, PEG to gravity mod. amt dark brown/burgundy coffee ground drain., NPO except meds, dsg cdi. foley draining inadeq. HUO. HUO < 30 cc/hr approx 2300. Diamox given early per PA without brisk diureses. HUO remains approx. 30-40 cc/hr.

endo: no SS coverage needed.

"

"RESP CARE: Pt recieved trached with 8.0 portex TT/cuff pressure 25cmH20 with 14cc air inserted. Inner cannula patent. Sxd scant amt bld tinged sputum.. Remained on CPAP/PS all shift [**11-1**]/.40. Vts 350-400/RR 24-30. Lungs ess. clear. AM RSBI-144. AM ABG pending. Will continue to wean vent as tol.

"

"resp care

Pt remained on a/c 450x14 50% 12 peep with peak/plat 28/26.Abg revealed improved oxygenation with resp alk. Pt overbreathing consistently.BS [**Month (only) 88**] and clear.Suct for no sput.Rsbi held due to inc peep level.Will cont to follow and make adjustments as needed.

"

"7A->7P

Neuro- Opens eyes, does not fix or follow, some withdrawl to nailbed pressure. Positive gag and cough. PERRLA 3mm->2mm OU. Followed by Neruo.

CV- SR 70's to 90's with burst of Afib up into the 150's, Lopressor increased to 37.5 mg po BID and a 1 time dose of 2.5mg IV given. Replaced K+ x 2. Some PVC's noted throughout the day. SBP 110's-150's by cuff. UOP > 30cc/hr without diuretic. + [**3-1**]+ edema to hands.

Resp- CPAP->Trach collar 40% for the morning, ABG with decreased Pao2 from 97 to 77, FIO2 increased to 50%. Sats in the high 90's all day. Lungs clear, suctioned x 2 for thick white/bld tinged sec in moderate amounts. Back on CPAP at 1700 d/t prolonged HR in the 150's, ? Afib. ? tiring from Trach collar.

GI/GU-Biscodyl supp given and then Fleets enema with good results, 2 bms this afternoon. Brown, semiformed. TF of Nutren 2.0 started today at 10cc/hr, increased every 4 hours until a goal of 35cc/hr. Hold for residuals > 100. Max for me was 12cc. Free H2O also started at 250cc every 6hrs. Foley to gravity with marginal UOP at times. No extra fluid or diuretics given.

Skin- Coccyx wound assessed, dark skin over wound bed, appears to be a blister or skin tear that has broken and lying on wound bed below. New allyeven dsg placed. Trach care done but inner cannula not changed out. GT dsg, left alone d/t no drainage and dsg C/D/I. A new spot just below trach was noted and cleaned, dsg in place.

Social- No contact with family today. SW in and called husband, appeared to have high expectations for his wife once at rehab. ? if he is being unrealistic. Will follow family. Rehab screening has started with placement expected to be soon.

Plan- Prepare for rehab, monitor rhythm and b/p. Watch resp status and follow sats, suction PRN. Advance TF as tolerated to goal of 35cc/hr. Monitor UOP.

"

"7A->7P

Neuro- with drawls bilateral legs to pain, no movement of upper extremities to pain or other stimuli noted.

"

"Resp Care

Pt currently on PSV via trach. Had TM trial for 8hrs, placed back on PSV, for Afib. Sx small yellow thick recieved mdi's as ordered. Plan to continue with trach mask trials and prepare for rehab.

"

"Neuro: does grimace to nail bed pain in bilat lower and left upper extrem, none in right arm, does grimace to mouth care and sternal rub, no seziure activity, pupils are equal and non-reactive though there was time that ? did look slightly sluggish to react np aware will continue to monitor status and cont dilantin.

Cardiac: nsr, no ectopy, continues nitro gtt for bp, pedial pulses, skin warm and intact, afebrile, did have ultrasunds of bilat legs and did r/o for dvt's, +2 edema in extremities, will place venodyme boots.

Resp: lungs are clear, doing chest pt to left lower lobe for atelectisis, sxned for scant thick white, no vent changes made.

Skin: intact, chest with dsd that is cdi, old ct dsd is cdi.

GI/GU: npo, og tube to lwsxn draining small amount of billeous, on riss, abd is soft and round no bowel sounds yet, did start lasix gtt for low u/o and has not responded to lasix as gtt has been slowly increased with no good u/o yet.

Social: no calls yet this shift.

Plan: continue eeg, monitor for any sezizure activity, wean nitro as tolerates, monitor u/o, monitor neuro status.

"

"Respiratory CAre:

Pt remians orally intubated and vented. Fio2 weaned to 40%. Lung sounds ronchi. Suctioned for minimal thick white/tan secretions. Plan to weaned vent support as tolerated. Will follow.

"

"Respiratory Care Addendum

Per team FiO2 kept at 50%, PEEP weaned to 10.

"

"CVICU-B NSG NOTE

1200>>1900

78 yo female s/p repair aortic anuerysm dissection [**7-15**] which was complicated by new right CVA(per CT [**7-16**]).

EVENTS: patient remains unresponsive with upper extremity extension to nailbed pressure and withdrawal of lower extremities to nailbed pressure. NO response to voice, but immediate response to stimulation: mild stimulation results in head turn to right and left shoulder shrug; occassionally upper extremity extension, and one or both feet flexing and sometimes rotating outward. Patient exhibits sucking reflex to oral stimulation. Occasional nonpurposeful lower extremitiy movement as described above. No eye opening. Pupils are equal and round; there is a delayed constriction of pupils equally to eyelid opening to ambient light; no reaction to direct light stimulation with flashlight. Corneals are intact, although left corneal is currently impaired. Cough is strong; gag is present but impaired. NO sedative medication being given. Dilantin dosing continues with bolus dose of 300mg ivp x1 today. Dilantin level is pending. No seizure activity noted; continues EEG active.

CVS- goal BP is less than 150/systolic with desired blood pressure around 130 for adequate perfusion of tissues(pt's baseline BP allegedly ~ 200/systolic.) NTG infusion titration to achieve BP goals with every 4 hour lopressor(2.5mg ivp) and prn dosing of hydralizine(20mg ivp every 6 hours). See careview for specific details. Heart rate remains regualr without VEA; rythym is questionably junctional (EKG pending). Brief self-limiting episode of A. Fib.

RIJ [**Location (un) 873**] introducer was rewired with MLC. CVP transduced with values of 17>>14. Some sanginous draainge from around insertion site which is stitched but continues with some oozing. CXR confirms placement(required adjustment as catheter is 20cm and was in too far.)

** Pacing wires discontinued today; scant s/s draiange to dressing following removal of wires.

RENAL- lasix infusion initiated today(dosed with bolus lasix and bumex without success). Infusion at 10mg per hour with hourly urine outoput ar 35-60cc; clear, yellow; lights pending.

Serum elctrolytes repleted per sliding scales.

**creatinine elevated to 1.9(1.6); lasix to be weaned as tolerated.

RESP- remains vented on AC with overbreathing of set ventilator rate.

PEEP weaned to 10(12); fio2 remains 50%; saturations remain 100%. Adequate gas excahnge per abg; continues with compensated values:respiratory alkalosis/metabolic acidosis. Breath sounds remain coarse with decreased LLL; minimal tan thick secretions. Atrovent inhalers ordered.

ID- t.max 99.1; wbc mid teens; no antibiotics.

ENDO- insulin infusion discontinued; ssri coverage per protocol: 8 units given at 1800 for 176. (Pt is non-insulin dependant diabetic.)

GI- Dohoff feeding tube placed; xray confirms post-pyloric placement. Nutren renal started at 10cc/hour with goal of 35cc/hour. Abdomen is soft with hypoactive bowel sounds; no stool.

HEME- repeat HCT 28.7(30)

SKIN- warm & dry; palpable periphe

"

"CVICU-B NSG NOTE

(Continued)

ral pulses; peripheral edema evident. Compression boot therapy initiated today after LE ultrasound revealed adquate arterial perfusion.

NO breakdown areas noted on pressure point areas.

[**Name (NI) **] husband called for update which was provided. He plans on visiting QOD in aftenoon. He states he understands patient's condition is is taking ir 'every day at a time'.

ASSESS- 78 yo female s/p aortic aneurysm repair complicated by water shed CVA and seizure activity. Patient remains unresponsive with some abnormal reflex. Sedation, analgesia therapy on hold pending patient waking.

PLAN- continue with stated plan of care for BP management, seizure control, and pulmonary care.

"

"7a-7p

Neuro: Pt unresponsive throughout the shift. PERRLA brisk/slightly sluggish right eye. Pt moves all extremities to tactile stimuli nonpurposefully. Pt with no evidence of pain using nonverbal scale. Neuro docs in to see pt in AM and pt on continuing EEG monitor. Pt to remain on monitor for another 24hrs.

CV: HR 60's-80's. Pt in and out of junctional rhythm/a-fib. [**Name8 (MD) **] NP[**MD Number(3) 94**] and EKG obtained. no ectopy. SBP 90's-150's. Hydralazine given prn. Pt also started on Norvasc and Metoprolol and pt weaned off nitro drip. See flow sheet for pulses.

Resp: LS-coarse and diminshed left lower lobe. Pt switched over from CMV to CPAP. Pt currently on CPAP with 50% FiO2, 5 PEEP, 5 PS with no signifigant changes in ABG's. Pt given diamox for pH > 7.50 x3 doses [**Name8 (MD) **] NP [**Doctor Last Name **]. Pt suctioned prn with thick white secretions.

GI/GU: Abd soft with hypoactive/present bowel sounds. Pt continuing to receive Nutren Renal tube feed at 35cc/hr with no residual. Foley draining clear, yellow urine. Pt continuing on lasix drip at 10cc/hr. Pt with output ranging from on average 60-110cc/hr. Pt not meeting goal of [**1-27**].5L/day. NP [**Doctor Last Name **] aware. Pt also given diamox to help with diuresing.

Skin: See flow sheet.

Endo: Pt with blood sugars 120's-170's. Pt placed on Humalog sliding scale q4h and given 20 units of lantus SQ at 1100 [**Name8 (MD) **] NP [**Doctor Last Name **].

Plan: Continue to monitor hemodynamics with goal SBP 130's. Monitor sugars and monitor urine output. Continue to monitor respiratory status and check ABG's.

"

"RESPIRATORY CARE:

Pt's resp status remains unchanged, supported on PSV/CPAP. BS's diminished and coarse, sxing thick white secretions from ETT. Administering Combivent MDI Q4. RSBI=59 this am. See flowsheet for further pt data. Will follow.

"

"NEURO: PEARL AT 3-4MM/BRISK, NOT OPENING EYES TO ANY STIMULATION, FREQUENTLY COUGHING, + GAG. WITHDRAWS FEET TO TACTILE STIMULATION, L FOOT MORE EXAGGERATED THAN R. POSTURING OF UPPER EXTREMITIES WITH SXING. CONTINUOUS EEG ON, NO SEIZURE ACTIVITY NOTED. DILANTIN IV AS ORDERED. LEVEL THERAPEUTIC.

PULM: ORIALLY INTUBATED, CPAP MODE, NO VENT CHANGES. RSBI 59. ABGS IMPROVING CONTINUES WITH SLIGHT RESPIRATORY ALKALOSIS. LUNGS COARSE THROUGHOUT, SX'D ~ Q30 MINUTES FOR SMALL AMOUNTS THICK TAN-WHITE SECRETIONS. TACHYPNEIC AT TIMES. T AMX 100.8, TYLENOL 650 VIA FEEDING TUBE.

CV: JUNCTIONAL RHYTHM-NSR WITHOUT ECTOPY. BP LABILE, NTG GTT OFF ALL SHIFT. HYDRALAZINE 20MG IV X 1 FOR SBP > 160. SBP DOWN TO 91 AFTER LOPRESSOR DOSE. PEDAL PULSES PALPATED.

ENDO: Q4H HUMALOG SLIDING SCALE. BS 120-186.

GI: ABDOMEN SOFT, AUDIBLE FLATUS, NO BM. TOLERATING TUBE FEED AT GOAL 35CC/HR VIA DOBHOFF, NO RESIUDUALS.

RENAL: CREATININE 2.0. ON LASIX GTT AT 10MG/HR, GOOD HUO ESPECIALLY WHEN SBP > 130. NEGATIVE 330CC FOR 24H. K REPLETED PER LABS/ORDER.

SOCIAL: NO VISITORS OR PHONE INQUIRIES.

PLAN: CONTINUE EEG UNTIL DC'D BY NEURO. NEURO ASSESSMENTS, ? CT SCAN ONCE EEG DONE. IV DILANTIN FOR SEIZURE COTROL, MONITOR LEVELS. CONTINUE CPAP MODE, PULMN HYGIENE, IV DIURESIS, ELECTROLYTE REPLETION.

+

"

"update

Dilantin level this am was 11. Team ordered 500 mg Dilatin x 1 in additon to the patients TID order of Dilantin. no seizure activity noted. pt continues on Nitro gtt for BP control. On morning rounds the team increased the pt's dose of norvasc and increased to frequency of PO Lopressor.

"

"RESPIRATORY CARE:

Pt remains intubated, vent supported. No changes overnight. Continue to sx large amts secretions, administering MDI's as ordered. See flowsheet for further pt data. Will follow.

"

"Neuro:Patient remains unrespnsive,does not follow commands.Pupils equal and reactive.Moves both feet/toes with stimulation,Left foot>right.No movement of upper extremeties with stimulation. Receiving IV Dilantin dose increased->No seizure activity and continuous EEG monitoring d/c.Head CT done without contrast,results pending.

CV:NSR/first degree AVB 60's and no VEA.After IV Dilantin given over 10min-> transient occurrence of SB 56-59 no vea that resolved spontaneously.Followed arterial BP b/c sharp waveform and 20 points >

cuff pressure.Kept SBP<150 at goal per attending,MAP 80-90's with Lopressor,Norvasc,IV Hydralazine ->IV NTG wean off.Palpable DP/PT pulses bilat,warm csm.Electrolytes replaced.

Resp:Reeceived patient on CPAP/PS 5,FiO2 .50/PEEP 5,ABG->metabolic alkolosis tx with IV Diomox.Patient had kussmal breathing with frequent apneic periods lasting 10sec,team notified. Vent settings changed to MMV .50/ 500x12/

PEEP5/PS 5->ABG->metabolic alkolosis and apnea/Kussmal breathing

resolved. Lungs initially rhonchirous upperlobes/coarse in lower lobes .After suctioning patient for moderate amountof thick white->lungs in upper lobes clear and mildly coarse in lower lobes.O2 sat >95,RR 20's.No bronch scheduled today

GI/GU:Positive bowel sounds,abdomen is soft,nondistended. No BM yet->colace. Tolerating Tubefeedings well at goal rate 35ml/hr and no residuals.KUB done->confirmed placement of dophof below pyloris. Received patient on IV Lasix gtt at 5ml/h-> u/o low 60-80ml/hr and 250ml positive.Notified [**Last Name (NamePattern4) **] PA->extra dose IV Diomox-> low u/o.IV Lasix gtt increased 8ml/hr and IV Diuril given->u/o >100ml/hr.Goal is >75ml/hr and 1.5L negative.

Endo:fingersticks managed well with SS Humulog insulin and am dose Lantus.

ID:afebrile,no IV antibiotics.

Skin:sternal /mediastinal dsd dressing have old serosanquinous drainage

Social:Husband visited and updated about patient's plan of care

Plan:Keep sbp<150,U/O >75 ml/hr and goal is 1.5L negative.Dilantin serum goal level 15-20.Monitor neuro status for seizure activity. Social work consult for emotional support for husband

"

"Respiratory Care

Patient remains intubated and on mechanical ventilatory support, breath sounds revealed bilateral expiratory crackles, suctioned intermittently for moderate amounts of thick white secretions, treated with Combivent inhaler, travelled to CT for head and chest scan, switched from PSV to MMV because she was often apneic, will continue to be followed.

"

"NIGHT SHIFT 11P-7A.

PT. REMAINS A FULL CODE AT THIS TIME.

PT. HAS NKDA.

PT. REMAINS UNRESPONSIVE AT THIS TIME AND DOES NOT FOLLOW ANY COMMANDS. PT. IS NOTED TO MOVE BOTH LOWER EXTREMITIES, NOT TO COMMAND. WHILE BILAT UPPER EXT'S EXHIBIT NO MOVEMENT AT ALL. PT. EXHIBITS LOW GRADE TEMP WITH TMAX 99.8. PUPILS REMAIN 3-4MM AND BILAT REACTIVE. PT. CONTINUES TO RECEIVE DILANTIN I.V. WITH NO SEIZZURE ACTIVITY NOTED THIS SHIFT. CONTINUOUS EEG MONITOR HAS CEASED AND CT HEAD AND CHEST PERFORMED LAST EVENING WITH RESULTS STILL PENDING.

PT. HAS REMAINED IN A NSR60-70'S WITH NO NOTED ECTOPY. PT [**Name (NI) 2238**] HAS REMAINED IN THE MID 70'S BUT WITH DILANTIN DOSES, PT. DROPS INTO THE MID 60'S. SAME EFFECT NOTED DURING DAY SHIFT WHEN PT. DROPPED INTO THE MID 50'S. B/P HAS RANGED 124-152/50-70'S. GOAL IS TO MAINTAIN SBP <150. LEFT RADIAL ALINE EXHIBITS SHARP WAVEFORM. PEDAL PULSES HAVE VARIED FROM EASILY PALPABLE ON DAY SHIFT AND THIS NIGHT SHIFT. DURING EVENINGS PULSES WERE DOPPLED. POTASSIUM WAS REPLETED ON EVENINGS AND CLIMBED FROM 2.8-3.9 AFTER 60MEQ KCL. CVP REMAINS 13-18 WITH LASIX GTT STILL INFUSING AT 8MG/HR.

PT. IS CURRENTLY INTUBATED ON MMV VENT SETTINGS. 50%/450/10/5 PEEP. RESP RATE HAS REMAINED >20 BPM. LUNGS HAVE BEEN CLEAR MID TO UPPER WITH CRACKLES NOTED IN RIGHT BASE. NOW LUNGS ARE NOTED TO BE CLEAR FROM MID TO UPPER, WHILE BIBASILAR DIMINISHED. PT. HAS BEEN SUCTIONED FOR SMALL TO MODERARTE AMT'S OF CLEAR FROTHY SPUTUM. MODERRATE AMT'S OF CLEAR ORAL SECRETIONS NOTED AS WELL. PT. CONTINUES TO EXHIBIT METALBOLIC ALKALOSIS.

ABD. IS SEMI-FIRM, WITH BOWEL SOUNDS EASILY AUDIBLE X4 QAUDRANTS. TUBE FEEDS OF NUTREN RENAL CONTINUES TO INFUSE AT GOAL RATE OF 35CC/HR VIA DOBHUF TUBE. BLOOD SUGARS ARE SLIGHTLY ELEVATED 150'S REQUIRING SMALL DOSES OF INSULIN FOR COVERAGE. NO STOOL NOTED THIS SHIFT.

FOLEY CATHETER REMAINS INTACT, WHILE DRAINING LARGE AMT'S OF CLEAR LIGHT YELLOW URINE. LASIX GTT REMAINS ON AT 8MG/HR TO MAINTAIN GOAL OF >75CC/HR OUT AND GOAL OF 1.5 LITERS NEGATIVE X24HRS.

SKIN INTEGRITY EXHIBITS DRESSING TO MID LINE CHEST AND ABD. THIS DRESSING WAS CHANGED ON EVENING SHIFT AND REMAIND CLEAN, DRY, AND INTACT. BOTH LEFT RADIAL ALINE, AND RIGHT TLC ALL REMAIN INTACT, SECURED, AND FUNCTIONING WELL.

PLAN IS TO CONTINUE TO MONITOR B/P CLOSELY AND UTILIZE ANTIHYPERTENSIVES PRN. MONITOR CLOSELY FOR ANY SEIZURE ACTIVITY. OBTAIN CAT SCAN RESULTS. OBTAIN A SOCIAL WORK CONSULT TO AID IN EMOTIONAL SUPPORT FOR PT'S HUSBAND.

"

"RESPIRATORY CARE NOTE

Patient remains intubated and ventilated on CPAP/PS settings at this time. On vent change was decreasiing the FiO2 to 40%. RSBI completed on PS 5=92. Plan to wean as tolerated.

[**First Name11 (Name Pattern1) 220**] [**Last Name (NamePattern4) 221**], RRT

"

"Addendum:

Pt. has converted between a junctional and an accelerated junctional rythm with rate ranging 44-64, with occasional PAC's. Team has been made aware and will discuss to decrease dose of betablockers. Pt. am potassium was 3.1. Pt. received a total of 60meq of KCL (40meq po, and 20meq IV). Pt. is continuing to duiresis large amt's. Vent changes made, Pt. was dropped to Fio2 of 40%, down from 50%.

Pt's CT head results came back as well. They are significant for: multiple subacute infarcts in the right frontal, parietal, temporal, bilat. occipital, and cerebellar lobes. No noted hemmorphage, no mass, nor was there a noted mid line shift.

"

"Respiratory Care

Patient remains on ventilatory support, changing to CPAP/PSV mode. No periods of apnea noted. Bronchoscopy preformed, moderate to copious amounts of thick light green/yellow secreations suctioned bilatterally and sent to lab for BAL's.

"

"See [**Name6 (MD) 66**] data, MD notes/orders.

Neuro: Remains unresponsive with intact cough/gag, pupils and cornea. Flex withdraws lower extremities to nail bed pressure.

CV: Fluctuating bp with increase in response to turning and suction. Hypotensive mid morning with cvp 0-2. Recieved one unit prbc and 12.5grams albumin with bp currently 146/60 and cvp 3. Lytes repleted prn.

Pulm: No vent changes, rr 22-26, 02 sat 95-98%. Lungs coarse with rhonci, pt suctioned for thick pale yellow secretions.

GU: Lasix gtt weaned and then dc'd for rising bun/cr and hypotension in setting of CRI and hx of one functioning kidney. Diamox initiated [**Hospital1 35**] x 48hrs. Pm bun/cr 61 and 1.7 down from 65 and 1.9.

GI: Abd soft, bs present. +flatus/no stool this shift. Tube feed formula changed to Nutren 2 with goal rate 35cc/hr.

Endo: Lantus this am and ssc per [**Month (only) **] q4hr. Glucose at 1800 42 with repeat 43. 12.5grams D50 IVP with increase to 69.

Skin: Grossly intact with 2+ dependent edema. Coccxy with bony prominence and skin color changes. Peripheral pulses palpable. Right IJ TLC with persistent bloody oozing, team aware of same.

Soc: Husband in today and spoke with neuromed fellow re: prognosis and time line improvement if it occurs (it should be within thirty days of stroke). He also states understanding of the [**Doctor Last Name 464**] magnitude and the possibility of mulitple deficits if his wife does ""[**Name2 (NI) **] up"". Social worker [**Name (NI) 605**] for support, pt does have grown children and states that if the outcome is poor that he and [**Last Name (un) 341**] family have had a ""good life together"". [**Last Name (un) 2239**] paged at family request.

P: Continue to follow neuro status, notify neuromed of any decline in exam. Continue antihypertensives as tolerated for sbp<150, observe for recurring hypotension. Follow respiratory effort, 02 sats, abgs/cxr as indicated. Consider further diuresis if uo tapers off, diamox as ordered. Follow and replete lytes prn. Tube feeds as ordered, consider bowel stimulation if pt does not stool. Meticulous skin care, turn Q2hr as tolerated, may need air matress if hospitalization is prolonged. Keep family up todate on poc, offer support and encouragement. Parking stickers on board in room for pts husband, notify social worker when he visits next, contact clergy in am. Picc line assessment/dc tlc, peg/trach planned for near future.

"

"1900-0700:

neuro: remains unchanged, perrl, sluggish. corneals intact. moving ble on bed, no movement of ue. no evidence of pain.

cv: sr 80-90's, no ectopy noted. k persistently low, repletion per orders. remains hypertensive despite lopressor and hydralazine. goal sbp < 150. easily palpable pedal pulses bilaterally. t max 100.4. remains on cipro and zosyn.

resp: lungs coarse and rhoncherous throughout. placed on ac for rest. abg continues with metabolic alkalosis. o2 sat > 95%. suctioned for minimal thin secretions despite rhoncherous lung sounds.

gi/gu: abd softly distended, bs positive. tol tube feeding at goal. foley to gravity, good huo. diamox x 24 hours. bun/cr pending.

endo: fs q 4 hours, humalog ss and lantus q am. bg remained stable overnight 96-129.

plan: monitor neuro status, trach and peg next week.

"

"Respiratory Care:

Patient switched from CPAP/PSV to A/C ventilatory support due to increased WOB, demonstrated with rr>30-35. Ventilatory pattern demonstrated less strained effort. Latest abg results determined a partially compensated metabolic alkalemia with good oxygenation on the current settings.

RSBI = 150 on 0-PEEP and 5 cm PSV.

"

"Respiratory Care

Patient remains on ventilatory support. Placed on CPAP/PSV mode for approximately six hours before developing prolonged periods of apnea, lasting 20-30 seconds, every one-two minutes in frequency. Placed on AC mode and then MMV. MDI given a ordered.

"

"NPN:

Neuro: Remains unarousable. Slight LE withdrawal to painful stimuli.

Movement of R leg seen in am but no L leg movement. No movement of UE's. Extremities flaccid. 2+ edema UE's.Pupils 2mm nonreactive. Corneals +, + gag and cough. Neuro following-only brainstem reflexes. PT/OT will defer eval until ? after trach/PEG. No seizure activity seen. Dilantin changed to 400mg qd.

ID: Temp 99.9-100.4 orally. IVAB dc'd. WBC 10.0. Awaiting evaluation for PICC.

Social: No family contact today. SW [**First Name8 (NamePattern2) 392**] [**Last Name (NamePattern1) 411**] left stickers for husband.

CV: 98-82 SR without VEA. L radial aline with SBP 20-30 points higher than cuff BP. Lopressor 12.5 given with lowered BP 100's/. Amlodipine dc'[**Name8 (MD) 2240**] NP [**Doctor Last Name 307**]-goal SBP 140-150/. Palpable pedal pulses. Skin warm and dry. Hct 31.6. Started on natrecor 0.01 increased to 0.015.

Resp: Remains orally intubated. Placed back on CPAP this am for 6 hrs with increasing apneic periods @ 14pm. Placed on AC then MMV. ET suctioned for small amounts clear secretions. Sats 96-98%.

GU: Foley. UA C&S sent. UO 60-100cc/hr despite natrecor and diamox. Creat stable at 1.7.

GI: Abdomen soft, nontender and nondistended. +bowel sounds and flatus. Tolerating TF's Nutren 2.0 at 35cc/hr with minimal residuals. Colace continues. Given lactulose 30cc X1 and dulcolax suppository with small soft brown to liquid stool X1. TF's off X2 hrs @ dilantin dose.

Endo: Lantus given as ordered. Treated with humalog per sliding scale. Glucoses. 148-112.

Incisions: Sternum and CT with DSD. R fem steri's C/D-OTA.

Skin-continues with 4cmX8cm DTI. Criticaid to coccyx. Discuss need for possible Kinair bed.

Activity: Turned side to side q 2 hrs with total assist.

A: Continues unresponsive without neuro change.

P: Attempt diurese 1 Liter/day, ? kinair bed?, Possible family meeting to evaluate family understanding of neuro findings. Plan trach and PEG for ? early next week. replete lytes prn.

"

"Respiratory Care:

Patient switched from CPAP/PSV mode to A/C due to ^ WOB as demonstrated by an increased rr(>35). Also having short periods of apnea. Latest abg results determined a metabolic alkalemia with good oxygenation on the current settings.

RSBI = 97 on 0-PEEP and 5 cm PSV.

"

"Neuro) See neuro assessment. Pt. does not respond to any commands and all movements are non-puposeful. Noted to move RLE > LLE with knee flexion spont. and to nailbed pressure. Both upper extr. extend and then rotate inwards slightly to nailbed pressure. Continuous EEG monitoring with no outward evidence of seizure activity. Dilantin level sent with morning labs.

CV) Heart rhythm remains nodal at rate 70-80's. No evidence of p-waves in multilead tracings. Lopressor held after discussion with Dr. [**Last Name (STitle) 249**].

Iv NTG titrated to keep SBp 130's. Very difficult to maintain stable BP range. Hydralizine increased to Q4 hr frequency.

Pulm) Peep weaned to 5cm. Sao2 >95% throughout. ABG's mild resp. alkalosis. Set vent rate 14 with ~ 6-8spont breaths above set rate.

Secretions thick yellow. Combivent per in-line circuit by RT.

GU) Lasix drip at 10mg/hr. Goal to have pt. negative 1-2 liters in 24 hrs. K+ repleted prn. Bun/Creat pending.

GI) Nutren renal per nasal FT at 35cc/hr goal rate. Tube reported to be post-pyloric. No stool as yet.

Skin) intact. Incisions C&D. Right IJ CVL site dsg changed x2 due to bleeding at site. Pressure points free of ulcers.

Plan) Pulm. management. Diuresis. Monitor neuro status and events.

"

"RESPIRATORY CARE:

Pt remains intubated, fully vent supported. Minimal changes overnight, weaned peep 10->5. BS's diminished, sxing tenacious secretions. Administering Combivent MDI as ordered. RSBI=98 this am. Left on vent support. See flowsheet for further pt data. Will follow.

"

"RESpiratory CAre:

Pt remains orally intubated and vented. Pt weaned to PS 5, Follow up ABG showed respiratory alkalosis with mild hypoxemia.Traveled to and form CT without incident (test was cancelled). Lung sounds coarse. Suctioned for moderate thick yellow secretions. MDIs given per order. Will follow.

"

"AARRIVED @ 0550 S/P AORTA DISSECTION WIHT HEMIARCH REPAIR. INTUBATED SEDATED. BP LABILE. NEO/NTG/FLUID. CT OUTOUT=200X2HRS. ACT=175. 50MG PROTAMINE IV X2. A-PACED @ 90 WITH UNDERLYING RHTHYM = NSR @ 68. K REPLETED X1. HCT=24.2 WITH CO/CI 2.0/1. 3UPRBCS TO BE INFUSED. BAIR HUGGAR PLACED ON PT.

_x0013_

"

"Respiratory Therapy

Pt remains orally intubated on full mechanical support. Continues on SIMV/PSV w/ PIP/Pplat = 26/22, maintaining Ve ~6L/M not overbreathing set vent RR of 14. ABG WNL. See resp flowsheet for specific vent settings/data.

Plan: maintain support; wean PEEP as tolerated

"

"Neuro: Pt initially sedated on propofol. After warming pt reversed and propofol off at 10am. Pt has not yet woken. Pupils pinpoint, sluggishly reactive. Pt +cough reflex and feet will flex when babinski checked. No spont movement noted. Plan to hold all sedation and narcs. Frequqnr neuro checks

CV: Initially apaced pt for CO, but now in own intrinsic rhythm 70-80 nsr, with rare pvc. Pt noted to have ST elevation on monitor, EKG performed, not impressive per [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **]. Initial BP goal to maintain sbp 90-100. Pt needed combo of NTG/SNP and nicradipine. All currently off. New goal for BP <140 per Dr. [**Last Name (STitle) 816**] to help with renal perfusion. Dopplerable pedal pulses. CT with marginal output. Pt transfused 3 untis PRBC throughout day for HCT<30 and CI<2 and SVO2 <52. Current CI by fick >2.3 and svo2 60's. Pt received additional 2.5 L crystalloid. Per team if pt needs further fluid replacement to use albumin. V wires don't work

Resp: Remains orally intubated. No vent changes made. ABG WNL. Plan to wean peep. Lungs dim lt base. Sx for minimal thick white. O2 sats improved from 92-96%

GI: OGT to lcws--drng initially bloody now bilious. Abd soft, absent bs

GU: UOP initally < 20cc for many hours. Pt given total of lasix 60mg in divided doses with no response. When BP parameter increased pt uop increased---see flowsheet. urine clear yellow

Endo: started on insulin gtt per protocol. Requiring only 0.5 units/hr. Hourly bs done

Social: No family calls or visits. [**Initials (NamePattern4) **] [**Last Name (NamePattern4) 87**] called husband [**Name (NI) 2236**] this PM and gave update on pt. Family not visiting today.

Plan: Cont frequent neuro checks. Hold sedation. Cont assess cardio/resp status. Let BP go as high as 140 for renal perfusion. If sustains bp>140, ntg 1st drug to use per [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **]. Cont q1hr bs while on gtt. wean vent when appropriate.

"

"Neuro:At onset of shift,patient continued to be unresponsive. Gradually,patient became more responsive by moving toes with painfull stimulation to both feet and she moved her mouth with suctioning.No spontaneous movement of extremeties,pupils pinpoint and no corneal response.No c/o pain.Positive cough reflex with suctioning but no gag response.

CV:HR Increased to97 NSR- 102 ST with stimulation->NSR 70- low90's occassional PAC's at rest.Continues with ST elevations on monitor.At rest SVO2 >60 but with turning/bathing SVO2 decreased 54-> Recovered to 57-58 at rest with fick CI<2 and U/O 8-10ml/hr.Called [**First Name8 (NamePattern2) 353**] [**Last Name (NamePattern1) **] MD->gave 5% IV Albumin infusionx2->SVO2 increased 60-64, with fick CI>2,reclibrated mixed venous 63 and uo increased 35ml.See careview for filling pressure and SVR.Followed NBP b/c arterial line dampened.With stimulasation SNBP increased

184 tx with titrating doses IV NTG/Nicardin->effective in keeping goal SNBP<140. HCT 36 and electrlytes wnl.DP/PT pullses palpable bilat/warm csm.Chest tube to wall suction and drained small amounts serosanquinous drainage.

Resp:Received patient on SIMV+PS FiO2 .50/450 x14/PEEP 8/PS 5->ABG nl,no changes in vent settings and sat96-98.RR15-19 ocassionally overbreathed vent.Suctioned for small amounts thick blood tinged sputum.Lungs clear upper lobes and diminished lower lobes.

Skin:Sternal/mediastinal dsd dressing with old bloody drainage.Skin intact

ID:Low grade T100 max and wbc13.4.Patient receiving IV antibiotics.

GI/GU:B/CR increased 24/1.5. U/O remains <20ml/hr clear yellow urine.No bowel sounds,abdomen is soft,nontender and nondistended.OGT draining modeerate amounts bilious drainage to low wall suction.

Endo:Fingersticks wnl ,no insulin given.

Social:Husband called and asked a lot of questions.He was updated about patient's condition.

Plan: Wean Iv NTG/Nicardin to Keep SBP<140 and monitor u/o .?head CT to eval neuro status

"

"resp care

Pt remained on imv 450x14 50% 8peep 5psv with peak/plat 20/16.Pt starting to overbreath. RSBI and abg acceptable. Will cont to follow and wean as tolerated.

"

"resp. care

pt. remains intubated/vented. not waking up. ? seizure. head scaned.

eeg in place. did well on cpap/ps until ? seizure. back on full

support. see flowsheet for more.

"

"Neuro: Pt continues to be unresponsive. Pt had 2 witnessed seizures today, both lasting less than 2 minutes and affecting left side. Ativan given. CT showed CVA on rt side, neuro following. Noted spont movmt lower legs, and legs withdraw from pain, otherwise on change in neuro assessment. Pupils non reactive. Pt given dilantin load at 1230 to receive dose q8hr. Cont EEG placed this pm.

CV: SR this am with pac's, lopressor given IV. During dilantin load pt bradycardic into 50's, pt apaced. Now HR back in 70's flipping bewtween junctional and sr. required neo briefly during bradycardic episode. Now titrating ntg to maintain sbp >110<130. New aline placed. Swan dc'd. PRN lopressor. CT dc'd. Palp pedal pulses. Pt ordered for NIVS, if negative venodynes to be placed for DVT prophlayxis.

RESP: PT cont to be orally intubated. Placed on PS this am, pt did well but switched back to IMV post sz. This pt exhibiting irregular resp pattern alternating rapid rate and the slower. Pt hypertensive with tachypnea. Placed on AC to maintain TV. PT also had acute desaturation requiring peep ^12. Sx thick tan blood tinged. Awaiting repeat CXR. AM CXR showed lll collapse. CPT performed. Sat now on peep 12 94-96%.

GI: OGT to LCWS, bilious drng. Abd soft, absent BS.

GU: UOP still margianl 10--40cc/hr. creat 1.5. Plan to give albumin follwed by lasix this pm.

Endo: BS rose post dilantin >120. Insulin gtt restarted per protocol.

Social: Husband into visit. Spoke with [**Last Name (NamePattern4) **] NP. Aware on CT results and need to ""wait and see"". Pt asked appropriate questions. Stated he will be the only visitor and will try to visit every other day around 1-3pm but will call for updates

Plan: COnt assess neuro, cv, and resp status. If cont to have increasingly worsening neuro status can sedate on prop but trying not to sedate at present due to EEG monitoring. Chekc with team. Maintain sbp per above parameters. ALbumin/lasix when arrives. CPT. NIVS then vendoynes. Cont q1hr bs while on gtt

"

"Neuro: Patient remains unresponsive,does not follow commands.With

stimulation she moves her left foot >right foot.Ocassionally,left foot moves spontaneously in the bed .Patient had focal seizure x1

resulting in left arm/shoulder and right foot twitching/hypertensive bp and tachypnea-> lasting about 10min.Tx with

IV Ativan 2mg x1 and IV Hydralazine -> stopped seizure activity.

Remains on continuous EEG monitoring.Bilateral upper extremeties are flacid and fall to bed.Nail beds have capillary refill<3seconds.PERRL

and pinpoint.

CV:NSR-> first degree AVB 80-90's, no vea. SBP labile and increased >150 with slightess stimulation of patient tx with titrating doses IV NTG,IV Hydralazine and IV Lopressor-> transient

BP control. Goal is to keep BP<140.After IV Lopressor dose->accelerated junctional rhythm 70'S, that resolved spontaneously.

Dr.[**Last Name (STitle) 2237**] was updated about BP .Electrolytes repleted.

Palpable DP/PT pulses bilaterally,warm csm.

Resp:Received patient on AC .50/450 x 14/PEEP 12 and patient over breathing the vent with RR 20's. ABG->marginal respiratory alkolosis and improved PaO2 so no vent changes.Lungs clear upper lobes / right base and diminished left base due to LLL collapse. Sat >94.

GI/GU: U/O <20ml/hr->Dr. [**Last Name (STitle) 2237**] notified multiple times and was asked about tx to increase negative fluid balance per Attending->40mg

IV lasix given->marginal increase in u/o.Urine is dark amber.

No bowel sounds present,nontender,soft and nondistended.OGT to low wall suction->bilious drainage. Patient not receiving nuitrional support.

ID:WBC 13.8 and low grade temps.

Endo:fingersticks was managed with insulin gtt->off due to fingersticks >100.

Skin:intact and no breakdown,Sternal/mediastinal dsd dressings intact

with old drainage.

Social:No family calls.

Plan:Keep SBP<140 with IV NTG/Hydralazine.Continuous EEG monitoring for seizure activity.No sedation/narcotics.Keep fliud balance negative and u/o>30ml/hr per team. ?nutritional support. ?compression sleeves after results of venous studies to r/o DVT.Blood glucose management.

"

"Patient on low ventilatory parameters with good spt VT and rate.ABG improved on present setting post elimination of VD from (Y) to ETT.BS clear with low lungs volume.Suctioned for small to moderate amount of thick yellow secretion.Posturing during insertion of suction catheter,not following commands.Patient remains on EEG surveillance with plan to go to CT Scan once EEG leads are removed.On Dilantin for seisure control will continue to follow.

"

"update

D: pt remains decerabrate to stimuli-upper extremities-lower-extended to stimuli. cont eeg today-dilantin level 13-inc dose to 125mg-

neuro unchanged except for right pupil slightly larger and less rx.

pt with inc u/o- thus [**Month (only) 88**] lasix to 5mg/hr. tol ft at present-

plan: await results of EEG- and neuo findings- ? CT once eeg completed. check dilantin level in am-

neuro: as noted above

cardiac: pt remains in nsr-no ectopy, sbp 110-150/ depending on stimulation. sbp will go up to 170's with stimulation--and then down to 130's thereafter. pt u/o better with inc sbp-

palp pedal pulses bilat. feet warm.

resp: bs coarse, dim left bases. sx for mod amt thicker clear to white sputum, abg relatively unchanged. remains on cpap with resp rate mid-hi 20's

gi: abd soft, bs present, positive flatus. tol tf at present.

gu; foley intact- creat 1.9- 2- pt cont on lasix- intial dose 10mg/hr with u/o >200cc/hr- [**Month (only) 88**] to 5 mg/hr with u/o about 100cc/hr.

skin: intact, midline chest inc intact. groin inc- intact with steri strips.

"

"7pm-7am update

Neuro: pt remians unresponsive. pt not following any commands. pt noted to move bil lower ext spontaneously, pt flexing bil feet in an upward motion. No spontaneous movement noted of bil upper ext. When nail bed pressure applied to bil upper ext the pt moved her arms slightly inward/decerabrate motion. + strong cough. impaired gag. PERRL, 4-5mm in size. no seizure activity overnight. pt remains on dilantin TID. Dilantin level 11.1 this am (dilantin level was 13 yesterday and dose was increased). pt remains on continuous EEG monitoring.

Cv: pt remains in NSR, no ectomy noted. HR 60-70's. pt initially had a hypertensive episode-> SBP up as high at 190 with stimulation -> treated with 20 mg hydrlazine, BP remained high -> pt then given 5 mg IV lopressor and started on nitro gtt per Dr [**Last Name (STitle) 859**]. SBP 120-140's on nitro gtt. Nitro gtt titrated to keep SBP ~ 130's. pt noted to becomes hypertesive with stimulation -> SBP 160's. PO lopressor dose increased last night. HCT stable. + pp

resp: LS coarse throughout. pt suctioned frequently for moderate to large amounts of thick yellow sputum. pt continues on CPAP 50% with 5 peep and 5 PS. ABG shows persistant met alkalosis. last abg 7.49/39/105/31/5. diamox re ordered (pt recieved 3 doses of diamox in the previous 2 days).

GI/GU: abd soft. pt with + bs. no stool. pt recieving Nutren Renal tube feedings at 35 cc/hr (goal). no residual. foley draining clear yellow urine. pt continues on lasix gtt at 5 mg/hr -> pt with negative 1788 cc's at midnight. dimox also restarted. BUN/Creatinine this am 60/1.8

endo: elvated BS treated with ss Humalog as ordered

social: no calls overnight.

plan: monitor neuro status, BP control, SBP goal ~ 130's, pulm toleit, continue diuresis, monitor lytes/abg's/BUN & Creatine, continue Dilantin

"

"Neuro: unresponsive; 0 FC; moves only LE, no movement noted in UE; pupils 3mm & reactive; + gag, cough, & corneal reflex; IV dilantin continued 125mg TID d/t sx activity on [**7-16**], no activity noted;

CV: SR 70's; sb/p 104 -142 (goal <150, but [**Doctor Last Name 816**] would like sb/p 140's for better renal perfusion); Hydralazine given x2 - 1st dose 20mg (seemed to be too much, sb/p low 100's) & 2nd dose 10mg (sb/p 120's); CVP 10-14; 2+ pulses bil;

Resp: #7.5 ETT taped 21 @ lip; PS 5, Peep 5, Fio2 40%, no apnea noted; ph 7.45/pco2 46/po2 89; Sat 95-100%; resp 15-24; lungs w/ exp/ins wheezes bil, dim. Lt base; bronched today, cx sent; small, white, frothy sx obtained via in-line sx cath;

GI: + bowel sounds; Lt nare DHT w/ Nutren Renal @ goal 35ml/hr; abd. soft, slightly distended; 0 BM;

GU: foley w/ clear, yellow drainage; excellent UOP (goal 100ml/hr, w/ 1.5L out for 24 hrs.); Lasix gtt @ 8mg/hr;

IV: Lt radial a-line; Rt IJ TLC; D5W @ KVO;

Lab/Endo: repleted K+ 3.2 w/ 40 kcl meq & iCa+ 1.05 w/ 2gm cal glut; Q4 hr SS tx w/ Humalog insulin; am scheduled dose 20 units Lantus;

Skin: sternal/abd incision dsg - D&I; Rt groin incision w/ steri-strips - D&I;

Social: brother called to check on sister; no phone call from husband, tried to contact him but was not successful; was told in report that the husband was having difficulty dealing w/ situation & that social services should be contact[**Name (NI) **]; spoke w/ [**Doctor First Name 392**] re: this, when able to speak w/ husband, ask if want to talk to social services;

Plan: keep sb/p <150; speak w/ husband re: social service contact; trach/peg Thurs???; monitor sx activity; tx labs as needed;

"

"1900-0700:

secretions thick yellow. remains on lasix gtt.

"

"1900-0700:

neuro: unresponsive, perrl. corneals intact. moving le on bed r>l. neuros remain unchanged. stroke team following. no evidence of pain.

po dilantin tid, level 14.6 this am.

cv: sr 70-90's, no ectopy. electrolytes low secondary to lasi gtt. treated per orders. sbp stable, goal < 150. remains on lopressor and norvasc po. sbp 80's after lopressor dose, resolved spontaneously. hydralazine prn sbp > 150. hct 27.5. dopplerable pedal pulses bilaterally.

resp: lungs clear bilaterally. remains on cpap/ps 40% 5/10. abg with mixed alkalosis, po2 71. rr high 20-30's at times. o2 sat 94-97%. suctioned for minimal thick tan secretions.

gi/gu: abd soft, nd. bs positive. tol tube feeding at goal, no residuals. foley to gravity, large huo secondary to lasix gtt. goal 1.5 L negative/day. bun 65, cr 1.9.

endo: fs q 4 hours, humalog ss. lantus in am.

id: t max 100.5. remains on zosyn. wbc 9.5.

plan: monitor neuro status, maintain sbp < 150. ? trach and peg in future.

"

"RESPIRATORY CARE NOTE

Patient remains intubated and ventilated on CPAP/PS settings. Increased PS to 10 d/t tachypnea. RSBi completed on PS 5=103. Sxn for thick yellow secretions. Plan for trach soon.

[**First Name11 (Name Pattern1) 220**] [**Last Name (NamePattern4) 221**], RRT

"

"Resp Care

Pt remains intubated on PSV, no vent changes. Sx for mod amts thick yellow. Plan to monitor nuero status and possible trach/peg early next week.

"

"Neuro:Patient remains unresponsive,does not follow commands,or move upper extremeties. She flexed toes / both feet and opened both eyes

when nail bed pressure applied and turning->EEG done at bedside per neurology team.Ocassionally she chews on the ET tube.+cough/gag.No

seizure activity.Given Dilantin bolus b/c level is subtherapeutic

at 11.5,po dose increased.

CV:NSR80's-90's no VEA.Followed arterial BP <155 which is goal bp.With stimulation SBP increased 160-190's-> Lopressor/IV Hydralazine ->

SBP<155. CVP 4-12->CVP line d/c.Palpable DP/PT pulses bilat,cool csm.

Resp:Received patient on AC .40/450x10/PEEP 5.Changed vent setting to

CPAP/PS .40/PS12/Peep5. ABG->metabolic alkolosis with combo compensation, PaO2 105. Repeat ABG unchanged so plan to decrease PEEP.

O2 sat >96. Suctioned moderate amounts thick white secreations->lungs clear upper lobes and diminished in bases. + cough/gag.

GI/GU:Positive bowel sounds.Abdomen is soft,nondistended.Tube feedings at goal 35 ml/hr via dophof and no residuals.? peg tube placement.

Iv Natrecor d/c [**Name6 (MD) **] [**Last Name (NamePattern4) **] NP. U/O->20-60ml/hr. Fluid balance

goal is to be as negative as possible per [**Last Name (NamePattern4) 2241**] NP.B/CR->50/1.5

ID: afebrile, u/a neg,WBC 12. Multi lumen cath in RIJ d/c and sent tip

for culture.

Skin:Sternal dsd dressing clean/dry/intact.+2 pitting edema in both hands,no LE edema. Large purple area on coxxyc and skin intact->open

to air and turn patient side to side.

Endo:Fingersticks 70's tx with D50. Patient receives am dose lantus.

Check FS every 4 hrs,tx with SS Humulog as needed.

Social:No family calls

IV:PICC line placed left arm,placement checked by xray->OK to use.

Plan:Keep SBP<150,monitor neuro status for seizure activity,CPAP/PS

and try to ween PEEP over night.Keep fluid balance as negative as possible

"

"CVICU NPN 1900-0700

Neuro: neuro status remains unchanged. pupils sluggish to light, reactive, L > R. Brief eye fluttering occurred with initial pressure to LE nailbeds. Withdraws BLE to painful stimuli. No purposeful movements.

CV: SR, no ectopy noted. HR 70-80. SBP 100-140 via aline. 25 mg PO lopressor given. Dopplerable pedal pulses. Afebrile. Goal SBP <155.

Resp: LS coarse, diminished at bases. Suctioned for thick amounts white secretions. Placed on AC d/t periods of apnea on CPAP. ABG WNL. O2 sat 99-100%.

GI/GU: abd soft, NT, ND. (+) BS, small loose BM. (+) flatus. Foley with clear yellow drainage, marginal urine output. BUN 46, Creat 1.3. TF at goal.

Endo: Q4h FS humalog insulin per pt specific sliding scale. Fixed dose lantus due at 0800.

Social: pt's brother called to check on pt status. stated having difficulty contacting pt's husband who is pt's spokesperson.

Plan: monitor cardiopulmonary and neuro status. Trach/peg on Monday. Rehab screen.

"

"Respiratory note:

Pt received on AC, remained on current setting overnight. No vent change made. Sx for thick white secretions. Combivent administered per order. ABG drawn at 2:00 am 7.48/35/97/27. RSBI not completed this am. ^^ RR. Will continue to follow.

"

"NSR. No ectopy. No additional bloods drawn today as discussed with Dr. [**First Name (STitle) 979**]. SBP within goal<150. Distal extremities warm. R DP easily palpated but L DP difficult to locate.

Breathsounds diminished. Occasional need to suction for white secretions. No vent weaning today.

Cotinues on Nutren renal at 35cc/hr (goal). Hypoactive bowel sounds. Passing flatus each time she is repositioned. Continues on qd Ducolax but no stool yet. No stool noted at time of Ducolax insertion.

Continues on q/4hr glucose checks. Lantus given this am but recieving sliding scale insulin every 4hrs. Lantus dose for tomorrow A.M. but glucose now 56. 1/2amp Dextrose given.

Partially opening eyes when name called but not movement of extremieties noted. Arms appear flaccid. R and L leg spasm noted (R more pronounced than L) when pt stimulated by lowering of head of bed or lifting of each leg. No seizure activity noted. Dilantin level 11.7 earlier today.

Continues with purple intact skin in area of coccyx. Area open to air, Criticaid applied and continues on Airbed.

Husband [**Name (NI) **] in to visit and will be here [**7-27**] to talk with the social worker at 1330-1400. Pt stated that he does not own a cell phone and can be reached at home. Dr. [**First Name (STitle) 979**] in to see Mr. [**Known lastname 2242**]. Consent signed by Mr. [**Known lastname 2242**] for tracheostomy and PEG. He stated that he was in aggreement of the trach and PEG as long as it was a ""step forward and not backwards"".

Plan to recheck glucose and continue to monitor. No date or time yet for trach and PEG but will need to stop tube feeding several hours before procedure.

"

"7p-7a

Neuro: Pt arousable to stimuli, opens eyes to care, and nail bed pressure. Moves feet on bed, no movement to upper extremities, grimaces to nail bed pressure. No pain med given per grimace scale.

CV: sr with some pac's, sbp 120's, palpable pulses. tolerating 37.5mg lopressor with no bradycardia.

Resp: Pt recieved trached/cpap on 10 peep 5 pressure support. ls clear dim at bases. sats 98%. rr 18-20's.

GI/GU: abd soft, +bs, tube feeds at goal, nutren at 35ml/hr. Foley to gravity with low urine output, pa [**Doctor Last Name **] aware 40mg iv lasix given, responded well, then urine output down to 20's-30cc's/hr.

Endo: humalog sliding scale every four hours

Skin: on airbed, allevyn to sacrum for skin tear, and allevyn under trach site for skin care.

Social: no calls this shift

Plan: Trach collar as pt tolerates today, oob to chair, screening for rehab, skin care, pulmonaryt toilet.

"

"RESP CARE: Pt remains trached with 8.0 perc Portex trach/25cmH20 cuff pressure. Lungs coarse, sxd thick white sputum. On CPAP/PS 10/5/.40. Vts 300s/RR 20s. Plan is to trach collar this am as tol. RSBI-108.

"

"7A->4P

Transfer note

S/P Aortic Dissection with hemi arch/valve repair on [**7-15**] with no OR complications. Started seizing on [**7-16**], loaded with dilantin and Head CT = evolving ischemic infarction on [**7-20**]. EEG showed mod encephalopathy of toxic metabolic or anoxic etiology. Patient has been unresponsive for many days with eye opening, withdraws to pain in BLE, grimices to pain in BUE. No purposeful movement noted. SR->ST 80's to 100's at times, on Lopressor 37.5 mg po TID, also has gotten Hydralazine for HTN x two today. B/P 130's-220's/70's-110's, treated with Hydralazine as ordered. Increased UOP with am Lasix, KCL given with lasix. Lungs coarse bilat, diminished in the bases. From CPAP over night to Trach collar at 50%, with sats in mid to high 90's. RR 28-38 today. Suctioned for thick yellow sec in mod amounts. Gets Albuterol/Atrovent MDI's, Positive bowel sounds, no stool today. Biscodyl given PR, with no results yet. TF advanced to 45cc/hr with that being the new goal rate. NPO for IR, and trip to LTC facility. Foley to gravity, Lasix given at 1200, with good response. Coccyx wound with allyeven dsg in place, skin tear on R neck/chest by trach, allyeven in place. Sternal dsg intact and R groin approximated and healing well. New 18ga PICC changed over wire today in IR. Husband called for update and will call back to make sure all has went as planed. Plan is to transfer her to LTC facility today ~ 3pm.

"