"Admission Date: [**2140-10-30**] Discharge Date: [**2140-11-11**]

Date of Birth: [**2118-9-4**] Sex: M

Service: SURGERY

Allergies:

Cefaclor

Attending:[**First Name3 (LF) 1481**]

Chief Complaint:

S/P ATV accident with traumatic brain injury

Major Surgical or Invasive Procedure:

[**2140-10-31**] right [**Last Name (un) 8745**] bolt placed

[**2140-11-2**] right chest tube for pneumothorax

History of Present Illness:

This is a 22 y/o patient who was transferred from OSH s/p fall off dirt bike at approximate speed of 35 mph. He was wearing a helmet and fell over the handlebars. He was found to be combative by EMS with GCS 6. He was intubated and sedated at OSH, no imaging was performed. He was transferred to [**Hospital1 18**] for further management. Mannitol 75 mg given prior to admission.

Past Medical History:

none

Social History:

+ Tobacco

ETOH -

Family History:

non contributory

Physical Exam:

On Admission:

Temp 98 HR47 BP 152/93 Intubated

HEENT Blood in both ears and oropharynx, right pupil 2mm and

reactive, left pupil 4mm and non reactive

Neck Cervicle collar in place

Chest clear and equal breath sounds bilat, no deformities

COR RRR

Abd no masses, right and left flank abrasions

Ext toes upgoing on left, feet warm

Pertinent Results:

[**2140-10-30**] 06:05PM WBC-21.6* RBC-4.85 HGB-15.0 HCT-43.6 MCV-90

MCH-30.9 MCHC-34.4 RDW-13.0

[**2140-10-30**] 06:05PM PLT COUNT-292

[**2140-10-30**] 06:05PM ASA-NEG ETHANOL-NEG ACETMNPHN-NEG

bnzodzpn-NEG barbitrt-NEG tricyclic-NEG

[**2140-10-30**] 06:07PM GLUCOSE-88 LACTATE-1.4 NA+-138 K+-3.3*

CL--101 TCO2-23

[**2140-10-30**] 08:11PM GLUCOSE-100 UREA N-14 CREAT-1.0 SODIUM-136

POTASSIUM-4.6 CHLORIDE-101 TOTAL CO2-23 ANION GAP-17

[**2140-10-30**] Head CT :1. Bilateral subarachnoid hemorrhage. Possible tiny left cerebral subdural hemorrhage measuring less than 2 mm.

2. Hemorrhage within the prepontine cistern and in the pons (anteriorly).
Linear hyperdensity anterior to the pons is likely extraaxial.
3. Bilateral longitudinal temporal bone fractures extending to the right
carotid canal. Left lateral and medial orbital wall fractures and left
zygomatic fracture. CTA is recommended to exclude carotid injury.
4. Sinus opacification with fractures of the sphenoid sinus.

[**2140-10-30**] Abd/Chest CT : 1. ET and NG tubes positioned adequately.

2. Consolidation in the superior segment of the right lower lobe and complete consolidation of the left lower lobe which reflect aspiration.
3. Anterior mediastinal density which is most compatible with residual thymic tissue. No evidence of aortic injury.
4. Nonspecific hypodense lesions in the liver and right kidney which are
incompletely characterized

[**2140-10-30**] C Spine CT : 1. No cervical spine fracture.
2. Bilateral skull base fractures, better evaluated on dedicated head CT.

3. Secretions within trachea surrounding endotracheal balloon concerning for aspiration.

[**2140-10-31**] Left forearm : No fracture of the left forearm is detected. Assessment of the left wrist is limited on these views. Allowing for this, the left wrist is grossly unremarkable. However, if there is specific clinical concern for wrist injury, dedicated views of the wrist would be recommended.

[**2140-10-30**] CTA Head :

1. No evidence of carotid artery dissection.
2. Focal abnormality of the right ACA just superior to the ACA/ACOM junction. This likely represents tortuosity of vessel, although tiny focal aneurysm cannot be excluded. Repeat CTA or MRA could be performed in two to three weeks for further evaluation.
3. Multiple bilateral skull base fractures, unchanged.
4. Bilateral subarachnoid hemorrhage and hemorrhage anterior to the pons
within the interpeduncular cistern is better appreciated on non-contrast head CT performed earlier.

[**2140-11-1**] Head CT : 1. Apparent resolution of subarachnoid hemorrhage.

2. Persistence of possible left cerebral subdural hemorrhage.
3. Bilateral longitudinal temporal bone fractures and left lateral medial orbital wall fractures and left zygomatic fracture (see CT fromSeptember 20, [**2140**] for details).

4. Sphenoid sinus opacification and sphenoid fractures.

5. High-density material in the bilateral maxillary sinuses is likely
hemorrhage.

[**2140-11-1**] CT sinus/mandible :
There is partial opacification of bilateral mastoid air cells as

well as fluid seen within the left external auditory canal. High-density
material is seen within the bilateral maxillary sinuses and sphenoid sinuses compatible with blood. The right skull base fracture extends longitudinally through the temporal bone (series 2, image 39; series 401B, image 16). There is also a fracture that extends from the right posterior wall of the sphenoid sinus (series 401B, image 41; series 2, image 41) into the right carotid canal. A longitudinal left temporal bone fracture is noted that extends into the left parietal bone superiorly series 2, image 4).There is a minimally displaced fracture of the left zygoma (series 2, image 35) as well as the left lateral wall of the left orbit. A thin lucency noted at the superomedial aspect may represent a subtle fracture. No obvious extension into the TMJ is noted, the lucency noted on the studies in the posterior aspect of the TMJ relating to the site of [**Hospital1 **] of the mastoid and squamous portions of the temporal bone and seen on both sides. Thin non-displaced fracture of the lateral pterygoid is noted on the left. Scattered foci of air are noted including the right side of the neck , related to the trauma. Evaluation for any other subtle

fractures may be limited.

[**2140-11-5**] CTA Chest :

1. Enlarged now moderate-to-large left pneumothorax. Left chest tube
terminates in the anterolateral subcutaneous soft tissues of the chest wall. Slight rightward shift of midline structures.

2. Pneumomediastinum. Subcutaneous gas along bilateral anterior chest wall, tracking up to the thoracic inlet on the left. Right chest wall laceration.

3. Multifocal consolidation involving all lobes of the lungs, likely due to aspiration and pneumonia.

4. Assessment is slightly limited due to respiratory motion, particularly along the lingula, but no evidence of PE seen.

[**2140-11-5**] MRI C Spine ;

Negative cervical spine MRI scan. Incomplete study of the thoracic spine.

[**2140-11-8**] MRI Head and orbits :

1. Punctate hemorrhagic diffuse axonal injury in the left parietal
subcortical white matter, and possibly also in the left posterior frontal
subcortical white matter. Extensive diffuse axonal injury in the splenium of the corpus callosum and associated infarction, with a small hemorrhagic
component.

2. Probable evolving acute/early subacute infarct in the right

pons, which is nonspecific but could be related to
nonhemorrhagic axial injury.

3. Bilateral small retrocerebellar subdural hematomas.
4. Subarachnoid hemorrhage again demonstrated.
5. Unremarkable appearance of the orbits.

[**2140-11-10**] CXR : Near resolution of left apical pneumothorax.

Brief Hospital Course:
[**Known firstname **] [**Known lastname **] was admitted to the Trauma ICU for management of his traumatic brain injury. His GCS at the scene was 3 and 7 at the time of admission. He was seen by the Neurosurgical service for evaluation and placement of a bolt for ICP monitoring.His initial ICP was 10. His left pupil was fixed and dilated and he had a left hemiparesis. His right upper and lower extremities were moving. He did require sedation while he was intubated as he was very agitated.

From a neurologic standpoint he has had marked improvement during his hospitalization. He was treated with dilantin for 12 days and had no seizure activity. Following his extubation from the respirator he was able to speak and understand, respond to commands and his left sided weakness improved. He continued to have a left HP though this had been improving daily. Most recent MRI of the C and T spine showed no cord contusion. MRI

of his brainshows axonal injury parietal and frontal white matter on left aswell as in the left corpus collosum and the right pons infarct,likely the cause of his left hemiparesis. His left CN III palsey is unchanged. With the help of physical therapy he is up and walking but needs to refocus and needs reminders to concentrate.

[**Known firstname **] developed drainage from his right ear about 1 week ago and the consistency was old blood. He was reevaluated by the Neurosurgery Service to assure that it was not CSF. His drainage gradually decreased and resolved 48 hours ago. He will continue to follow up with Neurosurgery as an outpatient.

He was treated with antibiotics in the ICU for a presumed pneumonia. His CXR is notable for b/l atelectesis and he has remained afebrile off antibiotcs for 24 hours. He is using his incentive spirometer. On [**2140-11-2**] a right chest tube was placed for a hemothotax and this drained and was removed without difficulya few days later. There is no effusion or pneumothorax on his post pull film.

His nutritional status is being monitored and he is tolerating a regular diet with nectar thick liquids. He has been seen by the Speech and Swallow Service who recommend strict aspiration precautions and a repeat study after he gets settled in rehab.

During his hospitalization his family has been with him 24/7 and are very supportive, attentive and concerned for his future recovery. They will appreciate

updates as his condition improves or changes.

Medications on Admission:

none

Discharge Medications:

1. Bisacodyl 5 mg Tablet, Delayed Release (E.C.) Sig: Two (2) Tablet, Delayed Release (E.C.) PO DAILY (Daily) as needed for Constipation.
2. Senna 8.6 mg Tablet Sig: One (1) Tablet PO BID (2 times a day) as needed for Constipation.
3. Docusate Sodium 50 mg/5 mL Liquid Sig: Ten (10) mls PO BID (2 times a day).
4. White Petrolatum-Mineral Oil 42.5-56.8 % Ointment Sig: One (1) Appl Ophthalmic PRN (as needed) as needed for dry eyes.
5. Acetaminophen 650 mg Tablet Sig: One (1) Tablet PO Q6H (every 6 hours) as needed for fever/pain.
6. Hydromorphone 2 mg Tablet Sig: 1-2 Tablets PO Q4H (every 4 hours) as needed for pain.
7. Heparin (Porcine) 5,000 unit/mL Solution Sig: 5000 (5000) units Injection TID (3 times a day).
8. Olanzapine 10 mg Tablet, Rapid Dissolve Sig: One (1) Tablet, Rapid Dissolve PO at bedtime.
9. Nystatin 100,000 unit/mL Suspension Sig: Five (5) ML PO QID (4 times a day) as needed for thrush: thru [**2140-11-14**].

Discharge Disposition:

Extended Care

Facility:

[**Hospital3 1107**] [**Hospital **] Hospital - [**Location (un) 38**]

Discharge Diagnosis:

Traumatic brain injury S/P ATV accident with

1. SAH

2. SDH

3. temporal bone fractures B/L

4. sphenoid sinus fracture

5. Maxillary fracture

6. right pneumothorax

7. pneumonia

8. left eye fixed and dilated secondary to left 3rd nerve

pupillary fibers affected by orbit fracture

Discharge Condition:

Improved, stable hemodynamics, walking with assistance,eating a

soft diet but needs direction and supervision

Discharge Instructions:

?????? Take your pain medicine as prescribed.

?????? Exercise should be limited to walking; no lifting, straining,

or excessive bending. Follow the Physical Therapists's

recommendations

?????? Increase your intake of fluids and fiber, as narcotic pain

medicine can cause constipation. We generally recommend taking an over the counter stool softener, such as Docusate (Colace) while taking narcotic pain medication.

?????? Unless directed by your doctor, do not take any anti-inflammatory medicines such as Motrin, Aspirin, Advil, or Ibuprofen etc.

CALL YOUR SURGEON IMMEDIATELY IF YOU EXPERIENCE ANY OF THE FOLLOWING

?????? New onset of tremors or seizures.

?????? Any confusion, lethargy or change in mental status.

?????? Any numbness, tingling, weakness in your extremities.

?????? Pain or headache that is continually increasing, or not relieved by pain medication.

?????? New onset of the loss of function, or decrease of function on one whole side of your body.

Followup Instructions:

Call [**Hospital 4695**] clinic at [**Telephone/Fax (1) 1669**] for a follow up appointment in 4 weeks.

Call Dr. [**Last Name (STitle) **] at [**Telephone/Fax (1) 2359**] for a follow up appointment in 6 weeks

Call the Plactic Surgery Clinic at [**Telephone/Fax (1) 5343**] for a follow up appointment in [**3-15**] wks.

Call [**Hospital 878**] Clinic at [**Telephone/Fax (1) 44**] for a follow up appointment in 2 weeks

Call [**Hospital **] clinic at [**Telephone/Fax (1) 253**] for a follow up appointment in 4 weeks

Completed by:[**2140-11-11**]"

"Subarachnoid hemorrhage (SAH)

Assessment:

Action:

Response:

Plan:

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

"

"Pt s/p ATV accident where he hit head on the handlebars, + helmet, GCS 6 at the scene and pt vomiting. Taken to [**Hospital3 735**] and intubated for airway protection and combativeness and then medflighted to [**Hospital1 19**] for further w/u. No PMX, no meds.

Head CT shows diffuse areas of SAH and tiny left SDH as well as hemmorhage w/in prepontine cistern and pons anteriorly, bilateral temporal bone fx's extending to carotid canal, left lateral and medial orbital wall fx and left zygomatic fx . Pt presents with dialated and fixed left pupil and left hemiparesis, right pupil brisk and purposeful movement with RUE. Spine clear radiographically, CT of torso significant for bibasilar consolidation c/w aspiration

Subarachnoid hemorrhage (SAH)

Assessment:

Action:

Response:

Plan:

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

"

"Demographics

Day of intubation:

Day of mechanical ventilation: 2

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Tube Type

ETT:

Position: 22 cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Lung sounds

RLL Lung Sounds: Clear

RUL Lung Sounds: Clear

LUL Lung Sounds: Clear

LLL Lung Sounds: Clear

Secretions

Sputum color / consistency: Bloody / Thick

Sputum source/amount: Suctioned / Small

Ventilation Assessment

Level of breathing assistance: Continuous invasive ventilation

Visual assessment of breathing pattern: Normal quiet breathing

Assessment of breathing comfort: No response (sleeping / sedated)

Invasive ventilation assessment:

Trigger work assessment: Triggering synchronously

Plan

Next 24-48 hours: Continue with daily RSBI tests & SBT's as tolerated

Reason for continuing current ventilatory support: Sedated / Paralyzed, Intolerant of weaning attempts, Cannot protect airway, Cannot manage secretions, Hemodynimic instability, Underlying illness not resolved

"

"Demographics

Day of intubation:

Day of mechanical ventilation: 3

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Airway Placement Data

Known difficult intubation: Unknown

Tube Type

ETT:

Position: cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 25 cmH2O

Lung sounds

RLL Lung Sounds: Clear

RUL Lung Sounds: Clear

LUL Lung Sounds: Clear

LLL Lung Sounds: Clear

Secretions

Sputum color / consistency: Blood Tinged / Thick

Sputum source/amount: Suctioned / Moderate

Ventilation Assessment

Level of breathing assistance: Continuous invasive ventilation

Visual assessment of breathing pattern: Accessory muscle use; Comments:

On protective lung strategies vent support. Overbreathing set vent

rate.

Assessment of breathing comfort: No response (sleeping / sedated)

Invasive ventilation assessment:

Trigger work assessment: Triggering synchronously

Dysynchrony assessment:

Comments:

Plan

Next 24-48 hours: Utilize ARDSnet protocol, Maintain PEEP at current level and reduce FiO2 as tolerated

Reason for continuing current ventilatory support: Sedated / Paralyzed, Hemodynimic instability, Underlying illness not resolved

"

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Assessment:

Action:

Response:

Plan:

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

"

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Assessment:

Action:

Response:

Plan:

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

Subarachnoid hemorrhage (SAH)

Assessment:

Pt neuro status unchanged, con
t w/ brisk pupillary response on right
and nonreactive on left, Right sided extremities with full strength and
able to lift left leg up off bed when lightened from sedation, left arm
still with extension and internal rotation to painful stimuli, ICP on
[**Last Name (un) **] from 14-20 at rest, spikes transiently with increased coughing
or wakefulness up to the high 20
s yet settles as soon as pt resedated,
Pt starting to briskly diuresed over night, Dilantin level 5.6 this AM,
some minor faciculations of left eyelid noted intermittently.

Action:

Full neuro checks every 4 hours with Propofol gtt off, urine and serum
lytes sent to evaluate pt
s brisk u/o, Team notified of low Dilantin
level

Response:

Neuro exam improving slightly and ICP

s remaining w/in nl limits, ? DI

vs. autodiuresing

Plan:

Follow up with urine lytes, con

t with neuro checks per team, ? rebolus

dilantin

Trauma, s/p

Assessment:

Pt with very rhoncherous breath sounds bilaterally yet diminished at

bilaterally bases, suctioned for thick bloody and pluggy sputum, O2 sat

marginal and pt spiked temp to 101.5 max, CHXray showed collapse on LLL

, ABG at the time w/ PaO2 of 57.

Action:

Pt bronched and sputum spec sent for culture, follow up xray done, FiO2

weaned back down to 80% w/ sats 99-100%. Pt pan cultured again.

Tylenol and cool bath given. Triple antibiotics started as ordered.

Response:

Post bronch xray showed improved aeration on left yet still poor on

right, con

t marginal oxygenation still suctioned for moderate amts

thick blood tinged sputum. Temp down gradually.

Plan:

? repeat bronch this AM, con

t pulm hygiene, abx

s as ordered

Pain control (acute pain, chronic pain)

Assessment:

Pt con

t restless and hyperdynamic when light, w/ occaisional grimaces.

Action:

Pt medicated with fentanyl 50-100mcgs every 1-2 hours

Response:

Improved hemodynamics after pain med and pt less restless

Plan:

Con

t to assess pain q 1-2 hours.

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head this am showed no change per neuro [**Doctor First Name 213**].

Action:

Cont Q1hr neuro checks, bolt placed this afternoon. Nicardipine off, sbp parameters increased to <160.

Response:

Essentially no change in neuro exam. Left pupil remains fixed and dilated. Opthomology states optic nerve injury. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, ? purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye to pain but not consistently, does not follow command.

Plan:

Cont Q 1 hr neuro checks.

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and

facial fx, + aspiration, no other injury noted per team.

Action:

Pt remains on c-spine and TLS precautions. Tf started, tolerating well, blood from bilat ears and nose. Vent weaned to CPAP 5/5 tol well sat 100%, left SC central line placed.

Response:

VSS, hyperdynamic with wake up assessment, , lung sounds clear, cont to sx bloody secreations for mouth and ETT, probably from facial fx and basilar skull fx, left arm cont to be swollen, IV removed left arm elevated.

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Pt restless and hyperdynamic during wake up assessments

Action:

Propofol cont. prn fentanyl , pain assessed frequently.

Response:

VS respond to fentanyl pt appears comfortable.

Plan:

Cont to asses pain and sedation.

"

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Plan:

Cont Q 1 hr neuro checks.

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

"

"Subjective

intubated

Objective

Height

Admit weight

Daily weight

Weight change

BMI

178 cm (estimated)

85.6 kg

27

Ideal body weight

% Ideal body weight

Adjusted weight

Usual body weight

% Usual body weight

75.3 kg

114%

Diagnosis: head injury

PMHx: none

Food allergies and intolerances: no known food allergies

Pertinent medications: RISS, normal saline, propofol, dilantin, KPhos

(15 mmol repletion), famotidine, others noted

Labs:

Value

Date

Glucose

130 mg/dL

[**2140-10-31**] 02:18 AM

Glucose Finger Stick

125

[**2140-10-31**] 09:00 AM

BUN

13 mg/dL

[**2140-10-31**] 02:18 AM

Creatinine

1.1 mg/dL

[**2140-10-31**] 02:18 AM

Sodium

140 mEq/L

[**2140-10-31**] 02:18 AM

Potassium

3.7 mEq/L

[**2140-10-31**] 02:18 AM

Chloride

107 mEq/L

[**2140-10-31**] 02:18 AM

TCO2

22 mEq/L

[**2140-10-31**] 02:18 AM

PO2 (arterial)

141 mm Hg

[**2140-10-31**] 09:29 AM

PCO2 (arterial)

38 mm Hg

[**2140-10-31**] 09:29 AM

pH (arterial)

7.41 units

[**2140-10-31**] 09:29 AM

pH (urine)

6.5 units

[**2140-10-31**] 01:34 AM

CO2 (Calc) arterial

25 mEq/L

[**2140-10-31**] 09:29 AM

Albumin

4.5 g/dL

[**2140-10-31**] 02:18 AM

Calcium non-ionized

9.4 mg/dL

[**2140-10-31**] 02:18 AM

Phosphorus

2.2 mg/dL

[**2140-10-31**] 02:18 AM

Ionized Calcium

1.16 mmol/L

[**2140-10-31**] 09:29 AM

Magnesium

2.0 mg/dL

[**2140-10-31**] 02:18 AM

Phenytoin (Dilantin)

6.2 ug/mL

[**2140-10-31**] 02:18 AM

WBC

27.4 K/uL

[**2140-10-31**] 02:18 AM

Hgb

14.5 g/dL

[**2140-10-31**] 02:18 AM

Hematocrit

41.5 %

[**2140-10-31**] 02:18 AM

Current diet order / nutrition support: Replete with fiber Full

strength;

Starting rate: 20 ml/hr; Advance rate by 20 ml q6h Goal rate: 80 ml/hr

Residual Check: q4h Hold feeding for residual >= : 200 ml

Flush w/ 30 ml water q8h

GI: soft, +bowel sounds

Assessment of Nutritional Status

At risk for malnutrition

Patient at risk due to: NPO / hypocaloric diet, trauma

Estimated Nutritional Needs

Calories: [**2100**]-2397 (BEE x or / 23-28 cal/kg)

Protein: 103-128 (1.2-1.5 g/kg)

Fluid: per team

Calculations based on: Admit weight

Estimation of previous intake: likely adequate

Estimation of current intake: Inadequate

Specifics: 22 year oldl male s/p ATV accident, helmeted CGS 6 in field,

intubated at outside hospital then transferred to [**Hospital1 19**] for blown left

pupil. Patient with multiple craniofacial fx with fixed and dilated

left pupil. Tube feedings started this morning currently running at 40

ml/hr. At goal tube feedings provide [**2051**] kcals/ 119 g protein.

Propofol is running at 30.8 ml/hr which provides 813 kcals will need to

decrease tube feeding to avoid overfeeding. Noted repletion.

Medical Nutrition Therapy Plan - Recommend the Following

1. While on propofol recommend Replete with Fiber @ 50 ml/hr =

1200 kcals/ 74 g protein

2. Once off propofol goal tube feeding is Replete with Fiber @ 85

ml/hr = 2040 kcals/ 126 g protein

3. Check residuals hold if greater than 200 cc

4. Check chemistry 10 daily and replete prn

5. Will follow page [**Numeric Identifier 2584**] with questions

"

"SICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

PMHx:

none

Current medications:

Acetaminophen

Albuterol Inhaler

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin SQ

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

ULTRASOUND - At [**2140-11-1**] 10:25 AM

left arm

CHEST TUBE PLACED - At [**2140-11-1**] 04:15 PM

FEVER - 101.8

F - [**2140-11-1**] 08:00 PM

Cooling blanket placed

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Ciprofloxacin - [**2140-11-1**] 04:55 PM

Vancomycin - [**2140-11-1**] 08:00 PM

Tobramycin - [**2140-11-2**] 04:00 AM

Infusions:

Propofol - 80 mcg/Kg/min

Other ICU medications:

Dilantin - [**2140-11-1**] 11:56 AM

Famotidine (Pepcid) - [**2140-11-1**] 08:00 PM

Fentanyl - [**2140-11-2**] 04:30 AM

Other medications:

Flowsheet Data as of [**2140-11-2**] 05:51 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.1

C (98.7

HR: 86 (86 - 119) bpm

BP: 110/57(73) {110/57(73) - 163/84(105)} mmHg

RR: 25 (17 - 39) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 84.2 kg (admission): 85.6 kg

ICP: 12 (12 - 16) mmHg

Total In:

5,227 mL

876 mL

PO:

Tube feeding:

1,543 mL

319 mL

IV Fluid:

3,484 mL

497 mL

Blood products:

Total out:

5,975 mL

570 mL

Urine:

5,975 mL

570 mL

NG:

Stool:

Drains:

Balance:

-748 mL

306 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 450 (450 - 450) mL

RR (Set): 22

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 50%

RSBI Deferred: PEEP > 10

PIP: 15 cmH2O

Plateau: 15 cmH2O

Compliance: 150 cmH2O/mL

SPO2: 100%

ABG: 7.41/38/81.[**Numeric Identifier 508**]/23/0

Ve: 12.5 L/min

PaO2 / FiO2: 164

Physical Examination

General Appearance: Anxious

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Percussion: Resonant :),

(Breath Sounds: CTA bilateral :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Absent), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Right Extremities: (Edema: Absent), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: (Responds to: Verbal stimuli, Tactile stimuli, Noxious

stimuli), No(t) Moves all extremities, (LUE: No movement), (LLE:

Weakness), Sedated; follows commands off sedation.

Labs / Radiology

226 K/uL

11.7 g/dL

169 mg/dL

0.9 mg/dL

23 mEq/L

3.8 mEq/L

8 mg/dL

113 mEq/L

146 mEq/L

34.1 %

25.0 K/uL

[image002.jpg]

[**2140-11-1**] 12:50 AM

[**2140-11-1**] 12:58 AM

[**2140-11-1**] 02:59 AM

[**2140-11-1**] 05:30 AM

[**2140-11-1**] 08:46 AM

[**2140-11-1**] 12:40 PM

[**2140-11-1**] 06:47 PM

[**2140-11-1**] 08:47 PM

[**2140-11-2**] 02:27 AM

[**2140-11-2**] 02:31 AM

WBC

20.5

25.0

Hct

36.4

34.1

Plt

252

226

Creatinine

1.0

0.9

TCO2

27

24

23

25

23

25

23

25

Glucose

142

170

169

Other labs: Lactic Acid:0.7 mmol/L, Albumin:3.6 g/dL, Ca:9.0 mg/dL,

Mg:2.0 mg/dL, PO4:2.1 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN,

CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

NEURO: Intubated and sedated on propofol, bolt removed [**11-1**] AM, SAH

resolved, f/u dilantin levels, CT [**11-1**] resolution SAH, small SDH,

unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 11T

Pain: Fentanyl prn, comfortable

Dilantin 10.9--monitor

CVS: Stable, resolving tachycardia

PULM: Intubated, wean to CPAP [**11-21**]

continue to wean; Right 20 fr chest

tube

now with Left Ptx

will need chest tube for Left given Positive

pressure vent with 10 Peep currently.

Purulent secretions

follow up cultures and repeat mini-BAL, possible

aspiration PNA

GI: OGT in place, TF to goal

RENAL: Foley in place, good urine output

HEME: Hct stable at 36; SQ Heparin started [**11-1**]

ENDO: RISS, sugars well controlled

ID: WBC 25 from 20. Spiked to 101.5, actively cooling, Vanc/Tobra/Cipro

for HCAP

TLD: ETT, OGT, L Rad A-line, Foley, R subclavian CVL , R CT

IVF: NS @ 80 + KCl

KVO today.

CONSULTS: Trauma, Neurosurgery, Plastics, Ophthomology

BILLING DIAGNOSIS: Traumatic head injury

ICU CARE:

GLYCEMIC CONTROL: RISS

PROPHYLAXIS:

DVT - Boots, Heparin SQ

STRESS ULCER - Famotidine

VAP BUNDLE - +

COMMUNICATIONS:

ICU Consent: In chart

CODE STATUS: Full

DISPOSITION: ICU

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control:

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Total time spent: 34 minutes

Patient is critically ill

"

"Family Information

Next of [**Doctor First Name **]: mother, [**Name (NI) 753**]/dad [**Name (NI) 1219**]

Health Care Proxy appointed: [**Name2 (NI) **] Proxy

Family Spokesperson designated: same

Communication or visitation restriction: none

Patient Information:

Previous living situation: Home w/ others

Previous level of functioning: Independent

Previous [**Hospital1 19**] or other hospital admissions: none

Past psychiatric history: none known

Past addictions history: none known; pt w/neg tox upon admission

Employment status: Employed

Legal involvement: none known

Mandated Reporting Information:

Additional Information:

Patient / Family Assessment: Pt is 22 yr-old male transferred from

[**Hospital **] hosp, adm on trauma service s/p ATV accident in which pt went

over handlebars of ATV near his home. Pt currently in TSICU, intubated,

sedated. Pt w/TBI, however, according to RN, [**Doctor First Name 3120**], he is following

commands at this point. Pt also w/aspiration pneumonia & bilateral

pneumothorax.

SW met with pt

s [**Last Name (LF) 1506**], [**First Name3 (LF) 753**] and [**Doctor First Name 1219**] and several other family

members. [**Doctor First Name 1219**] is one of 17 children and family is very large and

supportive. [**Doctor First Name **] are divorced & re-married and both sets of [**Doctor First Name 1506**]

are here supporting each other and their relationship is cordial, both

saying that only pt

s recovery is important. Pt has 12 yr old brother

who lives with [**Name (NI) 753**]. She reports that he is quiet, but school knows of

situation and is providing support. He has declined to visit pt at this

time & this SW suggested letting him make decisions about when he

wishes to see his brother. [**Name (NI) 753**] spoke abut police coming to her home

and how traumatic that was. She states that she left hosp yesterday and

went to sister

s home in [**Name (NI) 872**] to get some rest. SW validated need for

self-care. Several family members have been in hosp around the clock.

Family of this pt is quite large and friendly with each other,

supporting each other. [**Name (NI) **] are clearly concerned, but coping

appropriately at this time. SW provided empathic listening and

emotional support. Also provided contact info.

Clergy Contact: Name: Family has own [**Name (NI) **] priest coming to visit pt.

Communication with Team: Primary Nurse: [**First Name4 (NamePattern1) 3120**] [**Last Name (NamePattern1) 171**] / Follow up: SW will continue to follow & assist as needed. Will continue to assess coping of family and will follow-up with pt when he is awake. Please page PRN.

[**First Name4 (NamePattern1) 1746**] [**Last Name (NamePattern1) 363**], LICSW #[**Numeric Identifier 1747**]

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Sedated with propofol and prn fentanyl. On high dose propofol but wakes easily as soon as propofol decreased. Follows commands readily with R side, small amount of movement to pain on L side. Purposeful with right hand. Cervical collar remains on. Continues on dilantin. Multiple family members in to visit.

Action:

Q 2 hour neuro checks, fentanyl and propofol for sedation. Temperature control with antipyretics, other cooling measures. Dilantin administered. Multipodus splint applied to L foot

Response:

Following commands readily, L sided weakness continues, afebrile at present.

Plan:

Continue close neuro monitoring. Assess need for pain/med sedation. If continues to be intubated would consider switching to fentanyl/midazolam for sedation.

Pneumonia, aspiration

Assessment:

Orally intubated with coarse breath sounds in upper airways. Adequate saturation and ventilation. Suctioned for thick tan secretions. On vancomycin,

Action:

Response:

Plan:

"

"Chief Complaint: S/P ATV accident

HPI:

22M s/p ATV accident, helmeted. GCS 6 in the field, intubated at [**Hospital3 **], given mannitol and transferred to [**Hospital1 19**] for fixed and dilated left pupil.

Post operative day:

Allergies:

Last dose of Antibiotics:

Infusions:

Propofol - 40 mcg/Kg/min

Nicardipine - 1 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-30**] 09:15 PM

Hydralazine - [**2140-10-30**] 11:00 PM

Fentanyl - [**2140-10-30**] 11:23 PM

Other medications:

Past medical history:

Family / Social history:

None

1 Pack per day tobacco

Social alcohol use on weekends

Mother attests to marijuana use and a history of recreational oxycontin

use

Flowsheet Data as of [**2140-10-31**] 12:09 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since 12 AM

Tmax: 38.1

C (100.5

Tcurrent: 38.1

C (100.5

HR: 101 (72 - 101) bpm

BP: 139/75(89) {133/66(83) - 147/75(89)} mmHg

RR: 22 (16 - 24) insp/min

SpO2: 97%

Heart rhythm: SR (Sinus Rhythm)

Total In:

1,008 mL

PO:

TF:

IVF:

358 mL

Blood products:

Total out:

0 mL

1,210 mL

Urine:

1,210 mL

NG:

Stool:

Drains:

Balance:

0 mL

-202 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

RR (Set): 18

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 40%

PIP: 25 cmH2O

Plateau: 23 cmH2O

SpO2: 97%

ABG: 7.40/38/126/23/0

Ve: 13 L/min

PaO2 / FiO2: 315

Physical Examination

General Appearance: Well nourished, No acute distress

Eyes / Conjunctiva: Right pupil normal, left pupil fixed and dilated;

left eye ecchymotic

Head, Ears, Nose, Throat: Normocephalic, Endotracheal tube, OG tube

Cardiovascular: (S1: Normal), (S2: Normal)

Peripheral Vascular: (Right radial pulse: Present), (Left radial pulse:

Present), (Right DP pulse: Present), (Left DP pulse: Present)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: Clear :)

Abdominal: Soft, Non-tender, Bowel sounds present

Extremities: Right lower extremity edema: Absent, Left lower extremity edema: Absent

Skin: Not assessed

Neurologic: No(t) Attentive, No(t) Follows simple commands, Responds to: Noxious stimuli, No(t) Oriented (to): , Movement: Purposeful, Sedated, Tone: Normal

Labs / Radiology

100 mg/dL

1.0 mg/dL

23 mEq/L

4.6 mEq/L

14 mg/dL

101 mEq/L

136 mEq/L

[image002.jpg]

[**2140-10-30**] 08:11 PM

[**2140-10-30**] 08:22 PM

[**2140-10-30**] 11:00 PM

Cr

1.0

Glucose

100

Other labs: Lactic Acid:0.9 mmol/L, Ca++:9.4 mg/dL, Mg++:2.1 mg/dL, PO4:3.3 mg/dL

Imaging: -----CT Head

--B/L SAH. Possible tiny left cerebral SDH less than 2 mm.

--Hemorrhage in prepontine cistern and in pons (anteriorly). Linear hyperdensity anterior to pons likely extraaxial.

--B/L longitudinal temporal bone fractures extending to right carotid

canal. Left lateral & medial orbital wall fractures, left zygomatic fracture.

--Sinus opacification with fractures of sphenoid sinus

-----CT Chest/Abdomen/Pelvis

--ET and NG tubes positioned adequately.

--Consolidation in superior segment of RLL and complete consolidation of LLL which reflect aspiration.

--Anterior mediastinal density most compatible with residual thymic tissue. No evidence of aortic injury.

--Nonspecific hypodense lesions in liver and right kidney

Assessment and Plan

Assessment And Plan: 22M s/p ATV accident with multiple craniofacial fractures with fixed and dilated left pupil

Neurologic: Intubated and sedated on propofol, left eye injury consistent with optic nerve injury per ophthalmology; Q1H neuro checks

Cardiovascular: Maintain SBP<140 with nicardipine and hydralazine

Pulmonary: Intubated, check AM chest x-ray, possible bronchoscopy if no improvement in aeration

Gastrointestinal: OGT in place, NPO for now

Renal: Foley in place, follow urine output

Hematology: Hct 43, no acute blood loss

Infectious Disease: Afebrile, no antibiotics unless febrile

Endocrine: Regular insulin sliding scale

Fluids: Normal saline at 80 mL/hour

Electrolytes: Stable; recheck electrolytes in AM

Nutrition: NPO for now

General:

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

16 Gauge - [**2140-10-30**] 07:00 PM

18 Gauge - [**2140-10-30**] 07:00 PM

Arterial Line - [**2140-10-30**] 07:30 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP: HOB elevation, Mouth care, Daily wake up, RSBI

Need for restraints reviewed

Comments:

Communication: Patient discussed on interdisciplinary rounds Comments:

Code status: Full code

Disposition: ICU

Total time spent:

Patient is critically ill

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in the field, intubated at

[**Hospital3 **], given mannitol and transferred to [**Hospital1 19**] for blown left

pupil.

Chief complaint:

s/p ATV accident with head injury

PMHx:

None

Current medications:

Acetaminophen

Artificial Tear Ointment

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

HydrALAzine

Insulin

Magnesium Sulfate

Nicardipine

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

24 Hour Events:

ARTERIAL LINE - START [**2140-10-30**] 07:30 PM

FEVER - 101.9

F - [**2140-10-31**] 12:00 AM

Allergies:

Last dose of Antibiotics:

Infusions:

Nicardipine - 1 mcg/Kg/min

Propofol - 40 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-30**] 09:15 PM

Hydralazine - [**2140-10-30**] 11:45 PM

Fentanyl - [**2140-10-31**] 02:30 AM

Other medications:

Flowsheet Data as of [**2140-10-31**] 04:51 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.9

T current: 38.7

C (101.7

HR: 101 (72 - 117) bpm

BP: 108/70(81) {108/56(0) - 158/98(118)} mmHg

RR: 19 (16 - 24) insp/min

SPO2: 96%

Heart rhythm: ST (Sinus Tachycardia)

Total In:

1,014 mL

596 mL

PO:

Tube feeding:

IV Fluid:

364 mL

596 mL

Blood products:

Total out:

1,310 mL

320 mL

Urine:

1,210 mL

320 mL

NG:

100 mL

Stool:

Drains:

Balance:

-296 mL

276 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

RR (Set): 18

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 50%

RSBI Deferred: PEEP > 10

PIP: 27 cmH2O

Plateau: 21 cmH2O

SPO2: 96%

ABG: 7.45/34/77/22/0

Ve: 11.3 L/min

PaO2 / FiO2: 154

Physical Examination

General Appearance: No acute distress, Well nourished

HEENT: Left pupil dilated, Blood/fluid pooling in both ears

Cardiovascular: (Rhythm: Regular), tachycardic

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA

bilateral : , Diminished: bases)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: 1+), (Temperature: Warm), (Pulse - Dorsalis pedis: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse - Dorsalis pedis: Present)

Neurologic: (Responds to: Noxious stimuli), Sedated, Withdraws left upper/lower extremities to painful stimuli

Labs / Radiology

310 K/uL

14.5 g/dL

130 mg/dL

1.1 mg/dL

22 mEq/L

3.7 mEq/L

13 mg/dL

107 mEq/L

140 mEq/L

41.5 %

27.4 K/uL

[image002.jpg]

[**2140-10-30**] 08:11 PM

[**2140-10-30**] 08:22 PM

[**2140-10-30**] 11:00 PM

[**2140-10-31**] 02:18 AM

[**2140-10-31**] 02:29 AM

WBC

27.4

Hct

41.5

Plt

310

Creatinine

1.0

1.1

TCO2

25

24

24

Glucose

100

130

Other labs: Lactic Acid:0.9 mmol/L, Ca:9.4 mg/dL, Mg:2.0 mg/dL, PO4:2.2 mg/dL

Imaging: Left arm films with no fracture, no dislocation

Assessment and Plan

Assessment and Plan: 22M s/p ATV accident with fixed and dilated left pupil, withdrawing left side to noxious stimuli

Neurologic: Neuro checks Q: 1 hr, Phenytoin - therapeutic, Restraints

Cardiovascular: Nicardipine to keep SBP<140

Pulmonary: Cont ETT, (Ventilator mode: CMV), Wean to PSV; Goal CO2 35-40; Likely aspiration to left and right lower lobes - consider brochoscopy

Gastrointestinal / Abdomen: OGT in place, draining bloody secretions

Nutrition: NPO

Renal: Foley, Adequate UO

Hematology: Hct stable at 41; Lactate 0.9

Endocrine: RISS

Infectious Disease: Check cultures, Febrile to 101.9 overnight,

cultures sent; WBC 27, no antibiotics at this time

Lines / Tubes / Drains: Foley, OGT, ETT, Consider CVL today

Wounds:

Imaging: CXR today, CT scan head today

Fluids: NS, @ 80 mL/hour

Consults: Neuro surgery, Trauma surgery, Ophthalmology

Billing Diagnosis: (Hemorrhage, NOS: Sub-arachnoid), Multiple injuries

(Trauma)

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

16 Gauge - [**2140-10-30**] 07:00 PM

18 Gauge - [**2140-10-30**] 07:00 PM

Arterial Line - [**2140-10-30**] 07:30 PM

20 Gauge - [**2140-10-31**] 01:00 AM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: Patient discussed on interdisciplinary rounds Comments:

Code status: Full code

Disposition: ICU

Total time spent:

Patient is critically ill

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in the field, intubated at [**Hospital3 **], given mannitol and transferred to [**Hospital1 19**] for blown left pupil.

Chief complaint:

s/p ATV accident with head injury

PMHx:

None

Current medications:

Acetaminophen

Artificial Tear Ointment

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

HydrALAzine

Insulin

Magnesium Sulfate

Nicardipine

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

24 Hour Events:

ARTERIAL LINE - START [**2140-10-30**] 07:30 PM

FEVER - 101.9

F - [**2140-10-31**] 12:00 AM

Allergies:

Last dose of Antibiotics:

Infusions:

Nicardipine - 1 mcg/Kg/min

Propofol - 40 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-30**] 09:15 PM

Hydralazine - [**2140-10-30**] 11:45 PM

Fentanyl - [**2140-10-31**] 02:30 AM

Other medications:

Flowsheet Data as of [**2140-10-31**] 04:51 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.9

T current: 38.7

C (101.7

HR: 101 (72 - 117) bpm

BP: 108/70(81) {108/56(0) - 158/98(118)} mmHg

RR: 19 (16 - 24) insp/min

SPO2: 96%

Heart rhythm: ST (Sinus Tachycardia)

Total In:

1,014 mL

596 mL

PO:

Tube feeding:

IV Fluid:

364 mL

596 mL

Blood products:

Total out:

1,310 mL

320 mL

Urine:

1,210 mL

320 mL

NG:

100 mL

Stool:

Drains:

Balance:

-296 mL

276 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

RR (Set): 18

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 50%

RSBI Deferred: PEEP > 10

PIP: 27 cmH2O

Plateau: 21 cmH2O

SPO2: 96%

ABG: 7.45/34/77/22/0

Ve: 11.3 L/min

PaO2 / FiO2: 154

Physical Examination

General Appearance: No acute distress, Well nourished

HEENT: Left pupil dilated, Blood/fluid pooling in both ears

Cardiovascular: (Rhythm: Regular), tachycardia

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral : , Diminished: bases)

Abdominal: Soft, Non-distended, Non-tender

Left Extremities: (Edema: 1+), (Temperature: Warm), (Pulse - Dorsalis pedis: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse - Dorsalis pedis: Present)

Neurologic: (Responds to: Noxious stimuli), Sedated, Withdraws left upper/lower extremities to painful stimuli and moves spontaneously > Right; Minimally withdrawals left side to stim; Not opening eyes; GCS 7T

Labs / Radiology

310 K/uL

14.5 g/dL

130 mg/dL

1.1 mg/dL

22 mEq/L

3.7 mEq/L

13 mg/dL

107 mEq/L

140 mEq/L

41.5 %

27.4 K/uL

[image002.jpg]

[**2140-10-30**] 08:11 PM

[**2140-10-30**] 08:22 PM

[**2140-10-30**] 11:00 PM

[**2140-10-31**] 02:18 AM

[**2140-10-31**] 02:29 AM

WBC

27.4

Hct

41.5

Plt

310

Creatinine

1.0

1.1

TCO2

25

24

24

Glucose

100

130

Other labs: Lactic Acid:0.9 mmol/L, Ca:9.4 mg/dL, Mg:2.0 mg/dL, PO4:2.2

mg/dL

Imaging: Left arm films with no fracture, no dislocation

Assessment and Plan

Assessment and Plan: 22M s/p ATV accident with fixed and dilated left

pupil, withdrawing left side to noxious stimuli

Neurologic: Neuro checks Q: 1 hr, Phenytoin - therapeutic, Restraints; Cont PPF for sedation; Fentanyl PRN pain or gtt. Treat fever emergently; Will discuss neuro-monitoring with neurosurgery; Opthalmology following for left orbit; Clear CTLS spine if possible in collaboration with Trauma / Neurosurgery.

Cardiovascular: Would allow BP autoregulation;

Pulmonary: Cont ETT, (Ventilator mode: CMV), Wean to PSV; Goal CO2 35-40; Likely aspiration to left and right lower lobes - consider brochoscopy; Doubtful for extubation given mental status / GCS.

Gastrointestinal / Abdomen: OGT in place, draining bloody secretions; Start TF if unable to extubate

Nutrition: NPO currently

Renal: Foley, Adequate UO

Hematology: Hct stable at 41; Lactate 0.9

Endocrine: RISS

Infectious Disease: Check cultures, Febrile to 101.9 overnight, cultures sent; WBC 27, no antibiotics at this time

Lines / Tubes / Drains: Foley, OGT, ETT, Consider CVL today

Wounds: No issues;

Imaging: CXR today, CT scan head today with face.

Fluids: NS, @ 80 mL/hour

Consults: Neuro surgery, Trauma surgery, Ophthalmology

Billing Diagnosis: (Hemorrhage, NOS: Sub-arachnoid), Multiple injuries (Trauma)

ICU Care

Nutrition:

Glycemic Control: Regular insulin sliding scale

Lines:

16 Gauge - [**2140-10-30**] 07:00 PM

18 Gauge - [**2140-10-30**] 07:00 PM

Arterial Line - [**2140-10-30**] 07:30 PM

20 Gauge - [**2140-10-31**] 01:00 AM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: Patient discussed on interdisciplinary rounds Comments:

Code status: Full code

Disposition: ICU

Total time spent: 33

Patient is critically ill

"

"Pt s/p ATV accident where he hit head on the handlebars, + helmet, GCS

6 at the scene and pt vomiting. Taken to [**Hospital3 735**] and intubated

for airway protection and combativeness and then medflighted to [**Hospital1 19**]

for further w/u. No PMHX, no meds.

Head CT shows diffuse areas of SAH and tiny left SDH as well as

hemmorhage w/in prepontine cistern and pons anteriorly, bilateral

temporal bone fx's extending to carotid canal, left lateral and medial

orbital wall fx and left zygomatic fx . Pt presents with dialated and

fixed left pupil and left hemiparesis, right pupil brisk and purposeful

movement with RUE. Spine clear radiographically, CT of torso

significant for bibasilar consolidation c/w aspiration.

Subarachnoid hemorrhage (SAH)

Assessment:

Pt sedated on propofol gtt from 40-60mcgs/kg/min over night, neuro exam

essentially unchanged over night, Pt con
t to have right pupil at 3-4mm
and briskly rx with + corneal however left pupil con
t dialated at 6mm
and nonreactive, right side moving briskly and purposefully while left extremities w/ slightly less movement over night yet still w/drawing to nailbed pressure, Strong cough and gag, no eye opening even when lightened up for a long period. Repeat head CT done this AM, formal results pnd, BP 120-150
s /70
s. Pt with blood tinged fluid draining
from ears bilaterally and occasionally from nose.
Action:
Neuro checks q one hour as ordered, Pt taken for repeat Head CT, pt started on nicardipine gtt for BP management with goal SBP < 140.
Response:
Neuro exam unchanged over night, pt tolerated traveling to CT well, Moderate effect of nicardipine on BP
Plan:
Con
t to monitor closely, titrate gtts to manage BP, ? MRI today
Trauma, s/p
Assessment:
Pt slightly more tachy over the evening yet settles, Extremities cool to touch yet easily Palpable pulses, Pt suctioned for thick bloody secretions yet saturating well, abd soft nondistended, urine increasingly cloudy over night on the propofol, xrays done of left arm secondary to increased edema in that arm.
Action:

Pt febrile, pan cultured, no fractures left arm, arm elevated,

Response:

WBC

s elevated, no abx

s at this time, hct stable,

Plan:

Con

t to monitor closely, pulm hygiene as indicated.

Pain control (acute pain, chronic pain)

Assessment:

Pt very hyperdynamic at times when light

Action:

Medicated with fentanyl prn

Response:

Pt settled with decreased HR

Plan:

Con

t to monitor for signs and symptoms of pain

"

"Demographics

Day of intubation: [**10-30**]

Day of mechanical ventilation: 1

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Airway Placement Data

Known difficult intubation:

Procedure location: Outside hospital

Reason: Emergent (1st time)

Tube Type

ETT:

Position: 22 cm at teeth

Route:

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 25 cmH2O

:

Lung sounds

RLL Lung Sounds: Diminished

RUL Lung Sounds: Clear

LUL Lung Sounds: Clear

LLL Lung Sounds: Diminished

Comments:

Secretions

Sputum color / consistency: Bloody / Thick

Sputum source/amount: Suctioned / Small

Comments:

Ventilation Assessment

Level of breathing assistance: Continuous invasive ventilation

Visual assessment of breathing pattern: Normal quiet breathing

Assessment of breathing comfort: No response (sleeping / sedated)

Invasive ventilation assessment:

Trigger work assessment: Not triggering

Comments: sedated

Plan

Next 24-48 hours: Reduce PEEP as tolerated, Adjust Min. ventilation to

control pco2 35-40

Reason for continuing current ventilatory support: Pending procedure /

OR

Respiratory Care Shift Procedures

Transports:

Destination (R/T)

Time

Complications

Comments

CT

scheduled 0600

:

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. [** 10184**] 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

[**Doctor First Name **]

PMHx:

none

Current medications:

Acetaminophen

Albuterol 0.083% Neb Soln

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

HydrALAzine

Insulin

Ipratropium Bromide Neb

Magnesium Sulfate

Mannitol

Neutra-Phos

NiCARdipine

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

MULTI LUMEN - START [**2140-10-31**] 10:33 AM

ICP BOLT INSERTED - At [**2140-10-31**] 04:11 PM

ARTERIAL LINE - STOP [**2140-10-31**] 06:14 PM

ARTERIAL LINE - START [**2140-10-31**] 06:22 PM

BLOOD CULTURED - At [**2140-11-1**] 01:00 AM

URINE CULTURE - At [**2140-11-1**] 01:00 AM

BRONCHOSCOPY - At [**2140-11-1**] 01:30 AM

for LLL collapse and desaturation

BAL FLUID CULTURE - At [**2140-11-1**] 02:00 AM

FEVER - 101.5

F - [**2140-11-1**] 12:00 AM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Vancomycin - [**2140-11-1**] 03:00 AM

Tobramycin - [**2140-11-1**] 03:14 AM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-31**] 08:00 PM

Fentanyl - [**2140-11-1**] 04:00 AM

Other medications:

Flowsheet Data as of [**2140-11-1**] 06:43 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.5

T current: 38.3

C (100.9

HR: 103 (74 - 106) bpm

BP: 154/74(93) {93/59(74) - 162/93(106)} mmHg

RR: 17 (14 - 26) insp/min

SPO2: 100%

Heart rhythm: ST (Sinus Tachycardia)

ICP: 16 (12 - 49) mmHg

Total In:

3,666 mL

1,318 mL

PO:

Tube feeding:

667 mL

368 mL

IV Fluid:

2,969 mL

810 mL

Blood products:

Total out:

1,357 mL

1,610 mL

Urine:

1,357 mL

1,610 mL

NG:

Stool:

Drains:

Balance:

2,309 mL

-292 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

Vt (Spontaneous): 478 (478 - 595) mL

PS : 5 cmH2O

RR (Set): 16

RR (Spontaneous): 0

PEEP: 5 cmH2O

FiO2: 80%

RSBI Deferred: FiO2 > 60%

PIP: 31 cmH2O

Plateau: 26 cmH2O

SPO2: 100%

ABG: 7.42/34/143/25/-1

Ve: 12.2 L/min

PaO2 / FiO2: 179

Physical Examination

General Appearance: Well nourished

HEENT: Left pupil dilated

Cardiovascular: (Rhythm: Regular), tachycardic

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: Wheezes :

, Rhonchorous : , Diminished: R)

Abdominal: Soft, Non-distended

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Neurologic: (Responds to: Unresponsive), No(t) Moves all extremities,

(LUE: No movement), Sedated

Labs / Radiology

252 K/uL

12.5 g/dL

142 mg/dL

1.0 mg/dL

25 mEq/L

3.3 mEq/L

9 mg/dL

108 mEq/L

141 mEq/L

36.4 %

20.5 K/uL

[image002.jpg]

[**2140-10-30**] 11:00 PM

[**2140-10-31**] 02:18 AM

[**2140-10-31**] 02:29 AM

[**2140-10-31**] 09:29 AM

[**2140-10-31**] 06:44 PM

[**2140-10-31**] 07:58 PM

[**2140-11-1**] 12:50 AM

[**2140-11-1**] 12:58 AM

[**2140-11-1**] 02:59 AM

[**2140-11-1**] 05:30 AM

WBC

27.4

20.4

20.5

Hct

41.5

34.8

36.4

Plt

[**Telephone/Fax (3) 10178**]

Creatinine

1.1

1.0

1.0

TCO2

24

24

25

25

27

24

23

Glucose

130

119

142

Other labs: Lactic Acid:0.7 mmol/L, Albumin:4.5 g/dL, Ca:8.5 mg/dL,

Mg:2.1 mg/dL, PO4:1.6 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN,

CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 4 hr, Intubated and sedated on propofol.

Will wean as tolerated.

Pain: Fentanyl prn, comfortable

Improving MS [**First Name (Titles) 622**] [**Last Name (Titles) 10184**] 11T this am

Likely remove bolt per NS

ICP 15 range

Will need imaging of face which will be done on next head CT

Moving left arm to painful stimuli but not spontaneously

will observe

for now. US to today.

Cardiovascular: Able to autoregulate to SBP around 160, stable.

Pulmonary: Cont ETT, (Ventilator mode: CMV), wean to CPAP, bronched for desats, appears to be PNA, likely needs another bronch today. Will wean sedation and vent support after bronch and any imaging. Possible aspiration pna

on cipro/tobra/vanc pending cultures. Criteria met for [**Doctor Last Name 11**]

rx with lung conserving therapy.

Gastrointestinal / Abdomen: OGT in place, TF at goal

Nutrition: Tube feeding

Renal: Foley, Adequate UO, Foley in place, good urine output, urine lytes with evidence of normal diuresis.

Hematology: Serial Hct, Hct stable at 36; Hold off SQ Heparin for now after bolt removed.

Endocrine: RISS, good control

Infectious Disease: Check cultures, Spiked to 101.5, Vanc/Tobra/Cipro for HAP

Lines / Tubes / Drains: Foley, OGT, ETT

Wounds: superficial abrasions, healing

Imaging: CXR today

Fluids: NS, NS @ 80

K replacement

Consults: Neuro surgery, Trauma surgery

Billing Diagnosis: (Hemorrhage, NOS: Sub-arachnoid), (Respiratory distress: Failure)

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-10-31**] 08:50 AM 80 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: ICU consent signed Comments:

Code status: full

Disposition: ICU

Total time spent: 32 minutes

"

"Attending Physician: [**Name10 (NameIs) 518**]

Referral date: [**2140-11-3**]

Medical Diagnosis / ICD 9: head injury / 959.9

Reason of referral: Eval & treat

History of Present Illness / Subjective Complaint: 22 yo M s/p fall off

ATV at 35 mph, helmeted, GCS 6 in field, intubated at OSH and

transferred to [**Hospital1 19**] [**10-30**]. Sustained multiple facial fractures,

mastoid fx, skull base fx, L orbital fx, sustained B temporal SAH,

small frontal SDH, and prepontine SAH, as well as 3rd cranial nerve

injury. [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] bolt placed [**10-31**].

Past Medical / Surgical History: none

Medications: fentanyl, tylenol, heparin, dilaudid, lorazepam, nafcillin

Radiology: CXR [**11-3**]- Increased right lower lung and retrocardiac

opacities; Head CT [**11-2**]- Apparent resolution of subarachnoid

hemorrhage. Persistence of possible left cerebral subdural

hemorrhage. Bilateral longitudinal temporal bone fractures and left lateral medial orbital wall fractures and left zygomatic fracture

Labs:

33.7

11.3

265

16.6

[image002.jpg]

Other labs:

Activity Orders: OOB to chair

Social / Occupational History: lives with his mother and step-father, supportive father and stepmother also at bedside, 3 step-siblings.

Works for rental equipment company.

Living Environment: Lives in multi-level home but stays on [**Location (un) 2575**], steps to enter

Prior Functional Status / Activity Level: I pta, no DME

Objective Test

Arousal / Attention / Cognition / Communication: alert but mildly lethargic, oriented to self, medical center, not month or year.

Follows all simple commands, 50% multi-step commands. Communicates appropriately.

Hemodynamic Response

Aerobic Capacity

HR

BP

RR

O[2]sat

HR

BP

RR

O[2] sat

RPE

Supine

/

Rest

90

120/76

94% on 2L

Sit

/

Activity

98

153/83

100% on 2L

Stand

/

Recovery

74

142/72

96% on 2L

Total distance walked: 4'

Minutes:

Pulmonary Status: diminished BS bilaterally, strong congested cough, no expectoration.

Integumentary / Vascular: scalp incision with staples intact, L chest tube in place, foley, tele, 3+ edema L UE, ecchymosis/edema L orbit

Sensory Integrity: intact to light touch B UE/LE's

Pain / Limiting Symptoms: denies pain at rest and with mobility

Posture: WNL

Range of Motion

Muscle Performance

B LE's WNL, c/o L shoulder tightness

L hip flexion 3+/5 RLE grossly 4 to 4+/5 t/o

L knee extension 3-/5

L DF 0/5

L PF [**2-15**]

[**Initials (NamePattern4) **] [**Last Name (NamePattern4) 1689**] 0/5

Motor Function: decreased tone LUE/LE, L eyelid ptosis with fixed dilated pupil, vision R eye intact. Decreased coordination B, L more impaired than R.

Functional Status:

Activity

Clarification

I

S

CG

[**Last Name (NamePattern4) **]

Mod

Max

Gait, Locomotion: able to take [**6-15**] steps with B UE support, able to advance LLE with verbal and visual cues. Wide BOS, difficulty clearing L foot. Decreased step length R>L.

Rolling:

T

Supine /

Sidelying to Sit:

T

Transfer:

x-

x2

Sit to Stand:

x2

Ambulation:

x-

X2

Stairs:

Balance: CG static sitting, able to attain and maintain midline with

[**Month/Day (3) 83**] cues, able to weight shift out of BOS in all directions with cues

to return to midline. LOB laterally when attempting a task. [**Month/Day (3) **] A x2

to maintain static standing with L lateral [**Last Name (LF) **], [**First Name3 (LF) 83**]-mod x2 dynamic

standing activities.

Education / Communication: Reviewed PT [**Name (NI) **] and discussed d/c planning

with patient and family. Encouraged family to maintain LUE elevation

and to encourage patient to mobilize LUE/LE. Communicated with nsg re:

status

Diagnosis:

1.

Impaired functional mobility

2.

Impaired balance

3.

Impaired endurance

4.

Impaired strength

Clinical impression / Prognosis: 22 yo M s/p ATV accident with head

injury p/w above impairments a/w non-progressive CNS disorder. He is

most limited by L-sided weakness as well as impaired cognitive

function. Given his age and his neurological recovery, as well as his

strong family support, patient has a good prognosis to return to

independent or modifiend independent level of functiona and is an

excellent candidate for acute rehab. PT to continue to follow up at

acute level until d/c to rehab

Goals

Time frame: 1 week

1.

CG bed mobility, [**Name (NI) 83**] A transfers/ambulation

2.

[**Name (NI) **] A static/dynamic standing balance

3.

Ambulate >/= 20' with [**Name (NI) 83**] A and stable HDR

4.

Tolerate daily UE/LE therex

Anticipated Discharge: Rehab

Treatment Plan:

Frequency / Duration: 4-5x/wk

bed mobility, transfers, ambulation, balance, strengthening, endurance,

family training, education, d/c planning

T Patient agrees with the above goals and is willing to participate in

the rehabilitation program.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

Traumatic injury

PMHx:

Denies

Current medications:

Denies

24 Hour Events:

UNPLANNED EXTUBATION (PATIENT-INITIATED) - At [**2140-11-3**] 09:43 AM

ARTERIAL LINE - STOP [**2140-11-3**] 12:00 PM

BLOOD CULTURED - At [**2140-11-3**] 08:00 PM

URINE CULTURE - At [**2140-11-3**] 08:00 PM

FEVER - 101.8

F - [**2140-11-3**] 10:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-3**] 04:24 PM

Ciprofloxacin - [**2140-11-3**] 06:48 PM

Vancomycin - [**2140-11-3**] 11:58 PM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-3**] 08:30 AM

Fentanyl - [**2140-11-3**] 04:29 PM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 10:00 PM

Hydromorphone (Dilaudid) - [**2140-11-4**] 04:12 AM

Other medications:

Flowsheet Data as of [**2140-11-4**] 05:13 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.6

C (99.6

HR: 79 (78 - 108) bpm

BP: 132/67(83) {125/55(73) - 156/91(102)} mmHg

RR: 25 (19 - 36) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 85.2 kg (admission): 85.6 kg

Total In:

2,632 mL

175 mL

PO:

100 mL

Tube feeding:

536 mL

IV Fluid:

2,006 mL

75 mL

Blood products:

Total out:

4,940 mL

260 mL

Urine:

4,895 mL

260 mL

NG:

Stool:

Drains:

Balance:

-2,308 mL

-85 mL

Respiratory support

O2 Delivery Device: Nasal cannula

Ventilator mode: Standby

Vt (Spontaneous): 589 (589 - 589) mL

PS : 5 cmH2O

RR (Spontaneous): 35

PEEP: 5 cmH2O

FiO2: 70%

PIP: 11 cmH2O

SPO2: 96%

ABG: 7.48/34/70/26/2

Ve: 14 L/min

PaO2 / FiO2: 175

Physical Examination

General Appearance: Anxious, active

HEENT: Left pupil dilated, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft

Left Extremities: (Temperature: Warm)

Right Extremities: (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 2, x 1), Follows simple commands; Left sided weakness and sensory deficits.

Labs / Radiology

265 K/uL

11.3 g/dL

114 mg/dL

0.9 mg/dL

26 mEq/L

3.4 mEq/L

13 mg/dL

103 mEq/L

141 mEq/L

33.7 %

16.6 K/uL

[image002.jpg]

[**2140-11-2**] 08:00 AM

[**2140-11-2**] 10:09 AM

[**2140-11-2**] 02:00 PM

[**2140-11-2**] 05:55 PM

[**2140-11-2**] 08:00 PM

[**2140-11-3**] 02:02 AM

[**2140-11-3**] 02:10 AM

[**2140-11-3**] 09:26 AM

[**2140-11-3**] 07:03 PM

[**2140-11-4**] 02:12 AM

WBC

18.5

16.6

Hct

31.9

33.7

Plt

196

265

Creatinine

0.8

0.9

TCO2

23

26

28

28

26

Glucose

135

148

157

121

178

114

Other labs: Lactic Acid:1.3 mmol/L, Albumin:3.6 g/dL, Ca:8.5 mg/dL,

Mg:2.2 mg/dL, PO4:3.6 mg/dL

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN

CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, f/u dilantin levels, resolution SAH,

small SDH, unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 15; Neuro rec

s appreciated

will obtain MRI when mental status more clear. Optho rec

s appreciated.

Pain: Fentanyl, Dilaudid, Ativan prn

Cardiovascular: stable

Pulmonary: b/l chest tubes to water seal (no leak)

D/C right chest

tube today, self extubated [**11-3**]; PT / OT

Gastrointestinal / Abdomen: NPO; Speech and swallow eval today.

Nutrition: NPO

Renal: Foley in place, good urine output

Hematology: last HCT 33.7

no issues.

Endocrine: RISS

Infectious Disease: Check cultures, check pending cultures, WBC from

18.5. on Vanc/Tobra/Cipro for HCAP until [**11-8**]

Lines / Tubes / Drains: PIVs, Foley, R subclavian CVL, b/l CT

Imaging: MRI pending

Head, orbit, Cspine and T spine

per Neuro c/s

Fluids: KVO

Consults: Trauma surgery, Ophthalmology, Neurology, neurosurg

Billing Diagnosis: Respiratory insufficiency; Multiple injury, trauma

ICU Care

Glycemic Control:

Lines: PIVs, Foley, R subclavian CVL, b/l CT

Multi Lumen - [**2140-10-31**] 10:33 AM

18 Gauge - [**2140-11-3**] 03:02 PM

Prophylaxis:

DVT: SQ UF Heparin

Stress ulcer:

VAP bundle: NA

Communication: Comments:

Code status:

Disposition:

Total time spent: 32 min

Patient is critically ill.

"

"22 year old man s/p ATV accident [**2140-10-30**] with brain injury, pons infarct, witness aspiration, orbit fx, basilar skull fracture, ??L sided third nerve palsy (L pupil fixed and dilated since accident)

Trauma, s/p

Assessment:

Pt. awake but confused, able to state name, follows commands but restless at times. C/o lower back pain and pain in neck. Normal movement of right side but minimal movement of left arm, and left leg weakness. R pupil briskly reactive, can only open L eye a slit. L pupil remains non reactive at 5-6mm. Cervical collar remains in place. R hand mitted to prevent pt. pulling at lines, tube or collar. Other safety measures including bed alarm, high visibility with frequent checks utilized. Continues on dilantin 200 iv q 12 hours with level this am 9.6. BP remains < goal of 160, sats maintained on 3L np. Bilateral chest tubes to water seal. Multiple abrasions healing on arm and torso. Mom, dad, and [**Name2 (NI) 9576**] all updated with condition . Family continues to stay around the clock

Action:

Neuro checks q 2 hours, high visibility for safety. Dilaudid iv for pain control. Frequent reorientation. Family updated with status. MRI of orbits, cervical spine and thoracic spine ordered. After discussion with T/SICU house officer and MRI tech it was determined that pt would

not be able to cooperate with test at this point. Mri checklist completed and faxed to MRI. Decision was made to readdress as pt. becomes less restless. Labs drawn and lytes repleted as ordered.

Response:

Calmer this morning, more conversant, but still confused. Overall neuro status has improved greatly in the last 24 hours. Continues with L sided hemiparesis.

Plan:

Continue neuro checks. Obtain mri when feasible. Bedside speech and swallow today and advance diet as able. If no further pneumothorax, ?dcing pleural tubes. Obtain PT/OT consult. ??OOB to chair today. Continue family education. Consult case management about discharge plans. If continues to improve, will transfer to CC6 soon!

Pneumonia, aspiration

Assessment:

Self extubated yesterday. Tachypneic rr 30-35/min. Rhonchi in upper airways. Weak congested cough. Bilateral chest tubes to water seal. Febrile to 101.8 po. Continues on vanco, cipro, tobramycin for gram neg rods and gram + cocci in sputum.

Action:

Blood culture X 1, urine culture done, Tylenol given for temp as well as cool room and fan. Vancomycin trough obtained, AM chest x ray done. Encouraged to cough and deep breathe.

Response:

Fever down to 99.8 this am. Wbc down to 15. CXR results pending

Plan:

Follow vanc and tobra levels, follow culture results as well as CXR results. Continue pulmonary hygiene.

"

"Pt s/p ATV accident where he hit head on the handlebars, + helmet, GCS 6 at the scene and pt vomiting. Taken to [**Hospital3 735**] and intubated for airway protection and combativeness and then medflighted to [**Hospital1 19**] for further w/u. No PMHX, no meds.

Head CT shows diffuse areas of SAH and tiny left SDH as well as hemmorhage w/in prepontine cistern and pons anteriorly, bilateral temporal bone fx's extending to carotid canal, left lateral and medial orbital wall fx and left zygomatic fx . Pt presents with dialated and fixed left pupil (??L sided third nerve palsy ,L pupil fixed and dilated since accident) and left hemiparesis, right pupil brisk and purposeful movement with RUE. Spine clear radiographically, CT of torso significant for bibasilar consolidation c/w aspiration.

Trauma, s/p

Assessment:

Pt. awake but confused, able to state name, follows commands. Normal movement of right side but minimal movement of left arm, and left leg weakness. R pupil briskly reactive, can only open L eye a slit. L pupil remains non reactive at 5-6mm (believed to be third nerve palsy). Cervical collar remains in place. Continues on dilantin 200 iv q 12 hours with level this am 9.6. BP remains < goal of 160, sats maintained on 3L np. Bilateral chest tubes to water seal. Multiple abrasions healing on arm and torso. Mom, dad, and [**Name2 (NI) 9576**] all updated with condition . Family continues to stay around the clock

Action:

Right chest tube d/c

d (CXR ordered for this afternoon)Dilaudid iv for pain control. Frequent reorientation. Family updated with status. MRI of orbits, cervical spine and thoracic spine ordered (to be done once pt more clear and able to stay still). After discussion with T/SICU

house officer and MRI tech it was determined that pt would not be able to cooperate with test at this point. Mri checklist completed and faxed to MRI. Decision was made to readdress as pt. becomes less restless. Labs drawn and lytes repleted as ordered.

Response:

Calmer this morning, more conversant, but still confused. Overall neuro status has improved greatly in the last 24 hours. Continues with L sided hemiparesis.

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Response:

Fever down to 99.8 this am. Wbc down to 15. CXR results pending

Plan:

Follow vanc and tobra levels, follow culture results as well as CXR results. Continue pulmonary hygiene.

"

"History

Attending M.D.: [**Doctor Last Name 518**]

Referral Date: [**2140-11-4**]

Reason for Referral: Eval, [**Hospital **]

Medical Dx / ICD - 9: 959.9, 430

Activity Orders: OOB c A

HPI / Subjective Complaint: 22 yo M s/p fall off ATV at 35 mph,

helmeted, GCS 6 in field, intubated at OSH and transferred to [**Hospital1 19**]

[**10-30**]. Sustained multiple facial fractures, mastoid fx, skull base fx,

L orbital fx, sustained B temporal SAH, small frontal SDH, and

prepontine SAH, as well as 3rd cranial nerve injury. [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] bolt

placed [**10-31**]. B PTX c + Chest Tube placed.

Past Medical / Surgical History: none

Medications: Dilaudid, Tylenol, Lorazepam, Fentanyl Citrate

Labs

Hematocrit (serum): 33.7 ...

Hemoglobin: 11.3 ... g/dl

WBC: 16.6 ...

Platelet Count: 265 ...

Radiology Head CT [**10-30**]: B SAH, possible tiny L cerebral SDH measuring

less than 2mm. Hemorrhage within prepontine cistern and anterior pons.

B temporal bone fxs extending to R carotid canal. L lateral and medial

orbital wall fxs and L zygomatic fx.

Chest Xray [**11-3**]: Increased right lower lung and retrocardiac opacities,

which may represent pneumonia and less likely pulmonary hemorrhage

Occupational History

Occupational Profile: Works for [**Location (un) 468**] Rental

Performance Patterns: Lives with mother and step-father, also has father and step-mother involved in pt care.

Baseline Occupational Performance: Independent PTA, + Driving

Environmental History: Multi-level home but pt able to stay on 1st level

Current Activities of Daily Living

Self Feeding: Not tested.

Grooming: (mod A)

UE Bathing: (mod A)

LE Bathing: (mod A)

UE Dressing: (mod A)

LE Dressing: (max A) Impaired trunk control for seated dynamic activity.

Toileting: (Dependent) Foley intact.

Current Instrumental Activities of Daily Living

Home Management: Assist

Money Management: Assist

Community Integration: Assist

Performance Skills

Process Skills: A&Ox self. Place ""medical"" and ""[**Location (un) 23**],"" month ""[**Month (only) 3**]"" Date ""3rd"" Year ""[**2141**]."" Follows 100% 1-step commands c minimal cues. Decreased accuracy [**Location (un) **] hour hand on clock. Decreased arousal but becomes more alert with OOB activity. Minimal cues to maintain eyes open during supine activity. Impaired naming for toothbrush, states use ""to brush your eyelashes."" Able to recall ""toothbrush"" c orientation to its use. Intact naming and states correct uses for stethoscope, pen, comb. Decreased attention.

Communication / Interactive Skills: Speech WNL, makes eye contact. Unable to make needs fully known.

Motor Skills - Functional Transfers

Rolling: (min A)

Supine / Side-lying to Sit: (mod A)

Sit to Stand: (min A)

Transfer: (min A, mod A, Stand step)

Functional Transfers Clarification: AMB 4' to chair c min-mod A x2.

Difficulty advancing L LE, unsteady balance and states ""I'm confused.""

Cues to sequence step pattern.

Functional Balance: Sits EOB x10 mins c CG A. Able to correct posture

to midline c cues and lean in all directions without gross LOB.

Aerobic Capacity: Rest

Rest HR: 87

Rest BP: 144/80

Rest RR: 26

Rest O2 sat: 100 %

Supplemental O2: 3L NC

Aerobic Capacity: Activity

Activity HR: 98

Activity BP: 153/83

Activity RR: 22

Activity O2 sat: 100 %

Supplemental O2: 3 L NC

Aerobic Capacity: Recovery

Recovery HR: 82

Recovery BP: 142/72

Recovery RR: 21

Recovery O2 sat: 100 %

Supplemental O2: 3 L NC

Range of Motion

Range of Motion: B UE WFL

Muscle Performance: strength, power, endurance

Muscle Performance: R UE [**6-14**] throughout

L shoulder flex/abd 2+/5

L elbow flex/ext 2+/5

L wrist ext 3-/5

L wrist flex 2+/5

L grasp 2+/5

Additional Performance Skills

Motor Control: No abnormal movements noted.

Coordination: R serial opposition and FNF intact. L UE unable to

perform.

Pain (0 - 10): 0 / 10

Limiting Symptoms: Tightness at L shoulder c PROM

Sensation: B LE/UE intact to light touch

Integumentary: Chest Tube, Foley, PIV, O2 NC on 3L, Pneumo Boots, [**Location (un) 1083**]

J Collar

Team Communication: RN, Family at bedside, co-tx with PT

[**Name (NI) **] Education: Role of [**Hospital 2978**] Rehab, Orientation, L UE elevation with

Family and pt

Intervention: N/A

Other: N/A

Diagnosis

Diagnosis 1: Impaired trunk control

Diagnosis 2: Impaired orientation

Diagnosis 3: Impaired strength

Diagnosis 4: Impaired balance

Clinical Impression / Prognosis

Clinical Impression / Prognosis: 22 yo male s/p trauma who p/w above

impairments and is functioning well below baseline of independent. Pt participated with 100% of OT evaluation and is an excellent rehab candidate given prior level of function and family supports. Recommend intense rehab c daily OT and PT to maximize functional independence and safety.

Goals: patient / family, objective, measurable

Patient Goals: To get better

Goal 1: A&Ox3

Goal 2: Stand step transfer to commode c min A x1

Goal 3: Drink from cup c L UE and CG A to bring to mouth

Goal 4: Sit EOB I with no LOB for dynamic seated ADL task

Time Frame (expected attainment): 1 week

Anticipated Discharge: Rehab

Treatment Plan: Interventions; patient / family education, community resources

Treatment Plan: F/u for cognitive assessment, UE therex, ADL retraining, pt education

Frequency / Duration: 3-5xwk

Recommendations for Nursing: Elevate L UE to prevent swelling.

Encourage AROM of L UE

Therapist Information

Therapist's Name: [**First Name8 (NamePattern2) **] [**Last Name (un) 9922**] OT/L

Date: [**2140-11-4**]

Time: 9:20-10:00

Pager #: [**Numeric Identifier 9923**]

"

"Pt s/p ATV accident where he hit head on the handlebars, + helmet, GCS 6 at the scene and pt vomiting. Taken to [**Hospital3 735**] and intubated for airway protection and combativeness and then medflighted to [**Hospital1 19**]

for further w/u. No PMHX, no meds.

Head CT shows diffuse areas of SAH and tiny left SDH as well as hemmorhage w/in prepontine cistern and pons anteriorly, bilateral temporal bone fx's extending to carotid canal, left lateral and medial orbital wall fx and left zygomatic fx . Pt presented with dialated and fixed left pupil (??L sided third nerve palsy ,L pupil fixed and dilated since accident) and left hemiparesis, right pupil brisk and purposeful movement with RUE. Spine clear radiographically, CT of torso significant for bibasilar consolidation c/w aspiration.

Trauma, s/p

Assessment:

Pt. awake but confused, able to state name, follows commands. Normal movement of right side but minimal movement of left arm, and left leg weakness. R pupil briskly reactive, can only open L eye a slit. L pupil remains non reactive at 5-6mm (believed to be third nerve palsy). Cervical collar remains in place. Continues on dilantin 200 iv q 12 hours with level this am 9.6. BP remains < goal of 160, sats maintained on 3L np. Bilateral chest tubes to water seal. Multiple abrasions healing on arm and torso. Mom, dad, and [**Name2 (NI) 9576**] all updated with condition . Family continues to stay around the clock

Action:

Right chest tube d/c
d (CXR ordered for this afternoon)Dilaudid iv for pain control. Frequent reorientation. Family updated with status. MRI of orbits, cervical spine and thoracic spine ordered (to be done once pt more clear and able to stay still.) Mri checklist completed and faxed to MRI, please call once decided MRI is appropriate. Decision was made by ICU team to readdress as pt. becomes less restless. PT/OT working with patient this morning

Response:

Pt calmer, more conversant, but still confused. Overall neuro status has improved greatly in the last 24 hours. Continues with L sided hemiparesis. OOB to chair with 2 assist, speech and swallow determined pt needs crushed meds and nectar thick liquids

Plan:

Continue to monitor neuro status. Obtain mri when feasible. Advance diet as able. If no further pneumothorax, ?d/c left chest tube tomorrow, Continue family education. Consult case management about discharge plans.

Pneumonia, aspiration

Assessment:

Pt self extubated yesterday. Tachypneic rr 30-35/min. Clear lung sounds. Weak congested cough. Bilateral chest tubes to water seal. Febrile to 101.8 po. Continues on vanco, cipro, tobramycin for gram neg rods and gram + cocci in sputum.

Action:

Blood culture X 1, urine culture done overnight . Vanco, Tobra and Cipro d/c

d and Nafcilin started today. Encouraged to cough and deep breathe.

Response:

Afebrile, Wbc down to 15. CXR improving

Plan:

Follow culture results as well as CXR results. Continue pulmonary hygiene.

"

"TITLE:

BEDSIDE SWALLOWING EVALUATION:

HISTORY:

Thank you for consulting on this 22 y/o male who was transferred from OSH on [**10-30**] s/p fall off dirt bike at approximate speed of 35 mph. He was found to be combative by EMS with GCS 6 and was intubated and sedated at OSH. He was transferred to [**Hospital1 19**] for further management. Pt was found with small SDH, SAH, prepontine hemorrhage fractures of his L lateral orbit, left zygomatic, and bilateral temporal bones. He had a bolt in place on the 21st to the 22nd with normal pressures. Pt also with dilated left pupil, likely from peripheral 3rd nerve palsy per neurology notes. CXR on [**11-3**] revealed increased RLL and retrocardiac opacities which may represent PNA. CXR on [**11-4**] pending. Pt self extubated [**11-3**] and was apparently complaining of paresthesias in his left arm and leg. He is currently NPO, pending our eval. We were consulted to evaluate oral and pharyngeal swallow function to determine the safest diet.

EVALUATION:

The examination was performed while the patient was seated upright in the chair on the TSICU.

Cognition, language, speech, voice:

Pt was asleep upon entry to the room, but roused quickly. He was oriented to person, but not date, and was confused about place (first said ""[**Location (un) 2911**]"" and then ""hospital""). He was also confused about current job, at first reporting that he was in high school, but was able to correctly id his place of employment with prompting from step father (""High school was before, where do you work now?). He also perseverat ed on previous instructions and continued to say ""ahh"" with food in mouth x3, even after instruction to swallow before speaking. However, pt was able to follow simple commands and was without

dysarthria or paraphasias. Speech was fluent and well articulated.

Voice quality was low volume and hypophonic.

Teeth: WNL

Secretions: Thick, bloody secretions brought up with productive cough and removed with yankauer.

ORAL MOTOR EXAM:

Face was grossly symmetrical. Tongue protruded at midline with adequate ROM. Labial seal intact. Palatal elevation symmetric and gag present with deep prodding.

SWALLOWING ASSESSMENT:

Pt was offered ice chips, thin liquids (tsp, straw), nectar thick liquids (tsp, straw), puree, ground solids, and soft solids. Oral phase was timely and without anterior spill. Laryngeal elevation was WFL, but difficult to palpate due to cervical collar. Pt coughed with all trials of thin liquids and consecutive trials of soft solids. No choking, 02 desats, or vocal quality changes were observed. Sensation appeared intact, given pt report of pharyngeal residue and ""I'm choking"" with thin liquids.

SUMMARY / IMPRESSION:

Pt presents with s/sx of aspiration with thin liquids and consecutive trials of soft solids. A PO diet of ground solids and nectar thick liquids is recommended. Meds should be crushed in puree. 1:1 supervision is suggested with meals to assist with feeding and encourage alternating between solids and liquids. Consult Nutrition as needed. We will f/u early next week for diets upgrades and cognitive dx/tx as able.

This swallowing pattern correlates to a Functional Oral Intake Scale (FOIS) rating of 5 out of 7.

RECOMMENDATIONS:

1.) PO diet of ground solids and nectar thick liquids.

2.) Meds crushed in puree

3.) TID oral care

4.) 1:1 supervision to assist with feeding and encourage alternating

btwn solids and liquids.

5.) Please consult Nutrition as needed

6.) We will f/u early next week

These recommendations were shared with the patient, nurse and medical

team.

_____

[**First Name8 (NamePattern2) 9911**] [**Last Name (NamePattern1) 9912**], B.A., SLP/s

Pager #[**Numeric Identifier 5879**]

_____

[**Doctor First Name 3274**] Whitmill, M.S., CCC-SLP

Pager # [**Numeric Identifier 5011**]

Face time: 11:10-11:30

Total time: 75min

"

"TITLE:

BEDSIDE SWALLOWING EVALUATION:

HISTORY:

Thank you for consulting on this 22 y/o male who was transferred from

OSH on [**10-30**] s/p fall off dirt bike at approximate speed of 35 mph. He

was found to be combative by EMS with GCS 6 and was intubated and

sedated at OSH. He was transferred to [**Hospital1 19**]

for further management. Pt was found with small SDH, SAH, prepontine

hemorrhage fractures of his L lateral orbit, left zygomatic, and

bilateral temporal bones. He had a bolt in place on the 21st to the

22nd with normal pressures. Pt also with dilated left pupil, likely

from peripheral 3rd nerve
palsy per neurology notes. CXR on [**11-3**] revealed increased RLL and
retrocardiac opacities which may represent PNA. CXR on [**11-4**] pending.
Pt self extubated [**11-3**] and was apparently complaining of paresthesias
in his left arm and leg. He is currently NPO, pending our eval. We
were consulted to evaluate oral and pharyngeal swallow function to
determine the safest diet.
EVALUATION:
The examination was performed while the patient was seated upright in
the chair on the TSICU.
Cognition, language, speech, voice:
Pt was asleep upon entry to the room, but roused quickly. He was
oriented to person, but not date, and was confused about place (first
said ""[**Location (un) 2911**]"" and then ""hospital""). He was also confused about
current job, at first reporting that he was in high school, but was
able to correctly id his place of employment with prompting from step
father (""High school was before, where do you work now?). He also
perseverat ed on previous instructions and continued to say ""ahh"" with
food in mouth x3, even after instruction to swallow before speaking.
However, pt was able to follow simple commands and was without
dysarthria or paraphasias. Speech was fluent and well articulated.
Voice quality was low volume and hypophonic.
Teeth: WNL
Secretions: Thick, bloody secretions brought up with productive cough
and removed with yankauer.
ORAL MOTOR EXAM:
Face was grossly symmetrical. Tongue protruded at midline with adequate
ROM. Labial seal intact. Palatal elevation symmetric and gag present
with deep prodding.

SWALLOWING ASSESSMENT:

Pt was offered ice chips, thin liquids (tsp, straw), nectar thick liquids (tsp, straw), puree, ground solids, and soft solids. Oral phase was timely and without anterior spill. Laryngeal elevation was WFL, but difficult to palpate due to cervical collar. Pt coughed with all trials of thin liquids and consecutive trials of soft solids. No choking, 02 desats, or vocal quality changes were observed. Sensation appeared intact, given pt report of pharyngeal residue and ""I'm choking"" with thin liquids.

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Pt presents with s/sx of aspiration with thin liquids and consecutive trials of soft solids. A PO diet of ground solids and nectar thick liquids is recommended. Meds should be crushed in puree. 1:1 supervision is suggested with meals to assist with feeding and encourage alternating between solids and liquids. Consult Nutrition as needed. We will f/u early next week for diets upgrades and cognitive dx/tx as able.

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RECOMMENDATIONS:

1.) PO diet of ground solids and nectar thick liquids.

2.) Meds crushed in puree

3.) TID oral care

4.) 1:1 supervision to assist with feeding and encourage alternating btwn solids and liquids.

5.) Please consult Nutrition as needed

6.) We will f/u early next week

These recommendations were shared with the patient, nurse and medical team.

_____

[**First Name8 (NamePattern2) 9911**] [**Last Name (NamePattern1) 9912**], B.A., SLP/s

Pager #[**Numeric Identifier 5879**]

_____

[**Doctor First Name 3274**] Whitmill, M.S., CCC-SLP

Pager # [**Numeric Identifier 5011**]

Face time: 11:10-11:30

Total time: 75min

------ Protected Section ------

------ Protected Section Addendum Entered By:[**Name (NI) 3274**] Whitmill, SLP

on:[**2140-11-4**] 12:18 ------

"

"22 year old man s/p ATV accident [**2140-10-30**] with brain injury, pons

infarct, witness aspiration, orbit fx, basilar skull fracture, ??L

sided third nerve palsy (L pupil fixed and dilated since accident)

Trauma, s/p

Assessment:

Pt. awake but confused, able to state name, follows commands but

restless at times. C/o lower back pain and pain in neck. Normal

movement of right side but minimal movement of left arm, and left leg

weakness. R pupil briskly reactive, can only open L eye a slit. L pupil

remains non reactive at 5-6mm. Cervical collar remains in place. R

hand mitted to prevent pt. pulling at lines, tube or collar. Other

safety measures including bed alarm, high visibility with frequent

checks utilized. Continues on dilantin 200 iv q 12 hours with level

this am 9.6. BP remains < goal of 160, sats maintained on 3L np.

Bilateral chest tubes to water seal. Multiple abrasions healing on arm

and torso. Mom, dad, and [**Name2 (NI) 9576**] all updated with condition . Family

continues to stay around the clock

Action:

Neuro checks q 2 hours, high visibility for safety. Dilaudid iv for pain control. Frequent reorientation. Family updated with status. MRI of orbits, cervical spine and thoracic spine ordered. After discussion with T/SICU house officer and MRI tech it was determined that pt would not be able to cooperate with test at this point. Mri checklist completed and faxed to MRI. Decision was made to readdress as pt. becomes less restless. Labs drawn and lytes repleted as ordered.

Response:

Calmer this morning, more conversant, but still confused. Overall neuro status has improved greatly in the last 24 hours. Continues with L sided hemiparesis.

Plan:

Continue neuro checks. Obtain mri when feasible. Bedside speech and swallow today and advance diet as able. If no further pneumothorax, ?dcing pleural tubes. Obtain PT/OT consult. ??OOB to chair today. Continue family education. Consult case management about discharge plans. If continues to improve, will transfer to CC6 soon!

Pneumonia, aspiration

Assessment:

Self extubated yesterday. Tachypneic rr 30-35/min. Rhonchi in upper airways. Weak congested cough. Bilateral chest tubes to water seal. Febrile to 101.8 po. Continues on vanco, cipro, tobramycin for gram neg rods and gram + cocci in sputum.

Action:

Blood culture X 1, urine culture done, Tylenol given for temp as well as cool room and fan. Vancomycin trough obtained, AM chest x ray done. Encouraged to cough and deep breathe.

Response:

Fever down to 99.8 this am. Wbc down to 15. CXR results pending

Plan:

Follow vanc and tobra levels, follow culture results as well as CXR

results. Continue pulmonary hygiene.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

Traumatic injury

PMHx:

Denies

Current medications:

Denies

24 Hour Events:

UNPLANNED EXTUBATION (PATIENT-INITIATED) - At [**2140-11-3**] 09:43 AM

ARTERIAL LINE - STOP [**2140-11-3**] 12:00 PM

BLOOD CULTURED - At [**2140-11-3**] 08:00 PM

URINE CULTURE - At [**2140-11-3**] 08:00 PM

FEVER - 101.8

F - [**2140-11-3**] 10:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-3**] 04:24 PM

Ciprofloxacin - [**2140-11-3**] 06:48 PM

Vancomycin - [**2140-11-3**] 11:58 PM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-3**] 08:30 AM

Fentanyl - [**2140-11-3**] 04:29 PM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 10:00 PM

Hydromorphone (Dilaudid) - [**2140-11-4**] 04:12 AM

Other medications:

Flowsheet Data as of [**2140-11-4**] 05:13 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.6

C (99.6

HR: 79 (78 - 108) bpm

BP: 132/67(83) {125/55(73) - 156/91(102)} mmHg

RR: 25 (19 - 36) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 85.2 kg (admission): 85.6 kg

Total In:

2,632 mL

175 mL

PO:

100 mL

Tube feeding:

536 mL

IV Fluid:

2,006 mL

75 mL

Blood products:

Total out:

4,940 mL

260 mL

Urine:

4,895 mL

260 mL

NG:

Stool:

Drains:

Balance:

-2,308 mL

-85 mL

Respiratory support

O2 Delivery Device: Nasal cannula

Ventilator mode: Standby

Vt (Spontaneous): 589 (589 - 589) mL

PS : 5 cmH2O

RR (Spontaneous): 35

PEEP: 5 cmH2O

FiO2: 70%

PIP: 11 cmH2O

SPO2: 96%

ABG: 7.48/34/70/26/2

Ve: 14 L/min

PaO2 / FiO2: 175

Physical Examination

General Appearance: Anxious, active

HEENT: Left pupil dilated, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft

Left Extremities: (Temperature: Warm)

Right Extremities: (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 2, x 1), Follows simple commands

Labs / Radiology

265 K/uL

11.3 g/dL

114 mg/dL

0.9 mg/dL

26 mEq/L

3.4 mEq/L

13 mg/dL

103 mEq/L

141 mEq/L

33.7 %

16.6 K/uL

[image002.jpg]

[**2140-11-2**] 08:00 AM

[**2140-11-2**] 10:09 AM

[**2140-11-2**] 02:00 PM

[**2140-11-2**] 05:55 PM

[**2140-11-2**] 08:00 PM

[**2140-11-3**] 02:02 AM

[**2140-11-3**] 02:10 AM

[**2140-11-3**] 09:26 AM

[**2140-11-3**] 07:03 PM

[**2140-11-4**] 02:12 AM

WBC

18.5

16.6

Hct

31.9

33.7

Plt

196

265

Creatinine

0.8

0.9

TCO2

23

26

28

28

26

Glucose

135

148

157

121

178

114

Other labs: Lactic Acid:1.3 mmol/L, Albumin:3.6 g/dL, Ca:8.5 mg/dL,

Mg:2.2 mg/dL, PO4:3.6 mg/dL

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN

CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, f/u dilantin levels, resolution SAH,

small SDH, unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 15

Pain: Fentanyl, Dilaudid, Ativan prn

Cardiovascular: stable

Pulmonary: b/l chest tubes to water seal (no leak), self extubated [**11-3**]

Gastrointestinal / Abdomen: NPO

Nutrition: NPO

Renal: Foley, Foley in place, good urine output

Hematology: last crit 33.7

Endocrine: RISS

Infectious Disease: Check cultures, check pending cultures, WBC from

18.5. on Vanc/Tobra/Cipro for HCAP until [**11-8**]

Lines / Tubes / Drains: PIVs, Foley, R subclavian CVL, b/l CT

Imaging: MRI pending

Head, orbit, Cspine and T spine

per Neuro c/s

Fluids: KVO

Consults: Trauma surgery, Ophthalmology, Neurology, neurosurg

Billing Diagnosis:

ICU Care

Glycemic Control:

Lines: PIVs, Foley, R subclavian CVL, b/l CT

Multi Lumen - [**2140-10-31**] 10:33 AM

18 Gauge - [**2140-11-3**] 03:02 PM

Prophylaxis:

DVT: SQ UF Heparin

Stress ulcer:

VAP bundle: NA

Communication: Comments:

Code status:

Disposition:

Total time spent:

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil. Exam

much improved

Chief complaint:

s/p head trauma

PMHx:

None

Current medications:

Acetaminophen

Albuterol Inhaler

Artificial Tear Ointment

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin

Ibuprofen

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

CHEST TUBE PLACED - At [**2140-11-2**] 02:27 PM

BAL FLUID CULTURE - At [**2140-11-2**] 04:00 PM

FEVER - 101.4

F - [**2140-11-2**] 03:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-2**] 04:21 PM

Vancomycin - [**2140-11-3**] 03:35 AM

Ciprofloxacin - [**2140-11-3**] 06:17 AM

Infusions:

Propofol - 100 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-2**] 08:00 PM

Propofol - [**2140-11-3**] 04:27 AM

Fentanyl - [**2140-11-3**] 05:20 AM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 06:18 AM

Other medications:

Flowsheet Data as of [**2140-11-3**] 06:31 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.4

T current: 37.8

C (100

HR: 89 (74 - 111) bpm

BP: 131/63(84) {97/53(70) - 162/86(105)} mmHg

RR: 28 (17 - 33) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 86.2 kg (admission): 85.6 kg

Total In:

3,881 mL

1,261 mL

PO:

Tube feeding:

1,320 mL

349 mL

IV Fluid:

2,412 mL

852 mL

Blood products:

Total out:

2,260 mL

370 mL

Urine:

2,245 mL

370 mL

NG:

Stool:

Drains:

Balance:

1,621 mL

891 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CPAP/PSV

Vt (Spontaneous): 573 (460 - 597) mL

PS : 5 cmH2O

RR (Spontaneous): 28

PEEP: 5 cmH2O

FiO2: 50%

RSBI: 60

PIP: 23 cmH2O

SPO2: 100%

ABG: 7.39/44/173/25/1

Ve: 15.6 L/min

PaO2 / FiO2: 346

Physical Examination

General Appearance: No acute distress, Well nourished

HEENT: Left pupil dilated

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: Rhonchorous :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: Follows simple commands, (Responds to: Verbal stimuli),

No(t) Moves all extremities, (LUE: Weakness), (LLE: Weakness), Sedated

Labs / Radiology

196 K/uL

10.6 g/dL

121 mg/dL

0.8 mg/dL

25 mEq/L

3.9 mEq/L

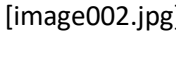
12 mg/dL

109 mEq/L

143 mEq/L

31.9 %

18.5 K/uL



[image002.jpg]

[**2140-11-1**] 08:47 PM

[**2140-11-2**] 02:27 AM

[**2140-11-2**] 02:31 AM

[**2140-11-2**] 08:00 AM

[**2140-11-2**] 10:09 AM

[**2140-11-2**] 02:00 PM

[**2140-11-2**] 05:55 PM

[**2140-11-2**] 08:00 PM

[**2140-11-3**] 02:02 AM

[**2140-11-3**] 02:10 AM

WBC

25.0

18.5

Hct

34.1

31.9

Plt

226

196

Creatinine

0.9

0.8

TCO2

23

25

23

26

28

Glucose

169

135

148

157

121

Other labs: Lactic Acid:1.0 mmol/L, Albumin:3.6 g/dL, Ca:7.9 mg/dL,

Mg:1.8 mg/dL, PO4:3.3 mg/dL

Microbiology: [**10-31**]: Sputum S aureus, S pneumoniae

[**11-1**]: Sputum S aureus

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN

CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, Phenytoin - therapeutic, Pain

controlled, Propofol gtt at 100 mcg/kg/min, Fentanyl prn, comfortable.

Wean today. Following commands, GCS 11T.

Cardiovascular: Stable

Pulmonary: (Ventilator mode: CPAP + PS), Consider extubation. Check

ABG.

Gastrointestinal / Abdomen: TF at goal.

Nutrition: Tube feeding

Renal: Foley, Adequate UO

Hematology: H/H slightly decreased.

Endocrine: RISS, well controlled.

Infectious Disease: Check cultures, Vanco frequency increased for

trough of 2.3. Temperature curve down, decreased WBC. CXR c/w

pneumonia. Rx with antibiotics for 7 days.

Lines / Tubes / Drains: Foley, OGT, ETT, Chest tubes

pleural,

Aline

will d/c not functioning

Imaging: CXR today

Fluids: KVO

Consults: Neuro surgery, Trauma surgery, Plastics, Ophthalmology

Billing Diagnosis: TBI, respiratory failure, bilateral ptx, pna

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting held , ICU consent signed Comments:

Code status: Full code

Disposition: ICU

Total time spent: 32 minutes

Patient is critically ill

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil. Exam

much improved

Chief complaint:

s/p head trauma

PMHx:

None

Current medications:

Acetaminophen

Albuterol Inhaler

Artificial Tear Ointment

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin

Ibuprofen

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

CHEST TUBE PLACED - At [**2140-11-2**] 02:27 PM

BAL FLUID CULTURE - At [**2140-11-2**] 04:00 PM

FEVER - 101.4

F - [**2140-11-2**] 03:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-2**] 04:21 PM

Vancomycin - [**2140-11-3**] 03:35 AM

Ciprofloxacin - [**2140-11-3**] 06:17 AM

Infusions:

Propofol - 100 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-2**] 08:00 PM

Propofol - [**2140-11-3**] 04:27 AM

Fentanyl - [**2140-11-3**] 05:20 AM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 06:18 AM

Other medications:

Flowsheet Data as of [**2140-11-3**] 06:31 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.4

T current: 37.8

C (100

HR: 89 (74 - 111) bpm

BP: 131/63(84) {97/53(70) - 162/86(105)} mmHg

RR: 28 (17 - 33) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 86.2 kg (admission): 85.6 kg

Total In:	
	3,881 mL
	1,261 mL
PO:	
Tube feeding:	
	1,320 mL
	349 mL
IV Fluid:	
	2,412 mL
	852 mL
Blood products:	
Total out:	
	2,260 mL
	370 mL
Urine:	
	2,245 mL
	370 mL
NG:	
Stool:	
Drains:	
Balance:	
	1,621 mL
	891 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CPAP/PSV

Vt (Spontaneous): 573 (460 - 597) mL

PS : 5 cmH2O

RR (Spontaneous): 28

PEEP: 5 cmH2O

FiO2: 50%

RSBI: 60

PIP: 23 cmH2O

SPO2: 100%

ABG: 7.39/44/173/25/1

Ve: 15.6 L/min

PaO2 / FiO2: 346

Physical Examination

General Appearance: No acute distress, Well nourished

HEENT: Left pupil dilated; Right reactive

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: Rhonchorous :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: Follows simple commands, (Responds to: Verbal stimuli),

No(t) Moves all extremities, (LUE: Weakness), (LLE: Weakness), Sedated

Labs / Radiology

196 K/uL

10.6 g/dL

121 mg/dL

0.8 mg/dL

25 mEq/L

3.9 mEq/L

12 mg/dL

109 mEq/L

143 mEq/L

31.9 %

18.5 K/uL

[image002.jpg]

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[**2140-11-2**] 02:00 PM

[**2140-11-2**] 05:55 PM

[**2140-11-2**] 08:00 PM

[**2140-11-3**] 02:02 AM

[**2140-11-3**] 02:10 AM

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Hct

34.1

31.9

Plt

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Creatinine

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TCO2

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Glucose

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Other labs: Lactic Acid:1.0 mmol/L, Albumin:3.6 g/dL, Ca:7.9 mg/dL,

Mg:1.8 mg/dL, PO4:3.3 mg/dL

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[**11-1**]: Sputum S aureus

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN

CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, Phenytoin - therapeutic, Pain

controlled, Propofol gtt at 100 mcg/kg/min, Fentanyl prn, comfortable.

Wean today. Following commands, GCS 11T. Start Ativan PRN and wean

PPF off for possible extubation.

Cardiovascular: Stable.

Pulmonary: (Ventilator mode: CPAP + PS), Consider extubation. Check ABG.

Gastrointestinal / Abdomen: TF at goal.

Nutrition: Tube feeding

Renal: Foley, Adequate UO

Hematology: H/H slightly decreased.

Endocrine: RISS, well controlled.

Infectious Disease: Check cultures, Vanco frequency increased for trough of 2.3. Temperature curve down, decreased WBC. CXR c/w pneumonia. Rx with antibiotics for 7 days.

Lines / Tubes / Drains: Foley, OGT, ETT, Bilat Chest tubes

pleural,

Aline

will d/c not functioning

Imaging: CXR today

Fluids: KVO

Consults: Neuro surgery, Trauma surgery, Plastics, Ophthalmology

Billing Diagnosis: TBI, respiratory failure, bilateral ptx, pna

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family meeting held , ICU consent signed Comments:

Code status: Full code

Disposition: ICU

Total time spent: 32 minutes

Patient is critically ill

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head this am showed no change per neuro [**Doctor First Name 213**].

Action:

Neuro checks cont Q2 hr.

Response:

Neuro status unchanged. Left pupil remains fixed and dilated no movement to left eye. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye and consistently follows commands. No csf noted from ears.

Plan:

Cont Q 2hr neuro checks, watch for CSF leak from ears.

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and facial fx, + aspiration, no other injury noted per team.

Action:

Cooling measure for temp Fan, cooling blanket , Tylenol, and motrin

given. Vent setting changed to CPAP, 10 peep, 12 ps 50%. Tol well. CT

placed for small left pnumo. Plastics in to eval face for ? surgical

intervention. Vaco level sent this pm. Bal sent by resp.

Response:

T- max 101.4, despite cooling measures temps remain over 100.

Plan:

Cont to support resp status. f/u cx. Cont abx for asp pneumonia. Tobra

level to be drawn before second dose tomorrow.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

[**Doctor First Name **]

PMHx:

none

Current medications:

Acetaminophen

Albuterol 0.083% Neb Soln

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

HydrALAzine

Insulin

Ipratropium Bromide Neb

Magnesium Sulfate

Mannitol

Neutra-Phos

NiCARdipine

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

MULTI LUMEN - START [**2140-10-31**] 10:33 AM

ICP BOLT INSERTED - At [**2140-10-31**] 04:11 PM

ARTERIAL LINE - STOP [**2140-10-31**] 06:14 PM

ARTERIAL LINE - START [**2140-10-31**] 06:22 PM

BLOOD CULTURED - At [**2140-11-1**] 01:00 AM

URINE CULTURE - At [**2140-11-1**] 01:00 AM

BRONCHOSCOPY - At [**2140-11-1**] 01:30 AM

for LLL collapse and desaturation

BAL FLUID CULTURE - At [**2140-11-1**] 02:00 AM

FEVER - 101.5

F - [**2140-11-1**] 12:00 AM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Vancomycin - [**2140-11-1**] 03:00 AM

Tobramycin - [**2140-11-1**] 03:14 AM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-31**] 08:00 PM

Fentanyl - [**2140-11-1**] 04:00 AM

Other medications:

Flowsheet Data as of [**2140-11-1**] 06:43 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.5

T current: 38.3

C (100.9

HR: 103 (74 - 106) bpm

BP: 154/74(93) {93/59(74) - 162/93(106)} mmHg

RR: 17 (14 - 26) insp/min

SPO2: 100%

Heart rhythm: ST (Sinus Tachycardia)

ICP: 16 (12 - 49) mmHg

Total In:

3,666 mL

1,318 mL

PO:

Tube feeding:

667 mL

368 mL

IV Fluid:

2,969 mL

810 mL

Blood products:

Total out:

1,357 mL

1,610 mL

Urine:

1,357 mL

1,610 mL

NG:

Stool:

Drains:

Balance:

2,309 mL

-292 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

Vt (Spontaneous): 478 (478 - 595) mL

PS : 5 cmH2O

RR (Set): 16

RR (Spontaneous): 0

PEEP: 5 cmH2O

FiO2: 80%

RSBI Deferred: FiO2 > 60%

PIP: 31 cmH2O

Plateau: 26 cmH2O

SPO2: 100%

ABG: 7.42/34/143/25/-1

Ve: 12.2 L/min

PaO2 / FiO2: 179

Physical Examination

General Appearance: Well nourished

HEENT: Left pupil dilated

Cardiovascular: (Rhythm: Regular), tachycardic

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: Wheezes :

, Rhonchorous : , Diminished: R)

Abdominal: Soft, Non-distended

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Neurologic: (Responds to: Unresponsive), No(t) Moves all extremities,

(LUE: No movement), Sedated

Labs / Radiology

252 K/uL

12.5 g/dL

142 mg/dL

1.0 mg/dL

25 mEq/L

3.3 mEq/L

9 mg/dL

108 mEq/L

141 mEq/L

36.4 %

20.5 K/uL

[image002.jpg]

[**2140-10-30**] 11:00 PM

[**2140-10-31**] 02:18 AM

[**2140-10-31**] 02:29 AM

[**2140-10-31**] 09:29 AM

[**2140-10-31**] 06:44 PM

[**2140-10-31**] 07:58 PM

[**2140-11-1**] 12:50 AM

[**2140-11-1**] 12:58 AM

[**2140-11-1**] 02:59 AM

[**2140-11-1**] 05:30 AM

WBC

27.4

20.4

20.5

Hct

41.5

34.8

36.4

Plt

[**Telephone/Fax (3) 10178**]

Creatinine

1.1

1.0

1.0

TCO2

24

24

25

25

27

24

23

Glucose

130

119

142

Other labs: Lactic Acid:0.7 mmol/L, Albumin:4.5 g/dL, Ca:8.5 mg/dL,

Mg:2.1 mg/dL, PO4:1.6 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 1 hr, Intubated and sedated on propofol

Pain: Fentanyl prn

Cardiovascular: Able to autoregulate to SBP around 160

Pulmonary: Cont ETT, (Ventilator mode: CMV), wean to CPAP, bronched for desats, appears to be PNA, likely needs another bronch today

Gastrointestinal / Abdomen: OGT in place, TF to goal

Nutrition: Tube feeding

Renal: Foley, Adequate UO, Foley in place, good urine output

Hematology: Serial Hct, Hct stable at 36; Hold off SQ Heparin for now

Endocrine: RISS

Infectious Disease: Check cultures, Spiked to 101.5, Vanc/Tobra/Cipro for HCAP

Lines / Tubes / Drains: Foley, OGT, ETT

Wounds:

Imaging: CXR today

Fluids: NS, NS @ 80

Consults: Neuro surgery, Trauma surgery

Billing Diagnosis: (Hemorrhage, NOS: Sub-arachnoid), (Respiratory distress: Failure)

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-10-31**] 08:50 AM 80 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: ICU consent signed Comments:

Code status:

Disposition: ICU

Total time spent:

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head this am showed no change per neuro [**Doctor First Name 213**].

Action:

Cont Q1hr neuro checks, bolt placed this afternoon. Neuro checks

changed to Q4hrs, Nicardipine off, sbp parameters increased to <160.

Response:

Essentially no change in neuro exam. Left pupil remains fixed and dilated. Opthomology states optic nerve injury. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, ? purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye to pain but not consistently, does not follow command.

Plan:

Cont Q 4 hr neuro checks. If ICP increase >25 for >10min treat with sedation and pain med

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and facial fx, + aspiration, no other injury noted per team.

Action:

Pt remains on c-spine and TLS precautions most of the day. TLS cleared by trauma at 1800. Tf started, tolerating well, blood from bilat ears and nose. Vent weaned to CPAP 5/5 tol well sat 100%, left SC central line placed.

Response:

VSS, hyperdynamic with wake up assessment, , lung sounds clear, cont to sx bloody secreations for mouth and ETT, probably from facial fx and basilar skull fx, left arm cont to be swollen, IV removed left arm elevated.

Plan:

Cont to monitor ICP, cont c-spine precautions.

Pain control (acute pain, chronic pain)

Assessment:

Pt restless and hyperdynamic during wake up assessments

Action:

Propofol cont. prn fentanyl , pain assessed frequently.

Response:

VS respond to fentanyl pt appears comfortable.

Plan:

Cont to asses pain and sedation. Follow ICP.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil. Exam

much improved

Chief complaint:

s/p head trauma

PMHx:

None

Current medications:

Acetaminophen

Albuterol Inhaler

Artificial Tear Ointment

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin

Ibuprofen

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

CHEST TUBE PLACED - At [**2140-11-2**] 02:27 PM

BAL FLUID CULTURE - At [**2140-11-2**] 04:00 PM

FEVER - 101.4

F - [**2140-11-2**] 03:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-2**] 04:21 PM

Vancomycin - [**2140-11-3**] 03:35 AM

Ciprofloxacin - [**2140-11-3**] 06:17 AM

Infusions:

Propofol - 100 mcg/Kg/min

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-2**] 08:00 PM

Propofol - [**2140-11-3**] 04:27 AM

Fentanyl - [**2140-11-3**] 05:20 AM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 06:18 AM

Other medications:

Flowsheet Data as of [**2140-11-3**] 06:31 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.4

T current: 37.8

C (100

HR: 89 (74 - 111) bpm

BP: 131/63(84) {97/53(70) - 162/86(105)} mmHg

RR: 28 (17 - 33) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 86.2 kg (admission): 85.6 kg

Total In:

3,881 mL

1,261 mL

PO:

Tube feeding:

1,320 mL

349 mL

IV Fluid:

2,412 mL

852 mL

Blood products:

Total out:

2,260 mL

370 mL

Urine:

2,245 mL

370 mL

NG:

Stool:

Drains:

Balance:

1,621 mL

891 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CPAP/PSV

Vt (Spontaneous): 573 (460 - 597) mL

PS : 5 cmH2O

RR (Spontaneous): 28

PEEP: 5 cmH2O

FiO2: 50%

RSBI: 60

PIP: 23 cmH2O

SPO2: 100%

ABG: 7.39/44/173/25/1

Ve: 15.6 L/min

PaO2 / FiO2: 346

Physical Examination

General Appearance: No acute distress, Well nourished

HEENT: Left pupil dilated

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Breath Sounds: Rhonchorous :)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: Follows simple commands, (Responds to: Verbal stimuli),

No(t) Moves all extremities, (LUE: Weakness), (LLE: Weakness), Sedated

Labs / Radiology

196 K/uL

10.6 g/dL

121 mg/dL

0.8 mg/dL

25 mEq/L

3.9 mEq/L

12 mg/dL

109 mEq/L

143 mEq/L

31.9 %

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[image002.jpg]

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[**2140-11-3**] 02:10 AM

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Creatinine

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TCO2

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Glucose

169

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121

Other labs: Lactic Acid:1.0 mmol/L, Albumin:3.6 g/dL, Ca:7.9 mg/dL,

Mg:1.8 mg/dL, PO4:3.3 mg/dL

Microbiology: [**10-31**]: Sputum S aureus, S pneumoniae

[**11-1**]: Sputum S aureus

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, Phenytoin - therapeutic, Pain controlled, Propofol gtt at 100 mcg/kg/min, Fentanyl prn

Cardiovascular: Stable

Pulmonary: (Ventilator mode: CPAP + PS), Consider extubation

Gastrointestinal / Abdomen:

Nutrition: Tube feeding

Renal: Foley, Adequate UO

Hematology:

Endocrine: RISS

Infectious Disease: Check cultures, Vanco frequency increased for trough of 2.3. Incres dose as well?

Lines / Tubes / Drains: Foley, OGT, ETT, Chest tube - pleural

Wounds:

Imaging: CXR today

Fluids: KVO

Consults: Neuro surgery, Trauma surgery, Plastics, Ophthalmology

Billing Diagnosis:

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots, SQ UF Heparin

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: Patient discussed on interdisciplinary rounds , Family

meeting held , ICU consent signed Comments:

Code status: Full code

Disposition: ICU

Total time spent:

Patient is critically ill

"

"Demographics

Day of mechanical ventilation: 4

Airway

Airway Placement Data

Known difficult intubation: Unknown

Tube Type

ETT:

Position: 25 cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 25 cmH2O

Lung sounds

RLL Lung Sounds: Diminished

RUL Lung Sounds: Rhonchi

LUL Lung Sounds: Rhonchi

LLL Lung Sounds: Diminished

Secretions

Sputum color / consistency: Blood Tinged / Thick

Sputum source/amount: Suctioned / Copious

Ventilation Assessment

Level of breathing assistance: Continuous invasive ventilation

Visual assessment of breathing pattern: Normal quiet breathing

Assessment of breathing comfort: No claim of dyspnea

Invasive ventilation assessment:

Trigger work assessment: Triggering synchronously

Plan

Next 24-48 hours: Continue with daily RSBI tests & SBT's as tolerated,

Adjust Min. ventilation to control pH

Reason for continuing current ventilatory support: Underlying illness

not resolved

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head

this am showed no change per neuro [**Doctor First Name 213**].

Action:

Bolt d/c this am. Neuro checks changed to Q2 hr this afternoon.

Dilantin bolus given for low level. pt to have head Ct this evening for

f/u

Response:

Neuro status improved. Left pupil remains fixed and dilated. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye and consistently follows commands. No csf noted from ears.

Plan:

Cont Q 2hr neuro checks,. SQ heparin to start at 2200. watch for CSF leak from ears.

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and facial fx, + aspiration, no other injury noted per team.

Action:

T- max 101.3, LUE ultrasound done, CXR done, CT sinus and maxillofacial done this evening. Vent setting changed to TV 450, rr 22, and 50%, peep 10, for lung protection given low pao2 to fio2 ratio, and aspiration pneumonia. CT placed for small right pnumo.

Response:

Tylenol given for temp. lytes replaced, US showed occlusive thrombus to left basilic vein (superficial) requiring no intervention per team, no DVT. CXR showed atelectasis, not requiring a bronch at this time, lung re-expanded post CT placement. Cont to autodiurese 1300cc neg for the day. u/o slowed this evening. Na up to 147, not DI per urine lytes of this am.

Plan:

Cont to support resp status. Monitor labs replace lytes as needed. f/u cx. Cont abx for asp pneumonia.

"

"SICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

PMHx:

none

Current medications:

Acetaminophen

Albuterol Inhaler

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin SQ

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

ULTRASOUND - At [**2140-11-1**] 10:25 AM

left arm

CHEST TUBE PLACED - At [**2140-11-1**] 04:15 PM

FEVER - 101.8

F - [**2140-11-1**] 08:00 PM

Cooling blanket placed

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Ciprofloxacin - [**2140-11-1**] 04:55 PM

Vancomycin - [**2140-11-1**] 08:00 PM

Tobramycin - [**2140-11-2**] 04:00 AM

Infusions:

Propofol - 80 mcg/Kg/min

Other ICU medications:

Dilantin - [**2140-11-1**] 11:56 AM

Famotidine (Pepcid) - [**2140-11-1**] 08:00 PM

Fentanyl - [**2140-11-2**] 04:30 AM

Other medications:

Flowsheet Data as of [**2140-11-2**] 05:51 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.1

C (98.7

HR: 86 (86 - 119) bpm

BP: 110/57(73) {110/57(73) - 163/84(105)} mmHg

RR: 25 (17 - 39) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 84.2 kg (admission): 85.6 kg

ICP: 12 (12 - 16) mmHg

Total In:

5,227 mL

876 mL

PO:

Tube feeding:

1,543 mL

319 mL

IV Fluid:

3,484 mL

497 mL

Blood products:

Total out:

5,975 mL

570 mL

Urine:

5,975 mL

570 mL

NG:

Stool:

Drains:

Balance:

-748 mL

306 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 450 (450 - 450) mL

RR (Set): 22

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 50%

RSBI Deferred: PEEP > 10

PIP: 15 cmH2O

Plateau: 15 cmH2O

Compliance: 150 cmH2O/mL

SPO2: 100%

ABG: 7.41/38/81.[**Numeric Identifier 508**]/23/0

Ve: 12.5 L/min

PaO2 / FiO2: 164

Physical Examination

General Appearance: No(t) No acute distress, Anxious

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Percussion: Resonant :),

(Breath Sounds: CTA bilateral :), (Sternum: Stable)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Absent), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present, No(t)

Diminished)

Right Extremities: (Edema: Absent), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: (Responds to: Verbal stimuli, Tactile stimuli, Noxious stimuli), No(t) Moves all extremities, (LUE: No movement), (LLE: Weakness), Sedated

Labs / Radiology

226 K/uL

11.7 g/dL

169 mg/dL

0.9 mg/dL

23 mEq/L

3.8 mEq/L

8 mg/dL

113 mEq/L

146 mEq/L

34.1 %

25.0 K/uL

[image002.jpg]

[**2140-11-1**] 12:50 AM

[**2140-11-1**] 12:58 AM

[**2140-11-1**] 02:59 AM

[**2140-11-1**] 05:30 AM

[**2140-11-1**] 08:46 AM

[**2140-11-1**] 12:40 PM

[**2140-11-1**] 06:47 PM

[**2140-11-1**] 08:47 PM

[**2140-11-2**] 02:27 AM

[**2140-11-2**] 02:31 AM

WBC

20.5

25.0

Hct

36.4

34.1

Plt

252

226

Creatinine

1.0

0.9

TCO2

27

24

23

25

23

25

23

25

Glucose

142

170

169

Other labs: Lactic Acid:0.7 mmol/L, Albumin:3.6 g/dL, Ca:9.0 mg/dL,

Mg:2.0 mg/dL, PO4:2.1 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN,

CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

NEURO: Intubated and sedated on propofol, bolt removed [**11-1**] AM, SAH resolved, f/u dilantin levels, CT [**11-1**] resolution SAH, small SDH, unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 11T

Pain: Fentanyl prn

CVS: Stable

PULM: Intubated, wean to CPAP; Right 20 fr chest tube

GI: OGT in place, TF to goal

RENAL: Foley in place, good urine output

HEME: Hct stable at 36; SQ Heparin started [**11-1**]

ENDO: RISS

ID: WBC 25 from 20. Spiked to 101.5, actively cooling, Vanc/Tobra/Cipro for HCAP

TLD: ETT, OGT, PIVs, R Rad A-line, Foley, R subclavian CVL

IVF: NS @ 80 + KCl

CONSULTS: Trauma, Neurosurgery,

BILLING DIAGNOSIS: Traumatic head injury

ICU CARE:

GLYCEMIC CONTROL: RISS

PROPHYLAXIS:

DVT - Boots, Heparin SQ

STRESS ULCER - Famotidine

VAP BUNDLE - +

COMMUNICATIONS:

ICU Consent: In chart

CODE STATUS: Full

DISPOSITION: ICU

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control:

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Total time spent: 34 minutes

Patient is critically ill

"

"Subarachnoid hemorrhage (SAH)

Assessment:

When lightened from sedation pt opening right eye spontaneously, not opening left eye, right con
t briskly rx and left still fixed and dilated at 6-7mm. does track speaker with right eye when very awake, con
t to move right side with full strength, LLE able to bend up on bed at best exam yet not lifting off bed, left arm con
t with minimal withdrawl to painful stimuli. Dilantin level > 10, no seizure activity noted. Propofol decreased to 80mcgs/kg/min towards AM. Restless at times yet does settle. Urine output wnl
s , lytes con
t with slightly elevated Na and Chloride.

Action:

Pt con
t with q 2hour neuro checks off propofol

Response:

Neuro status remains stable

Plan:

Con

t checks as ordered, wean Propofol if tolerated.

Trauma, s/p

Assessment:

Pt hemodynamically stable, tachycardic most of shift yet particularly

when febrile, strong pulses in all extremities, left arm less

edematous, Hct 34.1 this AM, phos and potassium low. Pt saturating

between 95-100% throughout shift, suctioned frequently for copious

amount creamy tan blood tinged sputum w/ foul smelling [**Last Name (un) **], Abg

wnl

s. Pt con

t febrile w/ T max 101.8 PO, Tylenol given times 2 yet

w/ minimal results, pt not to much cooler after cool bath, Pt

tolerating TF

s w/o difficulty, no stool thus far,

Action:

Pt placed on cooling blanket , frequent pulmonary hygiene, pt given

senna PO

Response:

Temp down on cooling blanket, pt maintaining O2 sats w/o diff. Pt

passing gas yet still no stool yet.

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Pt less restlees and hyperdynamic in general tonight

Action:

Medicated periodically for activity with fenatnyl 50mcg

Response:

Good response to fentanyl

Plan:

Con

t to assess for pain frequently esp when off Propofol.

"

"SICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

PMHx:

none

Current medications:

Acetaminophen

Albuterol Inhaler

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

Heparin SQ

Insulin

Ipratropium Bromide MDI

Magnesium Sulfate

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Potassium Phosphate

Propofol

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Vancomycin

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left arm

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FEVER - 101.8

F - [**2140-11-1**] 08:00 PM

Cooling blanket placed

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Ciprofloxacin - [**2140-11-1**] 04:55 PM

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Other ICU medications:

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Famotidine (Pepcid) - [**2140-11-1**] 08:00 PM

Fentanyl - [**2140-11-2**] 04:30 AM

Other medications:

Flowsheet Data as of [**2140-11-2**] 05:51 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.1

C (98.7

HR: 86 (86 - 119) bpm

BP: 110/57(73) {110/57(73) - 163/84(105)} mmHg

RR: 25 (17 - 39) insp/min

SPO2: 100%

Heart rhythm: SR (Sinus Rhythm)

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Total out:

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Stool:

Drains:

Balance:

-748 mL

306 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

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RR (Set): 22

RR (Spontaneous): 0

PEEP: 10 cmH2O

FiO2: 50%

RSBI Deferred: PEEP > 10

PIP: 15 cmH2O

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Compliance: 150 cmH2O/mL

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ABG: 7.41/38/81.[**Numeric Identifier 508**]/23/0

Ve: 12.5 L/min

PaO2 / FiO2: 164

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General Appearance: No(t) No acute distress, Anxious

HEENT: PERRL

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Percussion: Resonant :), (Breath Sounds: CTA bilateral :), (Sternum: Stable)

Abdominal: Soft, Non-distended, Non-tender, Bowel sounds present

Left Extremities: (Edema: Absent), (Temperature: Warm), (Pulse - Dorsalis pedis: Present), (Pulse - Posterior tibial: Present, No(t) Diminished)

Right Extremities: (Edema: Absent), (Temperature: Warm), (Pulse - Dorsalis pedis: Present), (Pulse - Posterior tibial: Present)

Neurologic: (Responds to: Verbal stimuli, Tactile stimuli, Noxious stimuli), No(t) Moves all extremities, (LUE: No movement), (LLE: Weakness), Sedated

Labs / Radiology

226 K/uL

11.7 g/dL

169 mg/dL

0.9 mg/dL

23 mEq/L

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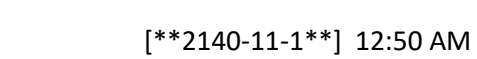
8 mg/dL

113 mEq/L

146 mEq/L

34.1 %

25.0 K/uL



[**2140-11-1**] 12:50 AM

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[**2140-11-2**] 02:27 AM

[**2140-11-2**] 02:31 AM

WBC

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25.0

Hct

36.4

34.1

Plt

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Creatinine

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Glucose

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Other labs: Lactic Acid:0.7 mmol/L, Albumin:3.6 g/dL, Ca:9.0 mg/dL,
Mg:2.0 mg/dL, PO4:2.1 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial fractures, b/l SAH and probable aspiration PNA

NEURO: Intubated and sedated on propofol, bolt removed [**11-1**] AM, SAH resolved, f/u dilantin levels, CT [**11-1**] resolution SAH, small SDH, unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 11T

Pain: Fentanyl prn, comfortable

Dilantin 10.9--monitor

CVS: Stable, resolving tachycardia

PULM: Intubated, wean to CPAP [**11-21**] continue to wean; Right 20 fr chest tube

New PTX right side, chest tube if needed

Purulent secretions follow up cultures and repeat mini-BAL, possible aspiration PNA

GI: OGT in place, TF to goal

RENAL: Foley in place, good urine output

HEME: Hct stable at 36; SQ Heparin started [**11-1**]

ENDO: RISS, sugars well controlled

ID: WBC 25 from 20. Spiked to 101.5, actively cooling, Vanc/Tobra/Cipro for HCAP

TLD: ETT, OGT, L Rad A-line, Foley, R subclavian CVL , R CT

IVF: NS @ 80 + KCl

CONSULTS: Trauma, Neurosurgery, Plastics, Ophthomology

BILLING DIAGNOSIS: Traumatic head injury

ICU CARE:

GLYCEMIC CONTROL: RISS

PROPHYLAXIS:

DVT - Boots, Heparin SQ

STRESS ULCER - Famotidine

VAP BUNDLE - +

COMMUNICATIONS:

ICU Consent: In chart

CODE STATUS: Full

DISPOSITION: ICU

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-11-1**] 07:59 PM 55 mL/hour

Glycemic Control:

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Total time spent: 34 minutes

Patient is critically ill

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Sedated with propofol and prn fentanyl. On high dose propofol but wakes easily as soon as propofol decreased. Follows commands readily with R side, small amount of movement to pain on L side. Purposeful with right

hand. Cervical collar remains on. Continues on dilantin. Multiple family members in to visit.

Action:

Q 2 hour neuro checks, fentanyl and propofol for sedation. Temperature control with antipyretics, other cooling measures. Dilantin administered. Multipodus splint applied to L foot

Response:

Following commands readily, L sided weakness continues, afebrile at present.

Plan:

Continue close neuro monitoring. Assess need for pain/med sedation. If continues to be intubated would consider switching to fentanyl/midazolam for sedation.

Pneumonia, aspiration

Assessment:

Orally intubated with coarse breath sounds in upper airways. Adequate saturation and ventilation. Suctioned for thick tan secretions. On vancomycin, cipro, tobramycin. Bilateral chest tubes to 20 cm suction with minimal drainage. RR 20

s, sats i99-100%. T max 100.0. WBC 18.2

Action:

Weaned to psv 5/peep5 50%. Suctioned for thick tan secretions. CXR obtained

Response:

RR 28-30, rsbi 55, abg wnl

Plan:

??ready for extubation today. Unclear whether pt. can handle own secretions.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. [** 10184**] 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

[**Doctor First Name **]

PMHx:

none

Current medications:

Acetaminophen

Albuterol 0.083% Neb Soln

Bisacodyl

Calcium Gluconate

Chlorhexidine Gluconate 0.12% Oral Rinse

Ciprofloxacin

Docusate Sodium (Liquid)

Famotidine

Fentanyl Citrate

HydrALAzine

Insulin

Ipratropium Bromide Neb

Magnesium Sulfate

Mannitol

Neutra-Phos

NiCARdipine

Phenytoin

Potassium Chloride

Potassium Phosphate

Propofol

Senna

Tobramycin

Vancomycin

24 Hour Events:

MULTI LUMEN - START [**2140-10-31**] 10:33 AM

ICP BOLT INSERTED - At [**2140-10-31**] 04:11 PM

ARTERIAL LINE - STOP [**2140-10-31**] 06:14 PM

ARTERIAL LINE - START [**2140-10-31**] 06:22 PM

BLOOD CULTURED - At [**2140-11-1**] 01:00 AM

URINE CULTURE - At [**2140-11-1**] 01:00 AM

BRONCHOSCOPY - At [**2140-11-1**] 01:30 AM

for LLL collapse and desaturation

BAL FLUID CULTURE - At [**2140-11-1**] 02:00 AM

FEVER - 101.5

F - [**2140-11-1**] 12:00 AM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Vancomycin - [**2140-11-1**] 03:00 AM

Tobramycin - [**2140-11-1**] 03:14 AM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-10-31**] 08:00 PM

Fentanyl - [**2140-11-1**] 04:00 AM

Other medications:

Flowsheet Data as of [**2140-11-1**] 06:43 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.6

C (101.5

T current: 38.3

C (100.9

HR: 103 (74 - 106) bpm

BP: 154/74(93) {93/59(74) - 162/93(106)} mmHg

RR: 17 (14 - 26) insp/min

SPO2: 100%

Heart rhythm: ST (Sinus Tachycardia)

ICP: 16 (12 - 49) mmHg

Total In:

3,666 mL

1,318 mL

PO:

Tube feeding:

667 mL

368 mL

IV Fluid:

2,969 mL

810 mL

Blood products:

Total out:

1,357 mL

1,610 mL

Urine:

1,357 mL

1,610 mL

NG:

Stool:

Drains:

Balance:

2,309 mL

-292 mL

Respiratory support

O2 Delivery Device: Endotracheal tube

Ventilator mode: CMV/ASSIST/AutoFlow

Vt (Set): 600 (600 - 600) mL

Vt (Spontaneous): 478 (478 - 595) mL

PS : 5 cmH2O

RR (Set): 16

RR (Spontaneous): 0

PEEP: 5 cmH2O

FiO2: 80%

RSBI Deferred: FiO2 > 60%

PIP: 31 cmH2O

Plateau: 26 cmH2O

SPO2: 100%

ABG: 7.42/34/143/25/-1

Ve: 12.2 L/min

PaO2 / FiO2: 179

Physical Examination

General Appearance: Well nourished

HEENT: Left pupil dilated

Cardiovascular: (Rhythm: Regular), tachycardic

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: Wheezes :

, Rhonchorous : , Diminished:)

Abdominal: Soft, Non-distended

Left Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Right Extremities: (Edema: Trace), (Temperature: Warm), (Pulse -

Dorsalis pedis: Present)

Neurologic: (Responds to: Unresponsive), No(t) Moves all extremities,

(LUE: No movement), Sedated, intermittently followed commands.

Labs / Radiology

252 K/uL

12.5 g/dL

142 mg/dL

1.0 mg/dL

25 mEq/L

3.3 mEq/L

9 mg/dL

108 mEq/L

141 mEq/L

36.4 %

20.5 K/uL

[image002.jpg]

[**2140-10-30**] 11:00 PM

[**2140-10-31**] 02:18 AM

[**2140-10-31**] 02:29 AM

[**2140-10-31**] 09:29 AM

[**2140-10-31**] 06:44 PM

[**2140-10-31**] 07:58 PM

[**2140-11-1**] 12:50 AM

[**2140-11-1**] 12:58 AM

[**2140-11-1**] 02:59 AM

[**2140-11-1**] 05:30 AM

WBC

27.4

20.4

20.5

Hct

41.5

34.8

36.4

Plt

[**Telephone/Fax (3) 10178**]

Creatinine

1.1

1.0

1.0

TCO2

24

24

25

25

27

24

23

Glucose

130

119

142

Other labs: Lactic Acid:0.7 mmol/L, Albumin:4.5 g/dL, Ca:8.5 mg/dL,

Mg:2.1 mg/dL, PO4:1.6 mg/dL

Assessment and Plan

SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 4 hr, Intubated and sedated on propofol.

Will wean as tolerated.

Pain: Fentanyl prn, comfortable

Improving MS [**First Name (Titles) 622**] [**Last Name (Titles) 10184**] 11T this am

Likely remove bolt per NS

ICP 15 range

Will need imaging of face which will be done on next head CT

Moving left arm to painful stimuli but not spontaneously

will US today.

Cardiovascular: Able to autoregulate to SBP around 160, stable.

Pulmonary: Cont ETT, (Ventilator mode: CMV), wean to CPAP, bronched for desats, appears to be PNA, Will wean sedation and vent support after bronch. Possible aspiration pna

on cipro/tobra/vanc pending cultures. Criteria met for [**Doctor Last Name 11**]

rx with lung protective vent settings.

Gastrointestinal / Abdomen: OGT in place, TF at goal

Nutrition: Tube feeding

Renal: Foley in place, good urine output, urine lytes with evidence of normal diuresis.

Hematology: Hct stable at 36; Hold off SQ Heparin for now

after bolt removed.

Endocrine: RISS, good control

Infectious Disease: Check cultures, Spiked to 101.5, Vanc/Tobra/Cipro for HAP

Lines / Tubes / Drains: Foley, OGT, ETT

Wounds: superficial abrasions, healing

Imaging: CXR today

Fluids: NS @ 80

K replacement

Consults: Neuro surgery, Trauma surgery

Billing Diagnosis: (Hemorrhage, NOS: Sub-arachnoid), (Respiratory distress: Failure)

ICU Care

Nutrition:

Replete with Fiber (Full) - [**2140-10-31**] 08:50 AM 80 mL/hour

Glycemic Control: Regular insulin sliding scale

Lines:

20 Gauge - [**2140-10-31**] 01:00 AM

Multi Lumen - [**2140-10-31**] 10:33 AM

Arterial Line - [**2140-10-31**] 06:22 PM

Prophylaxis:

DVT: Boots

Stress ulcer: H2 blocker

VAP bundle: HOB elevation, Mouth care, Daily wake up, RSBI

Comments:

Communication: ICU consent signed Comments:

Code status: full

Disposition: ICU

Total time spent: 32 minutes

Patient is critically ill.

"

"Subarachnoid hemorrhage (SAH)

Assessment:

-Patient self-extubated at ~0940

-Lung sounds improving to clear through day. Had suctioned thick tan secretions; now coughs & swallows.

-Bilateral chest tubes both with no fluctuation, leak, or crepitus

-Oriented to self, sometimes place; restless & impulsive. L pupil 7mm NR, R pupil 4mm briskly reactive.

Action:

-Pulmonary toileting, coughing and deep breathing

-Chest tubes to water seal

-Frequently reoriented, family at bedside for safety; enclosure bed ordered; Fentanyl & ativan for pain & safety

-Eyes dilated by opthamology

Response:

-SPO2 remains >97% on 2L nasal cannula

-No acute neuro changes; note pupils medically dilated

Plan:

-Chest x-ray at [**2131**] then chest tube to be d/c
d if okay

-Maintain safety with enclosure bed and family at bedside

-Continue pain management with Dilaudid / Fentanyl

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt neuro status unchanged, con
t w/ brisk pupillary response on right

and nonreactive on left, Right sided extremities with full strength and

able to lift left leg up off bed when lightened from sedation, left arm still with extension and internal rotation to painful stimuli, ICP on [**Last Name (un) **] from 14-20 at rest, spikes transiently with increased coughing or wakefulness up to the high 20

s yet settles as soon as pt resedated,

Pt starting to briskly diuresed over night, Dilantin level 5.6 this AM, some minor faciculations of left eyelid noted intermittently.

Action:

Full neuro checks every 4 hours with Propofol gtt off, urine and serum lytes sent to evaluate pt

s brisk u/o, Team notified of low Dilantin level

Response:

Neuro exam improving slightly and ICP

s remaining w/in nl limits, ? DI vs. autodiuresing

Plan:

Follow up with urine lytes, con

t with neuro checks per team, ? rebolus dilantin

Trauma, s/p

Assessment:

Pt with very rhoncherous breath sounds bilaterally yet diminished at bilaterally bases, suctioned for thick bloody and pluggy sputum, O2 sat marginal and pt spiked temp to 101.5 max, CHXray showed collapse on LLL , ABG at the time w/ PaO2 of 57.

Action:

Pt bronched and sputum spec sent for culture, follow up xray done, FiO2 weaned back down to 80% w/ sats 99-100%. Pt pan cultured again.

Tylenol and cool bath given. Triple antibiotics started as ordered.

Response:

Post bronch xray showed improved aeration on left yet still poor on

right, con

t marginal oxygenation still suctioned for moderate amts

thick blood tinged sputum. Temp down gradually.

Plan:

? repeat bronch this AM, con

t pulm hygiene, abx

s as ordered

Pain control (acute pain, chronic pain)

Assessment:

Pt con

t restless and hyperdynamic when light, w/ occaisional grimaces.

Action:

Pt medicated with fentanyl 50-100mcgs every 1-2 hours

Response:

Improved hemodynamics after pain med and pt less restless

Plan:

Con

t to assess pain q 1-2 hours.

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head

this am showed no change per neuro [**Doctor First Name 213**].

Action:

Bolt d/c this am. Neuro checks changed to Q2 hr this afternoon.

Dilantin bolus given for low level. pt to have head Ct this afternoon

for f/u

Response:

Neuro status improved. Left pupil remains fixed and dilated. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye and consistently follows commands.

Plan:

Cont Q 2hr neuro checks,. SQ heparin to start at 2200.

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and facial fx, + aspiration, no other injury noted per team.

Action:

T- max 101.3, LUE ultrasound done, CXR done, CT sinus and maxillofacial done this afternoon. Vent setting changed to TV 450, rr 22, and 60%, peep 10, for lung protection given low pao2 to fio2 ratio, and aspiration pneumonia.

Response:

Tylenol given for temp. lytes replaced, US showed occlusive thrombus to left basilic vein (superficial) requiring no intervention per team, no DVT. CXR showed atelectasis, not requiring a bronch at this time.

Plan:

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Pt s/p ATV accident with SAH , small SDH, and pontine bleed. CT head this am showed no change per neuro [**Doctor First Name 213**].

Action:

Neuro checks cont Q2 hr.

Response:

Neuro status unchanged. Left pupil remains fixed and dilated no movement to left eye. Right pupil [**4-13**] briskly reactive + corneal. Pt moving right side strong, purposeful, does attempt to pull at ETT if not restrained, left leg moves on bed, and bends at knee when off sedation, left arm withdraws to nailbed pressure only. Opens right eye and consistently follows commands. No csf noted from ears.

Plan:

Cont Q 2hr neuro checks, watch for CSF leak from ears.

Trauma, s/p

Assessment:

pt s/p ATV accident , wearing helmet hit handle bars, head trauma, and facial fx, + aspiration, no other injury noted per team.

Action:

Cooling measure for temp Fan, cooling blanket , Tylenol, and motrin given. Vent setting changed to CPAP, 10 peep, 12 ps 50%. Tol well. CT placed for small left pnumo. Plastics in to eval face for ? surgical intervention. Vaco level sent this pm. Bal sent by resp.

Response:

T- max 101.4, despite cooling measures.

Plan:

Cont to support resp status. f/u cx. Cont abx for asp pneumonia. Tobra level to be drawn before second dose tomorrow.

"

"Demographics

Day of intubation:

Day of mechanical ventilation: 5

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Airway Placement Data

Known difficult intubation: Unknown

Cuff Management:

Vol/Press:

Cuff pressure: 24 cmH2O

Cuff volume: mL /

Airway problems:

Comments: Pt self extubated in AM. ABG was drowned from RT radial site. Hands restrain back on after use, required a few hand manual assisted bagging. Team MD present to assess B$ placind on Cool mist 02.

Lung sounds

RLL Lung Sounds: Clear

RUL Lung Sounds: Clear

LUL Lung Sounds: Clear

LLL Lung Sounds: Clear

Secretions

Sputum color / consistency: Tan / Thick

Sputum source/amount: Suctioned / Moderate

Ventilation Assessment

Level of breathing assistance: Unassisted spontaneous breathing/ Was p;aced on Cool mist Nebulizer & Now on NC,

Plan

Continue present ICU monitoring.

"

"Demographics

Attending MD:

[**Doctor Last Name **] [**Doctor Last Name 1327**] F.

Admit diagnosis:

HEAD INJURY

Code status:

Full code

Height:

71 Inch

Admission weight:

85.6 kg

Daily weight:

85.2 kg

Allergies/Reactions:

Cefaclor

Rash;

Precautions: No Additional Precautions

PMH:

CV-PMH:

Additional history: no PMHx

Surgery / Procedure and date: Head CT shows diffuse areas of SAH and tiny left SDH as well as hemmorhage w/in prepontine cistern and pons anteriorly, bilateral temporal bone fx's extending to carotid canal, left lateral and medial orbital wall fx and left zygomatic fx . Pt presents with dialated and fixed left pupil and left hemiparesis, right pupil brisk and purposeful movement with RUE. Spine clear radiographically, CT of torso significant for bibasilar consolidation c/w aspiration

Latest Vital Signs and I/O

Non-invasive BP:

S:142

D:78

Temperature:

100

Arterial BP:

S:111

D:80

Respiratory rate:

29 insp/min

Heart Rate:

87 bpm

Heart rhythm:

SR (Sinus Rhythm)

O2 delivery device:

Nasal cannula

O2 saturation:

98% %

O2 flow:

3 L/min

FiO2 set:

70% %

24h total in:

1,279 mL

24h total out:

1,500 mL

Pertinent Lab Results:

Sodium:

141 mEq/L

[**2140-11-4**] 02:12 AM

Potassium:

3.4 mEq/L

[**2140-11-4**] 02:12 AM

Chloride:

103 mEq/L

[**2140-11-4**] 02:12 AM

CO2:

26 mEq/L

[**2140-11-4**] 02:12 AM

BUN:

13 mg/dL

[**2140-11-4**] 02:12 AM

Creatinine:

0.9 mg/dL

[**2140-11-4**] 02:12 AM

Glucose:

114 mg/dL

[**2140-11-4**] 02:12 AM

Hematocrit:

33.7 %

[**2140-11-4**] 11:02 AM

Finger Stick Glucose:

142

[**2140-11-4**] 02:00 PM

Valuables / Signature

Patient valuables: None

Other valuables:

Clothes: Sent home with:

Wallet / Money:

No money / wallet

Cash / Credit cards sent home with:

Jewelry:

Transferred from: TSICU 570

Transferred to: CC615

Date & time of Transfer: [**2140-11-4**]

Pt s/p ATV accident where he hit head on the handlebars, + helmet, GCS 6 at the scene and pt vomiting. Taken to [**Hospital3 735**] and intubated for airway protection and combativeness and then medflighted to [**Hospital1 19**] for further w/u. No PMHX, no meds.

Head CT shows diffuse areas of SAH and tiny left SDH as well as hemmorhage w/in prepontine cistern and pons anteriorly, bilateral temporal bone fx's extending to carotid canal, left lateral and medial orbital wall fx and left zygomatic fx . Pt presented with dialated and fixed left pupil (??L sided third nerve palsy ,L pupil fixed and dilated since accident) and left hemiparesis, right pupil brisk and purposeful movement with RUE. Spine clear radiographically, CT of torso significant for bibasilar consolidation c/w aspiration.

Trauma, s/p

Assessment:

Pt. awake but confused, able to state name, follows commands. Normal movement of right side but minimal movement of left arm, and left leg weakness. R pupil briskly reactive, can only open L eye a slit. L pupil remains non reactive at 5-6mm (believed to be third nerve palsy). Cervical collar remains in place. Continues on dilantin 200 iv q 12 hours with level this am 9.6. BP remains < goal of 160, sats maintained on 3L np. Bilateral chest tubes to water seal. Multiple abrasions healing on arm and torso. Mom, dad, and [**Name2 (NI) 9576**] all updated with condition . Family continues to stay around the clock

Action:

Right chest tube d/c

d (CXR ordered for this afternoon)Dilaudid iv for

pain control. Frequent reorientation. Family updated with status. MRI of orbits, cervical spine and thoracic spine ordered (to be done once pt more clear and able to stay still.) Mri checklist completed and faxed to MRI, please call once decided MRI is appropriate. Decision was made by ICU team to readdress as pt. becomes less restless. PT/OT working with patient this morning

Response:

Pt calmer, more conversant, but still confused. Overall neuro status has improved greatly in the last 24 hours. Continues with L sided hemiparesis. OOB to chair with 2 assist, speech and swallow determined pt needs crushed meds and nectar thick liquids, meds changed to po (need to be crushed)

Plan:

Continue to monitor neuro status. Obtain mri when feasible. Advance diet as able. If no further pneumothorax, ?d/c left chest tube tomorrow, Continue family education. Consult case management about discharge plans.

Pneumonia, aspiration

Assessment:

Pt self extubated yesterday. Tachypneic rr 30-35/min. Clear lung sounds. Weak congested cough. Bilateral chest tubes to water seal. Febrile to 101.8 po. Continues on vanco, cipro, tobramycin for gram neg rods and gram + cocci in sputum.

Action:

Blood culture X 1, urine culture done overnight . Vanco, Tobra and Cipro d/c

d and Nafcilin started today. Encouraged to cough and deep

breathe.

Response:

Afebrile, Wbc down to 15. CXR improving

Plan:

Follow culture results as well as CXR results. Continue pulmonary

hygiene.

"

"Demographics

Day of intubation:

Day of mechanical ventilation: 3

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Airway Placement Data

Known difficult intubation: Unknown

Procedure location: Outside hospital

Reason: Emergent (1st time)

Tube Type

ETT:

Position: 22 cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 25 cmH2O

Lung sounds

RLL Lung Sounds: Rhonchi

RUL Lung Sounds: Rhonchi

LUL Lung Sounds: Rhonchi

LLL Lung Sounds: Rhonchi

Secretions

Sputum color / consistency: Blood Tinged / Thick

Sputum source/amount: Suctioned / Moderate

Ventilation Assessment

Level of breathing assistance:

Visual assessment of breathing pattern: Normal quiet breathing

Assessment of breathing comfort:

Invasive ventilation assessment:

Trigger work assessment: Triggering synchronously

Comments: overbreathing rate and volume

Plan

Next 24-48 hours: Plan repeat bronch this AM

Reason for continuing current ventilatory support: Cannot protect airway, Cannot manage secretions, Underlying illness not resolved

Bedside Procedures:

Bronchoscopy (0100)

Comments: Pt presents on A/C 600X16/5 .4

Required frequent suctioning for thick blood tinged to bloody secretions

0100 pt bronched for moderate amounts thick creamy yellow secretions in lower airways.

"

"Subarachnoid hemorrhage (SAH)

Assessment:

Action:

Response:

Plan:

Trauma, s/p

Assessment:

Action:

Response:

Plan:

Pain control (acute pain, chronic pain)

Assessment:

Action:

Response:

Plan:

"

"Demographics

Day of intubation:

Day of mechanical ventilation: 4

Ideal body weight: 0 None

Ideal tidal volume: 0 / 0 / 0 mL/kg

Airway

Airway Placement Data

Known difficult intubation: Unknown

Tube Type

ETT:

Position: 25 cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 25 cmH2O

Lung sounds

RLL Lung Sounds: Rhonchi

RUL Lung Sounds: Rhonchi

LUL Lung Sounds: Rhonchi

LLL Lung Sounds: Rhonchi

Secretions

Sputum color / consistency: Tan / Thick

Sputum source/amount: Suctioned / Moderate

Comments: Mini Bal done & brought to Lab personally.

Ventilation Assessment

Level of breathing assistance: Continuous invasive ventilation

Visual assessment of breathing pattern: Normal quiet breathing,

Accessory muscle use; Comments: SWitch to PSV.

Assessment of breathing comfort: No response (sleeping / sedated)

Invasive ventilation assessment:

Trigger work assessment: Triggering synchronously

Dysynchrony assessment: Frequent alarms (High min. ventilation)

Plan

Next 24-48 hours: Reduce PEEP as tolerated; Comments: Wean as tol!!!!

Reason for continuing current ventilatory support: Sedated / Paralyzed,

Intolerant of weaning attempts, Underlying illness not resolved.

"

"Day of mechanical ventilation: 5

ETT:

Position: 25 cm at teeth

Route: Oral

Type: Standard

Size: 8mm

Cuff Management:

Vol/Press:

Cuff pressure: 24 cmH2O

Lung sounds

RLL Lung Sounds: Diminished

RUL Lung Sounds: Rhonchi

LUL Lung Sounds: Rhonchi

LLL Lung Sounds: Diminished

Secretions

Sputum color / consistency: Tan / Thick

Sputum source/amount: Suctioned / Moderate

Comments:

Intermittently restless. Weaned to CSV, [**6-14**] with RSBI of 59. ? extubate

pending assessment of neuro status.

"

"TSICU

HPI:

22M s/p ATV accident, helmeted. GCS 6 in field, intubated at [**Hospital1 **], given mannitol and tx to [**Hospital1 19**] for blown left pupil.

Chief complaint:

Traumatic injury

PMHx:

Denies

Current medications:

Denies

24 Hour Events:

UNPLANNED EXTUBATION (PATIENT-INITIATED) - At [**2140-11-3**] 09:43 AM

ARTERIAL LINE - STOP [**2140-11-3**] 12:00 PM

BLOOD CULTURED - At [**2140-11-3**] 08:00 PM

URINE CULTURE - At [**2140-11-3**] 08:00 PM

FEVER - 101.8

F - [**2140-11-3**] 10:00 PM

Allergies:

Cefaclor

Rash;

Last dose of Antibiotics:

Tobramycin - [**2140-11-3**] 04:24 PM

Ciprofloxacin - [**2140-11-3**] 06:48 PM

Vancomycin - [**2140-11-3**] 11:58 PM

Infusions:

Other ICU medications:

Famotidine (Pepcid) - [**2140-11-3**] 08:30 AM

Fentanyl - [**2140-11-3**] 04:29 PM

Heparin Sodium (Prophylaxis) - [**2140-11-3**] 10:00 PM

Hydromorphone (Dilaudid) - [**2140-11-4**] 04:12 AM

Other medications:

Flowsheet Data as of [**2140-11-4**] 05:13 AM

Vital signs

Hemodynamic monitoring

Fluid balance

24 hours

Since [**43**] a.m.

Tmax: 38.8

C (101.8

T current: 37.6

C (99.6

HR: 79 (78 - 108) bpm

BP: 132/67(83) {125/55(73) - 156/91(102)} mmHg

RR: 25 (19 - 36) insp/min

SPO2: 96%

Heart rhythm: SR (Sinus Rhythm)

Wgt (current): 85.2 kg (admission): 85.6 kg

Total In:

2,632 mL

175 mL

PO:

100 mL

Tube feeding:

536 mL

IV Fluid:

2,006 mL

75 mL

Blood products:

Total out:

4,940 mL

260 mL

Urine:

4,895 mL

260 mL

NG:

Stool:

Drains:

Balance:

-2,308 mL

-85 mL

Respiratory support

O2 Delivery Device: Nasal cannula

Ventilator mode: Standby

Vt (Spontaneous): 589 (589 - 589) mL

PS : 5 cmH2O

RR (Spontaneous): 35

PEEP: 5 cmH2O

FiO2: 70%

PIP: 11 cmH2O

SPO2: 96%

ABG: 7.48/34/70/26/2

Ve: 14 L/min

PaO2 / FiO2: 175

Physical Examination

General Appearance: Anxious, active

HEENT: Left pupil dilated, EOMI

Cardiovascular: (Rhythm: Regular)

Respiratory / Chest: (Expansion: Symmetric), (Breath Sounds: CTA bilateral :)

Abdominal: Soft

Left Extremities: (Temperature: Warm)

Right Extremities: (Temperature: Warm)

Neurologic: (Awake / Alert / Oriented: x 2, x 1), Follows simple commands

Labs / Radiology

265 K/uL

11.3 g/dL

114 mg/dL

0.9 mg/dL

26 mEq/L

3.4 mEq/L

13 mg/dL

103 mEq/L

141 mEq/L

33.7 %

16.6 K/uL

[image002.jpg]

[**2140-11-2**] 08:00 AM

[**2140-11-2**] 10:09 AM

[**2140-11-2**] 02:00 PM

[**2140-11-2**] 05:55 PM

[**2140-11-2**] 08:00 PM

[**2140-11-3**] 02:02 AM

[**2140-11-3**] 02:10 AM

[**2140-11-3**] 09:26 AM

[**2140-11-3**] 07:03 PM

[**2140-11-4**] 02:12 AM

WBC

18.5

16.6

Hct

31.9

33.7

Plt

196

265

Creatinine

0.8

0.9

TCO2

23

26

28

28

26

Glucose

135

148

157

121

178

114

Other labs: Lactic Acid:1.3 mmol/L, Albumin:3.6 g/dL, Ca:8.5 mg/dL,

Mg:2.2 mg/dL, PO4:3.6 mg/dL

Assessment and Plan

PNEUMONIA, ASPIRATION, SUBARACHNOID HEMORRHAGE (SAH), TRAUMA, S/P, PAIN

CONTROL (ACUTE PAIN, CHRONIC PAIN)

Assessment and Plan: 22M with head injury, multiple craniofacial

fractures, b/l SAH and probable aspiration PNA

Neurologic: Neuro checks Q: 2 hr, f/u dilantin levels, resolution SAH,

small SDH, unchanged skull base fractures

Neuro checks Q: 2H - improved exam - GCS 15

Pain: Fentanyl, Dilaudid, Ativan prn

Cardiovascular: stable

Pulmonary: b/l chest tubes to water seal (no leak), self extubated [**11-3**]

Gastrointestinal / Abdomen: NPO

Nutrition: NPO

Renal: Foley, Foley in place, good urine output

Hematology: last crit 33.7

Endocrine: RISS

Infectious Disease: Check cultures, check pending cultures, WBC from

18.5. on Vanc/Tobra/Cipro for HCAP until [**11-8**]

Lines / Tubes / Drains: PIVs, Foley, R subclavian CVL, b/l CT

Wounds:

Imaging: MRI?

Fluids: KVO

Consults: Trauma surgery, Ophthalmology, Neurology, neurosurg

Billing Diagnosis:

ICU Care

Glycemic Control:

Lines: PIVs, Foley, R subclavian CVL, b/l CT

Multi Lumen - [**2140-10-31**] 10:33 AM

18 Gauge - [**2140-11-3**] 03:02 PM

Prophylaxis:

DVT: SQ UF Heparin

Stress ulcer:

VAP bundle: NA

Communication: Comments:

Code status:

Disposition:

Total time spent:

"

"[**2140-10-31**] 11:04 AM

CHEST PORT. LINE PLACEMENT; -76 BY SAME PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 66395**]

Reason: ?left subclavian line placement, ?PTX

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p L subcalvian

REASON FOR THIS EXAMINATION:

?left subclavian line placement, ?PTX

FINAL REPORT

AP CHEST 11:20 A.M., [**10-31**]

HISTORY: Left subclavian line placement, question pneumothorax.

IMPRESSION: AP chest compared to 6:13 a.m. and 6:02 p.m. on [**10-30**].

Pneumomediastinum previously limited to the thoracic inlet has increased in volume. No pneumothorax, pleural effusion, or mediastinal widening. Left lower lobe collapse unchanged. New left subclavian line ends in the SVC. Nasogastric tube passes below the diaphragm and out of view. Dr. [**Last Name (STitle) 20042**] was paged.

"

"[**2140-11-8**] 3:17 PM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 67952**]

Reason: evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with chest tube now on waterseal please take at 3PM today

REASON FOR THIS EXAMINATION:

evaluate for interval change

FINAL REPORT

PROCEDURE: Chest PA and lateral.

REASON FOR EXAM: Evaluate for interval change. Chest drain now on waterseal.

FINDINGS: The left chest drain is unchanged with its tip abutting the left superior mediastinum. There is a new tiny left apical pneumothorax with unchanged atelectasis in the left lung base. The right lung is grossly normal. Cardiomegaly is unchanged.

IMPRESSION:

New tiny left apical pneumothorax with unchanged position of left chest tube and left lower lobe atelectasis.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-1**] 5:51 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67294**]

Reason: 22 year old man with L SDH, L frSAH, R temp SAH. eval for ch

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with L SDH, L frSAH, R temp SAH. eval for changes.

REASON FOR THIS EXAMINATION:

22 year old man with L SDH, L frSAH, R temp SAH. eval for changes.

No contraindications for IV contrast

PFI REPORT

1. Apparent resolution of subarachnoid hemorrhage.

2. Possible tiny left cerebral subdural hemorrhage persists.

3. Interval introduction of left frontal epidural sensor.

4. Unchanged appearance of skull based fractures.

5. Bilateral high-density material in maxillary sinuses.

"

"[**2140-11-1**] 5:52 PM

CT SINUS/MANDIBLE/MAXILLOFACIAL W/O CONTRAST Clip # [**Clip Number (Radiology) 66396**]

Reason: Please ennumerate and describe facial fractures for potentia

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident with multiple facial fractures

REASON FOR THIS EXAMINATION:

Please ennumerate and describe facial fractures for potential surgical repair

No contraindications for IV contrast

WET READ: GWp TUE [**2140-11-1**] 10:49 PM

Complex longit fracture thru b/l temporal bones

L zygomatic & lat orbital wall fractures

FINAL REPORT

INDICATION: Facial fractures.

COMPARISON: None available.

TECHNIQUE: Multiple MDCT axial images were obtained through the facial bones without intravenous contrast. Multiplanar reformats were derived.

FINDINGS: There is partial opacification of bilateral mastoid air cells as well as fluid seen within the left external auditory canal. High-density material is seen within the bilateral maxillary sinuses and sphenoid sinuses compatible with blood. The right skull base fracture extends longitudinally through the temporal bone (series 2, image 39; series 401B, image 16). There is also a fracture that extends from the right posterior wall of the sphenoid sinus (series 401B, image 41; series 2, image 41) into the right carotid canal. A longitudinal left temporal bone fracture is noted that extends into the left parietal bone superiorly series 2, image 4).There is a minimally displaced fracture of the left zygoma (series 2, image 35) as well as the left lateral wall of the left orbit. A thin lucency noted at the superomedial aspect may represent a subtle fracture.
No obvious extension into the TMJ is noted, the lucency noted on the studies in the posterior aspect of the TMJ relating to the site of [**Hospital1 4980**] of the mastoid and squamous portions of the temporal bone and seen on both sides.
Thin non-displaced fracture of the lateral pterygoid is noted on the left.
Scattered foci of air are noted including the right side of the neck , related to the trauma.
Evaluation for any other subtle fractures may be limited.

IMPRESSION: A complex fracture patent as enumerates above involving bilateral longitudinal temporal bone fractures, fractures of the left zygoma and left

lateral orbital wall as detailed above.

While the reason for blown pupil is not clear, MR [**Name13 (STitle) 1699**] may be helpful to exclude brainstem injury.

(Over)

[**2140-11-1**] 5:52 PM

CT SINUS/MANDIBLE/MAXILLOFACIAL W/O CONTRAST Clip # [**Clip Number (Radiology) 66396**]

Reason: Please ennumerate and describe facial fractures for potentia

Admitting Diagnosis: HEAD INJURY

FINAL REPORT

(Cont)

"

"[**2140-11-10**] 10:47 AM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 67154**]

Reason: eval for ptx

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p multitrauma, chest tube recently discontinued, with

previous L ptx

REASON FOR THIS EXAMINATION:

eval for ptx

FINAL REPORT

INDICATION: 22-year-old male status post multi-trauma, status post removal of chest tube. Evaluate left pneumothorax.

AP and lateral chest radiograph compared to [**2140-11-9**] shows near resolution of tiny left apical pneumothorax. Left basilar atelectasis at the region of previous chest tube insertion site is not significantly changed. Right basilar atelectasis persists. The heart size is normal. There is no pleural effusion or evidence of overhydration.

IMPRESSION: Near resolution of left apical pneumothorax.

"

"[**2140-11-5**] 8:24 PM

MR CERVICAL SPINE W/O CONTRAST Clip # [**Clip Number (Radiology) 67150**]

Reason: r/o cord injury

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with head trauma s/p ATV accident, decreased motor on L

REASON FOR THIS EXAMINATION:

r/o cord injury

No contraindications for IV contrast

FINAL REPORT

MRI SCAN OF THE CERVICAL SPINE

HISTORY: Head trauma with ATV accident. Decreased motor function of left face and cranial nerve III. Assess for ocular injury on the left.

TECHNIQUE: Only a cervical spine MR scan was obtained at this time as well as a single sagittal T1-weighted image of the thoracic spine. The patient, according to the technologist, could not complete the study.

COMPARISON STUDIES ON PACS ARCHIVE: CT scan of the cervical spine from [**2140-10-30**] reported as revealing ""no cervical spine fracture"" by Drs. [**Last Name (STitle) 5265**] and [**Name5 (PTitle) **].

FINDINGS: There is no disc or vertebral abnormality seen within the cervical spine and on the single available sagittal T1-weighted scan of the thoracic spine. There is no prevertebral soft tissue swelling, abnormality of signal of the cord, nor abnormality of the foramen magnum and its contents.

CONCLUSION: Negative cervical spine MRI scan. Incomplete study of the thoracic spine.

"

"[**2140-11-5**]

MR HEAD W/O CONTRAST; MR ORBIT W &W/O CONTRAST Clip # [**Clip Number (Radiology) 67809**]

Reason: r/o occular injury on the L

Admitting Diagnosis: HEAD INJURY

No contraindications for IV contrast

FINAL REPORT

BRAIN MRI SCAN

HISTORY: ATV accident. Decreased motor function on the left.

This study was aborted as the patient was unable to remain still. It is also incorrectly marked as the cervical spine MRI scan on the PACS worklist, but correctly noted, above.

"

"[**2140-11-9**] 8:45 AM

CHEST (PA & LAT) Clip # [**Clip Number (Radiology) 66399**]

Reason: evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with ct to waterseal with ptx on cxr CXR ON [**2140-11-9**] IN AM

PLEASE

REASON FOR THIS EXAMINATION:

evaluate for interval change

FINAL REPORT

PROCEDURE: Chest PA and lateral.

REASON FOR EXAM: Evaluate for interval change in left pneumothorax.

FINDINGS: There is no appreciable pneumothorax on today's study. The position of the left chest drain is unchanged, increased air space opacity in the periphery of the left lower lung is probably due to placement of the chest drain. The lungs are otherwise clear with no consolidation or pleural

effusion. Cardiomediastinal silhouette is unchanged.

IMPRESSION: Resolution of left apical pneumothorax, the position of the left

chest drain is unchanged.

"

"[**2140-11-9**] 10:00 PM

CHEST (PA & LAT); -76 BY SAME PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67153**]

Reason: interval change - please perform at 10 PM on [**2140-11-9**]

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with post-pull CT CXR

REASON FOR THIS EXAMINATION:

interval change - please perform at 10 PM on [**2140-11-9**]

WET READ: IPf WED [**2140-11-9**] 10:35 PM

Remaining small left apical penumothroax. Intreval chest tube removal. Stable

airspace opacity at the left lower lung. D/w Dr. [**First Name4 (NamePattern1) 13973**] [**Last Name (NamePattern1) 13974**] at 10:30 pm on

[**2140-11-9**]

FINAL REPORT

CHEST RADIOGRAPH

INDICATION: Evaluation for interval change.

COMPARISON: [**2140-11-9**].

FINDINGS: As compared to the previous radiograph, the left-sided chest tube has been pulled. There is a minimal left apical pneumothorax of several millimeters in size. At the bases of the left lung, the pre-existing parenchymal opacity is slightly better visible than on the previous radiograph, its extent, however, is unchanged. No newly occurred focal parenchymal opacities, unchanged size of the cardiac silhouette.

"

"[**2140-11-8**] 8:21 AM

MR HEAD W & W/O CONTRAST; MR ORBIT W &W/O CONTRAST Clip # [**Clip Number (Radiology) 67151**]

Reason: ?intracranial injury

Admitting Diagnosis: HEAD INJURY

Contrast: MAGNEVIST Amt: 18

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident gcs 7

REASON FOR THIS EXAMINATION:

?intracranial injury

No contraindications for IV contrast

WET READ: KKgc TUE [**2140-11-8**] 1:15 PM

Findings suggestive of Diffuse axonal injury.Acute infarct invlolving the splenium of corpus callosum.Questionable right pontine infarct.Stable Subarachnoid hemorrhage and posterior cranial fossa subdural hematoma.No evidence of orbital injury.

FINAL REPORT

INDICATION: A 32-year old man status post ATV accident with GCS 7.

TECHNIQUE: Sagittal short TR, short TE, spin echo images were obtained through the brain. Axial imaging was performed with long TR, long TE, fast spin echo, FLAIR, gradient echo, and diffusion technique. Contrast T1-weighted images were repeated in axial and sagittal projections following iv gadolinium. Axial and coronal T1W high- resolution images of the orbits were obtained before and after iv gadolinium. Coronal STIR images of the orbits were also obtained.

COMPARISON: CTs of the head performed on [**2052-10-29**] and 22, [**2140**]. No prior head MRI for comparison.

FINDINGS: There are small bilateral retrocerebellar subdural hematomas in the posterior fossa, with high signal on T1-weighted and FLAIR images indicating subacuity.

There is multifocal sulcal hyperintensity on FLAIR images, corresponding to the previously demonstrated subarachnoid hemorrhage.

There is a microhemorrhage in the left superior posterior frontal region, which could be subarachoid or at the [**Doctor Last Name 107**]/white matter junction (13:21; 11:21). If intra-axial, this microhemorrhage could represent diffuse axonal injury.

There is a microhemorrhage in the left parietal subcortical white matter (13:18), consistent with diffuse axonal injury.

There is extensive symmetric slow diffusion and high T2 signal in the splenium of the corpus callosum, and a microhemorrhage in the left aspect of the affected splenium (13:15). These findings are suggestive of diffuse axonal injury with a small hemorrhagic component and associated infarction.

There is high signal on T2-weighted and diffusion-weighted images in the right

(Over)

[**2140-11-8**] 8:21 AM

MR HEAD W & W/O CONTRAST; MR ORBIT W &W/O CONTRAST Clip # [**Clip Number (Radiology) 67151**]

Reason: ?intracranial injury

Admitting Diagnosis: HEAD INJURY

Contrast: MAGNEVIST Amt: 18

FINAL REPORT

(Cont)

pons, with equivocal associated low signal on the ADC map. There is no evidence of associated blood products. This could represent an evolving acute/early subacute infarct, possibly related to non-hemorrhagic diffuse axonal injury.

The ventricles are normal in size and configuration. There is no cerebral edema and no shift of midline structures.

There is opacification of the sphenoid sinuses, fluid in the right maxillary sinus and mucosal thickening in the ethmoid air cells, which could be related to the known facial and skull base fractures. There is opacification of the mastoid air cells bilaterally, which could be related to the known temporal

bone fractures and/or the presence of the endotracheal tube.

MRI ORBITS:

The globes appear intact. There is no evidence of an intraorbital hematoma. The extraocular muscles, optic nerves, and optic chiasm are unremarkable. The cavernous sinuses are unremarkable.

IMPRESSION:

1. Punctate hemorrhagic diffuse axonal injury in the left parietal subcortical white matter, and possibly also in the left posterior frontal subcortical white matter. Extensive diffuse axonal injury in the splenium of the corpus callosum and associated infarction, with a small hemorrhagic component.

2. Probable evolving acute/early subacute infarct in the right pons, which is nonspecific but could be related to nonhemorrhagic axial injury.

3. Bilateral small retrocerebellar subdural hematomas.

4. Subarachnoid hemorrhage again demonstrated.

5. Unremarkable appearance of the orbits.

The findings were discussed with Dr. [**Last Name (STitle) 11259**] at 1:00 p.m. on [**2140-11-8**].

"

"[**2140-11-8**] 8:21 AM

MR THORACIC SPINE W/O CONTRAST Clip # [**Clip Number (Radiology) 67152**]

Reason: ? ligamentous injury, bony injury

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident gcs 7

REASON FOR THIS EXAMINATION:

? ligamentous injury, bony injury

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): DFDkq TUE [**2140-11-8**] 4:56 PM

PFI: No evidence of ligamentous injury. No bone marrow edema in the vertebral bodies.

FINAL REPORT

INDICATION: Status post ATV accident with multiple head injuries.

COMPARISON: No previous dedicated thoracic spine imaging.

TECHNIQUE: Sagittal T1-weighted, T2-weighted, and STIR images of the thoracic spine, with axial T2-weighted images from T1-2 through T9-10 levels.

FINDINGS: Vertebral body height and alignment are normal. There is no evidence of edema in the bone marrow of the vertebral bodies. The spinal ligaments appear intact without signal abnormalities. There is no epidural collection.

At T3-4, there is a left paracentral disc protrusion with overlying endplate

osteophytes, which abuts the left ventral aspect of the spinal cord without evidence of cord deformation.

At T5-6, there are left paracentral endplate osteophytes without significant mass effect on the spinal cord.

At T11-12, there is a right paracentral disc protrusion with overlying endplate osteophytes. There is no significant mass effect on the spinal cord.

The spinal cord demonstrates normal signal intensity, terminating at T12-L1.

There are scattered dependent opacities in the imaged portions of the lungs, which could be related to atelectasis or contusions. Correlation with chest imaging is suggested.

IMPRESSION:

1. No evidence of ligamentous injury. No bone marrow edema in the vertebral bodies.

2. Mild spondylosis.

(Over)

[**2140-11-8**] 8:21 AM

MR THORACIC SPINE W/O CONTRAST Clip # [**Clip Number (Radiology) 67152**]

Reason: ? ligamentous injury, bony injury

Admitting Diagnosis: HEAD INJURY

FINAL REPORT

(Cont)

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] CC6A [**2140-11-8**] 8:21 AM

MR THORACIC SPINE W/O CONTRAST Clip # [**Clip Number (Radiology) 67152**]

Reason: ? ligamentous injury, bony injury

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident gcs 7

REASON FOR THIS EXAMINATION:

? ligamentous injury, bony injury

No contraindications for IV contrast

PFI REPORT

PFI: No evidence of ligamentous injury. No bone marrow edema in the

vertebral bodies.

"

"[**2140-10-31**] 12:40 AM

FOREARM (AP & LAT) LEFT PORT; HUMERUS (AP & LAT) LEFT PORT Clip # [**Clip Number (Radiology) 67951**]

Reason: Please evaluate for fracture

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with swollen left wrist swelling after ATV accident

REASON FOR THIS EXAMINATION:

Please evaluate for fracture

FINAL REPORT

HISTORY: Left wrist swelling after ATV accident, question fracture.

LEFT HUMERUS, TWO PORTABLE VIEWS:

No fracture of the left humerus is detected.

LEFT FOREARM, TWO PORTABLE VIEWS:

No fracture of the left forearm is detected. Assessment of the left wrist is limited on these views. Allowing for this, the left wrist is grossly unremarkable. However, if there is specific clinical concern for wrist injury, dedicated views of the wrist would be recommended.

"

"[**2140-10-31**] 5:27 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67290**]

Reason: Please assess for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22M s/p ATV accident, blown left pupil; Please perform at 0600

REASON FOR THIS EXAMINATION:

Please assess for interval change

No contraindications for IV contrast

FINAL REPORT

HISTORY: 22-year-old male post-ATV accident with a blown left pupil.

COMPARISON: Non-contrast head CT [**2140-10-30**], 18:22 hours.

TECHNIQUE: A non-contrast head CT was obtained.

FINDINGS: Hyperdensity of the anterior pons (2:8) is similar to one day prior. Blood in the prepontine cistern, and left frontal and right parietal subarachnoid hemorrhage are slightly less conspicuous. The previously identified possible 2-mm left extra-axial hematoma is unchanged, likely artifactual (2:21). No new intracranial hemorrhage is identified. The tiny focus of pneumocephalus along the left inferior frontal lobe persists (2:13 mm). [**Doctor Last Name **]-white matter differentiation is normal. The ventricles are unchanged in size and configuration. There is no evidence for uncal or transtentorial herniation, and there is no shift of normally midline structures.

Blood in the right maxillary sinus has increased. Blood in the left maxillary and sphenoid sinus, as well as in the ethmoid air cells is unchanged. Numerous facial and skull fractures are unchanged, as described on the initial head CT.

IMPRESSION:

1. Unchanged anterior pons hemorrhage.

2. Bilateral subarachnoid hemorrhage and blood in the prepontine cistern is slightly less conspicuous.

3. Increased blood in the right maxillary sinus.

4. Facial bone and skull fractures as described on the initial head CT.

"

"[**2140-10-31**] 5:40 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 66394**]

Reason: Please evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with likely aspiration event

REASON FOR THIS EXAMINATION:

Please evaluate for interval change

PROVISIONAL FINDINGS IMPRESSION (PFI): JEKh MON [**2140-10-31**] 12:28 PM

Left lower lobe collapse; clear right lung.

FINAL REPORT

HISTORY: 22-year-old male status post ATV accident and head injury with likely aspiration event, please evaluate for interval changes.

STUDY: AP semi-erect portable chest radiograph.

COMPARISON: [**2140-10-30**], portable chest radiograph and CT of the torso with contrast.

FINDINGS: The endotracheal tube ends 6 cm above the carina. An endogastric

tube courses inferiorly and below the GE junction out of the field of view. The heart size is normal. Mediastinum is shifted to the left. Retrocardiac opacification likely represents left lower lobe collapse. The right lung is essentially clear. There is no pleural effusion or pneumothorax. Mild pneumomediastinum at the thoracic inlet is new; should be followed to distinguish clinically insignificant barotrauma, from extrasation originating in the trachea or esophagus.

IMPRESSION: Left lower lobe collapse; clear right lung. Unexplained pneumomediastinum. Findyings discussed with Dr [**Last Name (STitle) 54365**].

"

"[**2140-11-1**] 12:43 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67008**]

Reason: interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with ETT and desats s/p [**Doctor First Name **]

REASON FOR THIS EXAMINATION:

interval change

PROVISIONAL FINDINGS IMPRESSION (PFI): JEKh TUE [**2140-11-1**] 10:57 AM

PFI: Left lower lobe collapse.

FINAL REPORT

HISTORY: A 22-year-old male with closed head injury status post ET tube placement and subsequent desaturations. Please evaluate for interval changes.

STUDY: Portable AP upright chest radiograph

COMPARISON: [**2140-10-31**].

FINDINGS: The heart and mediastinal contours are unchanged however they do appear slightly shifted to the left. There is retrocardiac opacity along with mediastinal shift suggestive of left lower lobe collapse. The previously noted pneumomediastinum appears unchanged. The right lung is clear. There is no pneumothorax. The ET tube is 6 cm above the carina. Left-sided subclavian line is in the mid-to-lower SVC and NG tube courses inferiorly with its side port and tip both below the GE junction.

IMPRESSION: Left lower lobe collapse.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-1**] 12:43 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67008**]

Reason: interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with ETT and desats s/p [**Doctor First Name **]

REASON FOR THIS EXAMINATION:

interval change

PFI REPORT

PFI: Left lower lobe collapse.

"

"[**2140-11-1**] 1:09 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67149**]

Reason: Please evaluate for lobar collapse

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with drop in O2 sats, recent plugging

REASON FOR THIS EXAMINATION:

Please evaluate for lobar collapse

PROVISIONAL FINDINGS IMPRESSION (PFI): JEKh TUE [**2140-11-1**] 5:26 PM

PFI: Right pneumothorax with right lower lobe collapse. These findings were

communicated to Dr. [**First Name4 (NamePattern1) 234**] [**Last Name (NamePattern1) 2688**] at 15:40 on [**2140-11-1**].

FINAL REPORT

HISTORY: A 22-year-old male with a drop in O2 sats and recent mucous

plugging. Please evaluate for lobar collapse.

STUDY: Portable AP upright chest radiograph at 13:20 on [**2140-11-1**].

COMPARISON STUDY: [**2140-11-1**] 3:37 a.m.

FINDINGS: There is a right pneumothorax with collapse of the right lower

lobe. There is no mediastinal shift nor any deformation of the diaphragm. The

heart and mediastinal contours are unchanged with persistent

pneumomediastinum. The left lung is well aerated with no focal or lobar

consolidation. The right upper lung is clear. There is no pleural effusion.

The ET tube is 6 cm above the carina. There has been interval placement of a

left subclavian line with its tip in the mid [**Last Name (LF) 1844**], [**First Name3 (LF) **] endogastric tube courses

inferiorly below the GE junction and out of the field of view.

IMPRESSION: Right pneumothorax with right lower lobe collapse. These

findings were communicated to Dr. [**First Name4 (NamePattern1) 234**] [**Last Name (NamePattern1) 2688**] at 15:40 on [**2140-11-1**].

"

"[**2140-11-1**] 10:03 AM

UNILAT UP EXT VEINS US LEFT PORT Clip # [**Clip Number (Radiology) 67148**]

Reason: Please evaluate for venous flows to rule out DVT. Thank you

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident with swollen left arm

REASON FOR THIS EXAMINATION:

Please evaluate for venous flows to rule out DVT. Thank you.

PROVISIONAL FINDINGS IMPRESSION (PFI): [**Last Name (un) 13**] TUE [**2140-11-1**] 12:16 PM

PFI: Occlusive thrombus in the left basilic vein which is a superficial vein.

No left arm DVT.

FINAL REPORT

INDICATION: 22-year-old man with swollen left arm.

COMPARISON: No previous exam for comparison.

FINDINGS: Grayscale, color and Doppler son[**Name (NI) 14**] of the left IJ, subclavian, axillary, brachial, basilic, and cephalic veins were performed. There is occlusive thrombus seen within the left basilic vein which is a superficial vein. This vein does not compress and there is no vascular flow identified within it. There is normal flow, compression and augmentation seen in all of the deep veins of the left arm.

IMPRESSION: Occlusive thrombus in the left basilic vein which is a superficial vein. No evidence of deep vein thrombosis in the left arm.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-1**] 10:03 AM

UNILAT UP EXT VEINS US LEFT PORT Clip # [**Clip Number (Radiology) 67148**]

Reason: Please evaluate for venous flows to rule out DVT. Thank you

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident with swollen left arm

REASON FOR THIS EXAMINATION:

Please evaluate for venous flows to rule out DVT. Thank you.

PFI REPORT

PFI: Occlusive thrombus in the left basilic vein which is a superficial vein.

No left arm DVT.

"

"[**2140-11-2**] 10:12 AM

WRIST(3 + VIEWS) LEFT PORT; HAND (AP, LAT & OBLIQUE) LEFT PORT Clip # [**Clip Number (Radiology) 67884**]

Reason: fx

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with hand pain s/p trauma

REASON FOR THIS EXAMINATION:

fx

FINAL REPORT

THREE VIEWS OF THE LEFT HAND AND THREE VIEWS OF THE LEFT WRIST

INDICATION: 22-year-old male with hand pain following trauma.

COMPARISON: Not available at the [**Hospital1 184**].

FINDINGS: There is no acute fracture or dislocation. Mineralization is normal. There is no radiopaque foreign body or soft tissue calcification. Peripheral IV line is in place in the volar distal forearm tissues.

IMPRESSION: No fracture or dislocation.

"

"[**2140-10-30**] 5:49 PM

CT CHEST W/CONTRAST; CT ABDOMEN W/CONTRAST Clip # [**Clip Number (Radiology) 67288**]

CT PELVIS W/CONTRAST

Reason: eval for solid organ injury

Contrast: OPTIRAY Amt:

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with posturing left side s/p ATV, blown right pupil

REASON FOR THIS EXAMINATION:

eval for solid organ injury

No contraindications for IV contrast

WET READ: SHfd SUN [**2140-10-30**] 7:11 PM

Bibasilar consolidation likely atelectasis.

soft tissue in ant mediastinum is likely residual thymus.

FINAL REPORT

CHEST, ABDOMEN, AND PELVIS CT SCAN PERFORMED ON [**2140-10-30**].

CLINICAL HISTORY: Status post ATV accident with question of internal injury.

TECHNIQUE: MDCT was used to obtain contiguous axial images through the chest, abdomen, and pelvis following the administration of IV contrast. Coronal and sagittal reformations were provided.

FINDINGS:

CHEST: Endotracheal tube is seen with its tip approximately 4.7 cm above the carina. An NG tube is seen coursing inferiorly with its tip coiled in the

stomach. The heart is normal in size and shape. There is anterior mediastinal density which appears most compatible with residual thymic tissue. The aorta is normal in course and caliber without evidence of intimal flap. There is no lymphadenopathy. At the level of the ET tube tip there is material that is dependently in the upper trachea, best seen on series 2, image 6.

There is complete consolidation of the left lower lobe which may be secondary to aspiration. There is consolidation within the superior segment of the right lower lobe which may be secondary to aspiration. Additionally diffuse tree-in-[**Male First Name (un) 462**] peripheral opacities in the right mid-lung are also likely reflective of aspiration. There is no pneumothorax or pleural effusion. Subsegmental right basilar atelectasis is noted.

The liver and spleen appear intact without evidence of traumatic injury or adjacent free fluid. There are two subcentimeter vague hypodensities within the liver seen on series 2, image 56 and 60 which are incompletely assessed. The gallbladder is unremarkable. The pancreas, adrenal glands have a normal appearance bilaterally. Kidneys enhance symmetrically and excrete contrast promptly. There is a cortical hypodensity in the lower pole of the right kidney seen on series 2, image 66, which is incompletely characterized given its small size. The abdominal aorta and the major branch vessels are widely patent. There is no retroperitoneal lymphadenopathy. The stomach and duodenum appear grossly unremarkable. There is no free air or free fluid.

(Over)

CT PELVIS W/CONTRAST

Reason: eval for solid organ injury

Contrast: OPTIRAY Amt:

FINAL REPORT

(Cont)

PELVIS: Loops of small bowel demonstrate no evidence of ileus or obstruction. There is no mesenteric contusion. Large bowel appears unremarkable throughout its visualized course. A Foley catheter is noted within the distended bladder. There is no pelvic free fluid or lymphadenopathy.

BONE WINDOWS: No suspicious lytic or blastic osseous lesion is seen. There is no acute fracture. Vertebral bodies are normal in height and alignment. There is no evidence of sternal fracture.

IMPRESSION:

1. ET and NG tubes positioned adequately.
2. Consolidation in the superior segment of the right lower lobe and complete consolidation of the left lower lobe which reflect aspiration.
3. Anterior mediastinal density which is most compatible with residual thymic tissue. No evidence of aortic injury.
4. Nonspecific hypodense lesions in the liver and right kidney which are incompletely characterized.

Findings were discussed with the trauma team at the time of initial review.

SESHa

"

"[**2140-10-30**] 6:33 PM

CTA HEAD W&W/O C & RECONS Clip # [**Clip Number (Radiology) 67289**]

Reason: trauma

Admitting Diagnosis: HEAD INJURY

Contrast: OPTIRAY Amt:

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with trauma

REASON FOR THIS EXAMINATION:

trauma

No contraindications for IV contrast

WET READ: GWp SUN [**2140-10-30**] 8:18 PM

CoW patent. No extravasation of contrast at fracture site No definate

dissection flap although MR FS more sensitive GWlms

FINAL REPORT

CTA HEAD WITH CONTRAST.

COMPARISON: Non-contrast head CT immediately prior.

TECHNIQUE: MDCT axially acquired images of the brain were obtained. IV contrast was administered. Coronal, sagittal, and volume-rendered reformats were performed.

HISTORY: Status post ATV accident with bilateral skull base fractures extending to the right carotid canal. Evaluate for vascular injury.

FINDINGS:

HEAD CT: Please note that a repeat non-contrast head CT was not performed as the CTA was performed immediately after the initial non-contrast head CT. Therefore, evaluation of known bilateral subarachnoid hemorrhages, hemorrhage anterior to the pons and in the interpeduncular cistern is not well appreciated on this contrast- enhanced study. There is no significant shift of normally midline structures or evidence of hydrocephalus. Multiple skull base fractures are again identified, better evaluated on initial head CT.

CTA OF THE BRAIN: The bilateral internal carotid arteries are intact. There is no evidence of intimal flap or dissection. There is no evidence of stenosis or occlusion within the intracranial portions of the bilateral internal carotid arteries or vertebral arteries or their branches. Focal prominence of the right ACA just superior to the takeoff of the ACOM is noted on the source images only. This likely represents a tortuous vessel, although tiny focal aneurysm cannot be entirely excluded. No abnormalities are otherwise seen in the anterior or posterior intracranial circulation.

IMPRESSION:

1. No evidence of carotid artery dissection.

2. Focal abnormality of the right ACA just superior to the ACA/ACOM junction. This likely represents tortuosity of vessel, although tiny focal aneurysm cannot be excluded. Repeat CTA or MRA could be performed in two to three

(Over)

Reason: trauma

Admitting Diagnosis: HEAD INJURY

Contrast: OPTIRAY Amt:

FINAL REPORT

(Cont)

weeks for further evaluation.

3. Multiple bilateral skull base fractures, unchanged.

4. Bilateral subarachnoid hemorrhage and hemorrhage anterior to the pons

within the interpeduncular cistern is better appreciated on non-contrast head

CT performed earlier.

"

"[**2140-11-2**] 3:27 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 66398**]

Reason: Please evaluate for tube placement, resolution of pneumothor

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with pneumothorax on left, now s/p chest tube placement

REASON FOR THIS EXAMINATION:

Please evaluate for tube placement, resolution of pneumothorax

---

FINAL REPORT

CHEST RADIOGRAPH

INDICATION: Pneumothorax on the left, recent chest tube placement.

COMPARISON: [**2140-11-2**], 5:59 a.m.

FINDINGS: As compared to the previous radiograph, a chest tube has now been introduced into the left hemithorax. The extent of the pre-existing left pneumothorax has decreased, the pneumothorax is now millimetric. Unchanged course and position of the remaining monitoring and support devices. There are no signs of tension. The pre-existing retrocardiac atelectasis has slightly decreased in extent. Unchanged size of the cardiac silhouette. Moderate decrease in severity of the pre-existing right lower lung opacity.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-1**] 1:09 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67149**]

Reason: Please evaluate for lobar collapse

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with drop in O2 sats, recent plugging

REASON FOR THIS EXAMINATION:

Please evaluate for lobar collapse

PFI REPORT

PFI: Right pneumothorax with right lower lobe collapse. These findings were

communicated to Dr. [**First Name4 (NamePattern1) 234**] [**Last Name (NamePattern1) 2688**] at 15:40 on [**2140-11-1**].

"

"[**2140-11-1**] 3:41 AM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67291**]

Reason: interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with ETT, low sats, s/p bronch

REASON FOR THIS EXAMINATION:

interval change

FINAL REPORT

CHEST RADIOGRAPH

INDICATION: 22-year-old man with endotracheal tube, low saturation, status post bronchoscopy. Evaluation for interval change.

COMPARISON: [**2140-11-1**].

FINDINGS: As compared to the previous radiograph, the course and position of the endotracheal tube, the nasogastric tube and the left-sided central venous access line are unchanged. Newly appeared is a right basal relatively homogeneous area of opacity with scarce air bronchograms that shows unusually sharp borders at the lateral, medial and caudal aspects. This suggests that the opacity correspond collapsed lung in the presence of a small ventrobasal

pneumothorax.

The size of the cardiac silhouette and the pre-existing retrocardiac opacity are unchanged. No other newly occurred parenchymal opacities.

Unchanged overall extent of the pre-existing pneumomediastinum.

The responsible nurse, Crystal was contact[**Name (NI) **] by telephone at the time of dictation.

"

"[**2140-11-4**] 4:36 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 7**] # [**0-0-**]

Reason: ?interval change - Right chest tube removed

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with PTX

REASON FOR THIS EXAMINATION:

?interval change - Right chest tube removed

WET READ: GWp FRI [**2140-11-4**] 7:43 PM

Small R apical PTX R basal opacity likley atelectasis persists R rib fraactures GWlms

---

FINAL REPORT

HISTORY: 22-year-old man with pneumothorax. Right chest tube removed.

COMPARISON: [**2140-11-4**] at 5:47 a.m.

FINDINGS:

Portable, AP radiograph of the chest demonstrates removal of the right chest tube. The right lateral chest and right costophrenic angle are not included in the field of view.

Left chest tube remains in place. The left subclavian central venous catheter has been removed.

Patchy consolidation in both mid to lower lungs is unchanged. There may be tiny residual right and left pneumothoraces. Small amount of subcutaneous emphysema in the left supraclavicular region is unchanged.

"

"[**2140-10-30**] 5:49 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67286**]

Reason: eval fx, head bleed

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with posturing left side s/p ATV, blown right pupil

REASON FOR THIS EXAMINATION:

eval fx, head bleed

No contraindications for IV contrast

WET READ: SBNa SUN [**2140-10-30**] 7:00 PM

b/l skull base fx extending into right carotid canal- recommend CTA to exclude

vasc injury. left orbital walls and left zygoma fx. b/l subarachnoid hemmorhage, hemmorhage in prepontine cistern and anterior inferior aspect of pons.

FINAL REPORT

CT HEAD WITHOUT CONTRAST.

COMPARISON: None.

HISTORY: 22-year-old male status post ATV accident with blown right pupil. Evaluate for head bleed.

TECHNIQUE: MDCT axially acquired images through the brain were obtained. No IV contrast was administered. Coronal and sagittal reformats were performed.

FINDINGS: Scattered foci of subarachnoid hemorrhage noted. Specifically, in the left frontal lobe (2, 25), right parietal lobe (2, 18). Hemorrhage is noted within the prepontine cistern (2, 12). There is a possible 2-mm left cerebral subdural hematoma (2, 21) although this may represent streak artifact. Anterior to the pons, there is hyperdensity which appears linear on sagittal views (400B, 44), likely an extra-axial hematoma. Increased density within the anterior inferior aspect of the pons may represent a hemorrhagic intra-axial contusion (400B, 44 and 2, 8). There is no shift of normally midline structures or hydrocephalus. There is no intraventricular hemorrhage. Tiny foci of pneumocephalus is identified (2, 13) along the inferior left frontal lobe. There is normal [**Doctor Last Name 107**]- white matter differentiation. There is no evidence of acute major vascular territorial infarction.

There is hyperdense fluid (compatible with blood) within the left maxillary,

sphenoid and ethmoid air cells as well as a small amount within the frontal sinuses. There are multiple skull base fractures including bilateral longitudinal temporal bone fractures, which extend to the middle ear bilaterally. The mastoid air cells are opacified, right greater than left. The right skull base fracture extends from the right posterior wall of the sphenoid sinus into the right carotid canal. The left temporal bone fracture extends into the posterior wall of the left TMJ joint as well as superiorly into the left parietotemporal bone (3, 25). There are fractures of the left zygoma, left lateral and medial orbital wall (3, 15). The left orbital globe appears grossly intact. There is a small amount of periorbital soft tissue swelling. Possible left lateral pterygoid fracture, although this is only seen on a single image and may represent artifact (3, 6).

(Over)

[**2140-10-30**] 5:49 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67286**]

Reason: eval fx, head bleed

FINAL REPORT

(Cont)

IMPRESSION:

1. Bilateral subarachnoid hemorrhage. Possible tiny left cerebral subdural hemorrhage measuring less than 2 mm.
2. Hemorrhage within the prepontine cistern and in the pons (anteriorly). Linear hyperdensity anterior to the pons is likely extraaxial.
3. Bilateral longitudinal temporal bone fractures extending to the right carotid canal. Left lateral and medial orbital wall fractures and left zygomatic fracture. CTA is recommended to exclude carotid injury.

4. Sinus opacification with fractures of the sphenoid sinus.

These findings were discussed with the trauma surgical team on-call at the
time of review.

"

"[**2140-10-30**] 5:49 PM

CT C-SPINE W/O CONTRAST Clip # [**Clip Number (Radiology) 67287**]

Reason: eval fx

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with posturing left side s/p ATV, blown right pupil

REASON FOR THIS EXAMINATION:

eval fx

No contraindications for IV contrast

WET READ: SBNa SUN [**2140-10-30**] 6:59 PM

no fx

FINAL REPORT

CT C-SPINE WITHOUT CONTRAST.

COMPARISON: None.

HISTORY: Status post ATV accident. Evaluate for C-spine fracture.

TECHNIQUE: MDCT axially acquired images through the cervical spine were obtained. No IV contrast was administered. Coronal and sagittal reformats were performed.

FINDINGS: There are multiple skull base fractures, better evaluated on dedicated head CT. There is no evidence of cervical spine fracture. The vertebral body heights and alignment are preserved. There is no prevertebral soft tissue swelling. The visualized lung apices are clear. Patient is intubated and incidental note is made of pooling of secretions surrounding endotracheal tube consistent with likely aspiration.

IMPRESSION:

1. No cervical spine fracture.
2. Bilateral skull base fractures, better evaluated on dedicated head CT.
3. Secretions within trachea surrounding endotracheal balloon concerning for aspiration.

"

"[**2140-11-1**] 4:26 PM

CHEST (PORTABLE AP); -76 BY SAME PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67293**]

Reason: ?chest tube placement

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with PTX s/p chest tube

REASON FOR THIS EXAMINATION:

?chest tube placement

PROVISIONAL FINDINGS IMPRESSION (PFI): JEKh TUE [**2140-11-1**] 7:17 PM

PFI: Right chest tube placement with near complete resolution of right pneumothorax; reexpansion of right lower lobe with minimal residual atelectasis.

FINAL REPORT

HISTORY: 22-year-old male with pneumothorax, status post chest tube. Please assess for chest tube placement.

STUDY: AP upright portable chest radiograph performed at 16:47 on [**11-1**], [**2140**].

COMPARISON: [**2140-11-1**], 13:20.

FINDINGS: There has been interval placement of a right-sided chest tube, resulting in near complete resolution of the right pneumothorax and reexpansion of the right lower lobe. Small locules of gas are seen along the right superior mediastinum and right diaphragmatic edge. The heart and mediastinal contours are unchanged. The lungs are clear with no focal or lobar consolidation. There is no pleural effusion. ET tube is 5.5 cm above the carina. A left-sided subclavian central line tip is in the mid [**Year (4 digits) 1844**]. An endogastric tube courses inferiorly with its side port well below the GE junction and continues to course out of the field of view.

IMPRESSION:

Right chest tube placement with near complete resolution of right pneumothorax; reexpansion of right lower lobe with minimal residual atelectasis.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-1**] 4:26 PM

CHEST (PORTABLE AP); -76 BY SAME PHYSICIAN [**Name Initial (PRE) 7**] # [**Clip Number (Radiology) 67293**]

Reason: ?chest tube placement

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with PTX s/p chest tube

REASON FOR THIS EXAMINATION:

?chest tube placement

PFI REPORT

PFI: Right chest tube placement with near complete resolution of right pneumothorax; reexpansion of right lower lobe with minimal residual atelectasis.

"

"[**2140-11-3**] 4:52 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 66397**]

Reason: Please evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident, chest tube, on ventilator

REASON FOR THIS EXAMINATION:

Please evaluate for interval change

PROVISIONAL FINDINGS IMPRESSION (PFI): [**First Name9 (NamePattern2) 4913**] [**Doctor First Name 141**] [**2140-11-3**] 12:16 PM

Increased right lower lung and retrocardiac opacities, which may represent pneumonia and less likely pulmonary hemorrhage.

FINAL REPORT

HISTORY: 22-year-old male status post ATV accident, now with a chest tube and on the ventilator. Please assess for interval changes.

STUDY: Portable AP semi-upright chest radiograph.

COMPARISON: [**2140-11-2**].

FINDINGS: The ET tube is 6 cm above the carina. Left subclavian line tip ends in the mid SVC. An endogastric tube tip courses inferiorly below the GE junction and out of field of view. The heart and mediastinal contours are unchanged. There is increased consolidation of the right lower lung and retrocardiac opacities that may represent developing pneumonia and less likely pulmonary hemorrhage given the timeframe. Right-sided chest tube is unchanged. There is no pneumothorax or pleural effusion.

IMPRESSION: Increased right lower lung and retrocardiac opacities, which may represent pneumonia and less likely pulmonary hemorrhage.

"

"[**2140-11-5**] 1:15 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67808**]

Reason: Eval. CT placement

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with new L sided chest tube.

REASON FOR THIS EXAMINATION:

Eval. CT placement

FINAL REPORT

INDICATION: New left chest tube.

COMPARISON: [**2140-11-4**].

FINDINGS: Compared to the prior film, there is substantial and improved aeration in the right lower lobe consolidation with some residual. A left-sided chest tube is seen with the tip at the left apex and the side port overlying left posterior rib. There are no new focal consolidations and the pulmonary vasculature remains within normal limits.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-10-31**] 5:40 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 66394**]

Reason: Please evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with likely aspiration event

REASON FOR THIS EXAMINATION:

Please evaluate for interval change

PFI REPORT

Left lower lobe collapse; clear right lung.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] TSICU [**2140-11-3**] 4:52 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 66397**]

Reason: Please evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man s/p ATV accident, chest tube, on ventilator

REASON FOR THIS EXAMINATION:

Please evaluate for interval change

PFI REPORT

Increased right lower lung and retrocardiac opacities, which may represent

pneumonia and less likely pulmonary hemorrhage.

"

"[**2140-11-5**] 9:11 AM

CTA CHEST W&W/O C&RECONS, NON-CORONARY Clip # [**Clip Number (Radiology) 67009**]

Reason: eval for PE

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with multiple facial fractures and b/l SAH now with agitation

and tachypnea

REASON FOR THIS EXAMINATION:

eval for PE

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): AGLc SAT [**2140-11-5**] 12:28 PM

1. Enlarged now moderate-to-large left pneumothorax. Left chest tube

terminates in the anterolateral subcutaneous soft tissues of the chest wall.

Slight rightward shift of midline structures.

2. Pneumomediastinum. Also possible tiny right pneumothorax

3. Multifocal consolidation involving all lobes of the lungs, likely due to

aspiration and consistent with multifocal pneumonia.

4. Assessment is slightly limited due to respiratory motion, particularly

along the lingula, no evidence of PE seen.

5. Right chest wall laceration. Also subcutaneous gas along bilateral

anterior chest wall, tracking up to the thoracic inlet on the left.

Findings discussed with Dr. [**First Name8 (NamePattern2) 8432**] [**Last Name (NamePattern1) 14911**] over the phone at 10:15 a.m.

FINAL REPORT

HISTORY: 22-year-old male with multiple facial fractures and bilateral

subarachnoid hemorrhage, now with agitation and tachypnea, concerning for pulmonary embolism.

COMPARISON: Initial CT torso of [**2140-10-30**] as well as multiple interval chest radiographs.

TECHNIQUE: MDCT axial imaging was performed through the chest after the uneventful administration of 100 mL of IV Optiray 350. Multiplanar reformatted images as well as oblique maximal intensity projection images were then obtained.

CTA CHEST: There is interval development of a sizable left pneumothorax with perhaps slight shift of the mediastinal contents towards the right since CT torso of [**2140-10-30**]. Also note is made that the patient has left-sided anterior chest tube is not within the pleural cavity and terminates within the subcutaneous soft tissues of the anterolateral chest wall. There is subcutaneous gas along bilateral anterior chest wall. Also, there is apparent gas within the anterior mediastinum (2:16), and also along the right heart margin (2:4, 31, 57).

The central airways are patent to the subsegmental levels. There are areas of

(Over)

[**2140-11-5**] 9:11 AM

CTA CHEST W&W/O C&RECONS, NON-CORONARY Clip # [**Clip Number (Radiology) 67009**]

Reason: eval for PE

Admitting Diagnosis: HEAD INJURY

FINAL REPORT

(Cont)

consolidation in the dependent portions involving all lobes of the lungs, possibly representing atelectasis and possible aspiration. Additionally, there are multiple foci of peribronchovascular nodules and consolidation which are most prominent in the left upper lobe, right middle lobe and right lower lobe, worrisome for multifocal pneumonia.

There is no pleural effusion or pericardial effusion. While the study is degraded by motion, no evidence for large or central pulmonary embolus is seen. Assessment is particularly limited in the lingula. No mediastinal, hilar or axillary adenopathy is noted. Again noted is thymic tissue remnant.

No evidence of acute fracture seen. Vertebral body heights are preserved.

IMPRESSIONS:

1. Enlarged now moderate-to-large left pneumothorax. Left chest tube terminates in the anterolateral subcutaneous soft tissues of the chest wall. Slight rightward shift of midline structures.

2. Pneumomediastinum. Subcutaneous gas along bilateral anterior chest wall, tracking up to the thoracic inlet on the left. Right chest wall laceration.

3. Multifocal consolidation involving all lobes of the lungs, likely due to aspiration and pneumonia.

4. Assessment is slightly limited due to respiratory motion, particularly along the lingula, but no evidence of PE seen.

Findings discussed with Dr. [**First Name8 (NamePattern2) 8432**] [**Last Name (NamePattern1) 14911**] over the phone at 10:15 a.m.

"

"[**Last Name (LF) **],[**First Name3 (LF) 2888**] F. [**Last Name (un) 1481**] CC6A [**2140-11-5**] 9:11 AM

CTA CHEST W&W/O C&RECONS, NON-CORONARY Clip # [**Clip Number (Radiology) 67009**]

Reason: eval for PE

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with multiple facial fractures and b/l SAH now with agitation

and tachypnea

REASON FOR THIS EXAMINATION:

eval for PE

No contraindications for IV contrast

PFI REPORT

1. Enlarged now moderate-to-large left pneumothorax. Left chest tube

terminates in the anterolateral subcutaneous soft tissues of the chest wall.

Slight rightward shift of midline structures.

2. Pneumomediastinum. Also possible tiny right pneumothorax

3. Multifocal consolidation involving all lobes of the lungs, likely due to

aspiration and consistent with multifocal pneumonia.

4. Assessment is slightly limited due to respiratory motion, particularly

along the lingula, no evidence of PE seen.

5. Right chest wall laceration. Also subcutaneous gas along bilateral

anterior chest wall, tracking up to the thoracic inlet on the left.

Findings discussed with Dr. [**First Name8 (NamePattern2) 8432**] [**Last Name (NamePattern1) 14911**] over the phone at 10:15 a.m.

"

"[**2140-10-30**] 5:48 PM

TRAUMA #3 (PORT CHEST ONLY) PORT Clip # [**Clip Number (Radiology) 67883**]

Reason: eval fxs, ptx

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with ATV, head injury

REASON FOR THIS EXAMINATION:

eval fxs, ptx

FINAL REPORT

TRAUMA CHEST RADIOGRAPH

COMPARISON: None.

HISTORY: Status post ATV accident.

FINDINGS: Cardiomediastinal and hilar contours are within normal limits.

There is no evidence of pneumothorax. There is dense retrocardiac opacity.

The ET tube terminates at the level of the clavicles and may be advanced. The

NG tube is within the stomach. The osseous structures are grossly

unremarkable.

IMPRESSION:

1. ET tube at the level of clavicles approximately 6 cm above the carina.
2. Retrocardiac opacity.
3. No evidence of pneumothorax.

Please refer to Chest CT performed subsequently for additional details.

"

"[**2140-11-4**] 5:14 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67297**]

Reason: ?interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man w/bilateral PTX

REASON FOR THIS EXAMINATION:

?interval change

FINAL REPORT

AP CHEST 5:47 A.M. ON [**11-4**]:

HISTORY: 22-year-old man with bilateral pneumothorax.

IMPRESSION: AP chest compared to [**11-2**] and 24:

Tiny right apical pneumothorax has increased since [**11-3**]. ___ region

of atelectasis or consolidation in the right lower lobe is improving. The course of the right pleural tube suggests it could be fissural, explain the persistence of pneumothorax. There is no pneumothorax or appreciable pleural fluid collection on the left, apical pleural tube still in place. Left infrahilar consolidation has remained relatively stable. Heart size top normal.

"

"[**2140-11-1**] 5:51 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67294**]

Reason: 22 year old man with L SDH, L frSAH, R temp SAH. eval for ch

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with L SDH, L frSAH, R temp SAH. eval for changes.

REASON FOR THIS EXAMINATION:

22 year old man with L SDH, L frSAH, R temp SAH. eval for changes.

No contraindications for IV contrast

PROVISIONAL FINDINGS IMPRESSION (PFI): GWp TUE [**2140-11-1**] 7:49 PM

1. Apparent resolution of subarachnoid hemorrhage.

2. Possible tiny left cerebral subdural hemorrhage persists.

3. Interval introduction of left frontal epidural sensor.

4. Unchanged appearance of skull based fractures.

5. Bilateral high-density material in maxillary sinuses.

FINAL REPORT

INDICATION: Subarachnoid hemorrhage. Evaluate for changes.

COMPARISON: [**2140-10-30**].

FINDINGS: There has been interval introduction of a right frontal approach bolt. Foci of subarachnoid hemorrhage appeared to have resolved. A possible left cerebral subdural hematoma measuring to 2 mm persists. There is no new intracranial hemorrhage. [**Doctor Last Name **]-white matter differentiation is preserved. Ventricles, sulci, and cisterns are of normal configuration and size for age. Basal cisterns are preserved. The foramen magnum is patent. Multiple skull base fractures including temporal bones are again seen (refer to [**2140-10-19**] CT for further description). Visualized mastoid air cells appear clear. High-density material within bilateral maxillary and ethmoid sinuses likely represents hemorrhage.

IMPRESSION:

1. Apparent resolution of subarachnoid hemorrhage.

2. Persistence of possible left cerebral subdural hemorrhage.

3. Bilateral longitudinal temporal bone fractures and left lateral medial orbital wall fractures and left zygomatic fracture (see CT from [**2140-10-30**] for details).

4. Sphenoid sinus opacification and sphenoid fractures.

5. High-density material in the bilateral maxillary sinuses is likely hemorrhage.

(Over)

[**2140-11-1**] 5:51 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67294**]

Reason: 22 year old man with L SDH, L frSAH, R temp SAH. eval for ch

Admitting Diagnosis: HEAD INJURY

FINAL REPORT

(Cont)

"

"[**2140-11-2**] 5:10 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 67292**]

Reason: Please evaluate for interval change

Admitting Diagnosis: HEAD INJURY

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with acute lung injury

REASON FOR THIS EXAMINATION:

Please evaluate for interval change

FINAL REPORT

PORTABLE CHEST, [**2140-11-2**]

COMPARISON: Study of one day earlier.

INDICATION: Acute lung injury.

FINDINGS: A small left pneumothorax is present, and has slightly increased from the recent radiograph. Right-sided chest tube remains in place. No residual visible pneumothorax on the right. Persistent pneumomediastinum and slight worsening of subcutaneous emphysema within the left chest wall. Cardiomediastinal contours are unchanged. Persistent bibasilar confluent opacities, with interval worsening on the right, with a few air bronchograms. Although the left-sided opacities have been present since the initial presentation radiograph of three days earlier, the right-sided opacities have more recently developed. Although potentially due to atelectasis, evolving aspiration pneumonia should be considered in the appropriate setting.

"

"[**2140-12-14**] 1:26 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 67295**]

Reason: assess for any changes

[**Hospital 2**] MEDICAL CONDITION:

22 year old man with subdoral

REASON FOR THIS EXAMINATION:

assess for any changes

No contraindications for IV contrast

FINAL REPORT

INDICATION: 22-year-old man with subdural hematoma. Assess for any changes.

COMPARISON: Multiple head CTs, most recent of [**2140-11-1**] and MRI of the brain, most recent of [**2140-11-8**].

FINDINGS: There is no acute hemorrhage, mass effect or shift of midline structures. There is normal preservation of [**Doctor Last Name 107**]-white matter differentiation. The sulci and ventricles are normal in size and configuration.

Extra-axial fluid matching the density of cerebral spinal fluid is seen in the posterior fossa central and posterior to the cerebellar hemispheres indenting the vermis. This appearance is likely due to evolution of subdural hematoma into chronic stage; as there is no normal baseline study for comparison, there may be a component of [**Last Name (un) 1452**] cisterna magna also.
The visualized paranasal sinuses and mastoid air cells are clear.
Previously noted fractures are not well assessed on the present study due to lack of dedicated bone alg. images.

IMPRESSION: Small extra-axial clear fluid-containing space in the posterior fossa, likely evolving subdural hematoma into chronic stage and superimposed possible [**Last Name (un) 1452**] cisterna magna. No acute findings.

"

"Subjective

Patient with good appetite and po intake PTA per father, patient c/o thirst

Objective

[**11-4**] wt: 85.32 kg

Food allergies and intolerances: none per patient

s father

Pertinent medications: Dextrose 5% 1/2 normal saline @ 75 ml/hr, KCl (20 mEq repletion), RISS, IV abx, famotidine, dilantin, heparin, others noted

Labs:

Value

Date

Glucose

114 mg/dL

[**2140-11-4**] 02:12 AM

Glucose Finger Stick

125

[**2140-11-4**] 08:00 AM

BUN

13 mg/dL

[**2140-11-4**] 02:12 AM

Creatinine

0.9 mg/dL

[**2140-11-4**] 02:12 AM

Sodium

141 mEq/L

[**2140-11-4**] 02:12 AM

Potassium

3.4 mEq/L

[**2140-11-4**] 02:12 AM

Chloride

103 mEq/L

[**2140-11-4**] 02:12 AM

TCO2

26 mEq/L

[**2140-11-4**] 02:12 AM

PO2 (arterial)

70 mm Hg

[**2140-11-3**] 07:03 PM

PCO2 (arterial)

34 mm Hg

[**2140-11-3**] 07:03 PM

pH (arterial)

7.48 units

[**2140-11-3**] 07:03 PM

pH (urine)

6.5 units

[**2140-11-1**] 12:49 AM

CO2 (Calc) arterial

26 mEq/L

[**2140-11-3**] 07:03 PM

Albumin

3.6 g/dL

[**2140-11-2**] 02:27 AM

Calcium non-ionized

8.5 mg/dL

[**2140-11-4**] 02:12 AM

Phosphorus

3.6 mg/dL

[**2140-11-4**] 02:12 AM

Ionized Calcium

1.14 mmol/L

[**2140-11-3**] 07:03 PM

Magnesium

2.2 mg/dL

[**2140-11-4**] 02:12 AM

Phenytoin (Dilantin)

9.6 ug/mL

[**2140-11-4**] 02:12 AM

WBC

16.6 K/uL

[**2140-11-4**] 02:12 AM

Hgb

11.3 g/dL

[**2140-11-4**] 02:12 AM

Hematocrit

33.7 %

[**2140-11-4**] 02:12 AM

Current diet order / nutrition support: Replete with Fiber @ 55 ml/hr =

1320 kcals/ 82 g protein (ON HOLD)

GI: soft, +bowel sounds

Assessment of Nutritional Status

Specifics: 22 year old male s/p ATV accident, helmeted CGS 6 in field.

Patient started on tube feedings on [**10-31**] while intubated, patient

self-extubated himself on [**11-3**]. Plan is for SLP eval today and advance

diet per recommendations. If patient remains NPO recommend restarting

tube feedings and advance to goal of Replete with Fiber @ 85 ml/hr =

2040 kcals/ 126 g protein since propofol is off.

Medical Nutrition Therapy Plan - Recommend the Following

1. Implement any SLP recommendations
2. If patient remains NPO restart tube feeding advance to goal of

Replete with Fiber @ 85 ml/hr =2040 kcals/ 126 g protein

3. Check chemistry 10 daily and replete prn
4. Will follow page [**Numeric Identifier 2584**] with questions

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