"Admission Date: [**2161-5-2**] Discharge Date: [**2161-5-22**]

Date of Birth: [**2085-10-4**] Sex: M

Service: NEUROLOGY

Allergies:

Patient recorded as having No Known Allergies to Drugs

Attending:[**First Name3 (LF) 2569**]

Chief Complaint:

Intraparenchymal hemorrhage, transferred from outside

hospital

Major Surgical or Invasive Procedure:

Intubation

Tracheostomy

PEG tube placement

IVC filter placement

History of Present Illness:

Patient is a 75 year old right-handed man with past medical

history of coronary artery disease status post inferior MI,

catheratization in [**10-19**] with mild LAD disease, history of

pulmonary embolus, history of DVT while on heparin SC so now on

life long coumadin, presumed Strep pneumoniae meninigitis [**12-19**]

with ? symptomatic seizures who presented to [**Hospital1 18**] ED on

[**2161-5-2**] at 5pm as a transfer from [**Hospital 1562**] Hospital for

evaluation of left temporal intraparenchymal hemorrhage.

He was in his usual state of health until earlier today. Per his wife, he went to get a haircut this morning and returned home at noon. When he went to talk to his wife, his words came out as gibberish. The words themselves were not slurred but it was like he was using totally inappropriate words. He seemed frustrated to her. She did not note any facial or limb weakness.

She drove him by car to [**Hospital 1562**] hospital. He walked into the hospital of his own [**Location (un) **]. Head CT showed a left temporal lobar hemorrhage, widest diameter of 2.5 cm present on three 5 mm cuts.

His INR was 2.5. He received Vitamin K and 4 units of FFP. After the fourth unit of FFP, he developed [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] red rash over his entire body. An additional two units of FFP had been ordered but were held due to concern for transfusion reaction.

On arrival here, he was bradycardic to the 30s with a 208/79. He was examined here off of sedation and was noted to move all extremities symmetrically. While in [**Hospital1 18**] ED, received 50 mg Benadryl IV (for rash), was bolused with Propofol and started on Propofol drip, and loaded with 1 gram of IV Dilantin. For repeat of INR 1.8, he was ordered for another 2 units FFP after getting Solumedrol 125 mg IV and Pepcid 20 mg IV.

He was seen by Neurosurgery who felt that surgical intervention

was not warranted at this time.

Per his wife, he had had no complaints in the days leading up to today's event.

Past Medical History:

1. Coronary artery disease, status post IMI, cath in [**10-19**] with left LAD disease
2. Hospitalization in [**12-19**] for Strep pneumonia meningitis. Was found in his car by the side of the road dazed. Taken to outside hospital, found to have fever and wbc count. Had sinusitis and reportedly had meningitis. Blood cultures were positive for Strep pneumoniae.
3. Obstructive sleep apnea
4. Right rotator cuff repair
5. History of pulmonary embolus [**2153**]
6. Deep vein thrombosis while on SC heparin, so now on lifelong coumadin
7. Mild pulmonary hypertension
8. Pulmonary nodules, felt to be granulomatous
9. Sick sinus syndrome

Social History:

Married x 36 years. One child. Retired from government work per his wife. [**Name (NI) **] tobacco use. Social alcohol use.

No drug use.

Family History:

No family history of neurological disease.

Physical Exam:

Afebrile

BP 110/55 HR 90 RR 20 Pox 94-100% FiO2 40%, trach collar

Gen: WD/WN man, intubated, NAD.

HEENT: Intubated. Anicteric. MMM.

Neck: Supple. No masses or LAD. No JVD. No thyromegaly. No carotid bruits.

Lungs: Coarse breath sounds anterolaterally. No R/R/W.

Cardiac: RRR. S1/S2. No M/R/G.

Abd: Soft, NT, ND, +NABS. No rebound or guarding. No HSM.

Extrem: Warm and well-perfused. No C/C/E.

Neuro:

Mental status: Eyes open. Answers yes or no with movements of head. Follows axial commands only; does not follow appendicular commands.

Cranial Nerves:

I: Not tested

II: Pupils equally round and reactive to light, 4 to 2 mm bilaterally. Visual fields are full to confrontation. Optic disc margins sharp.

III, IV, VI: EOMI, no nystagmus, no ptosis

V, VII: Mild right facial weakness. Bilateral corneal reflexes.

VIII: Hearing intact

IX, X: Positivcough reflex intact

XII: Tongue midline without fasciculations, albeit obscurred by

ETT.

Motor: Normal bulk and tone bilaterally. No abnormal movements,

tremors. There is very mild right upper extremity weakness.

THere is no drift. The legs are full power.

Sensation: Withdraws to ligght touch in all extremities

equally.

Reflexes: B T Br Pa Ac

Right 2 2 2 1 1

Left 2 2 2 1 1

Left toe upgoing. Right toe is equivocal.

Pertinent Results:

[**2161-5-2**] 04:50AM URINE BLOOD-NEG NITRITE-NEG PROTEIN-NEG

GLUCOSE-NEG KETONE-TR BILIRUBIN-NEG UROBILNGN-NEG PH-8.0

LEUK-NEG

[**2161-5-2**] 04:50AM URINE COLOR-Yellow APPEAR-Clear SP [**Last Name (un) 155**]-1.008

[**2161-5-2**] 05:00PM PT-18.6* PTT-30.5 INR(PT)-1.8*

[**2161-5-2**] 05:00PM PLT COUNT-212

[**2161-5-2**] 05:00PM NEUTS-83.9* LYMPHS-10.4* MONOS-5.4 EOS-0.2

BASOS-0.1

[**2161-5-2**] 05:00PM WBC-8.9# RBC-4.74 HGB-15.1 HCT-45.0 MCV-95
MCH-31.8 MCHC-33.5 RDW-13.0
[**2161-5-2**] 05:00PM ASA-NEG ETHANOL-NEG ACETMNPHN-NEG
bnzodzpn-NEG barbitrt-NEG tricyclic-NEG
[**2161-5-2**] 05:00PM CALCIUM-9.0 PHOSPHATE-1.3*# MAGNESIUM-1.8
[**2161-5-2**] 05:00PM cTropnT-<0.01
[**2161-5-2**] 05:00PM CK-MB-3
[**2161-5-2**] 05:00PM CK(CPK)-123
[**2161-5-2**] 05:00PM GLUCOSE-106* UREA N-12 CREAT-0.7 SODIUM-144
POTASSIUM-4.0 CHLORIDE-104 TOTAL CO2-26 ANION GAP-18
[**2161-5-2**] 11:00PM PT-18.4* PTT-29.6 INR(PT)-1.7*
[**2161-5-2**] 11:00PM CK-MB-NotDone cTropnT-<0.01
[**2161-5-2**] 11:00PM CK(CPK)-87
[**2161-5-2**] 11:08PM freeCa-1.18
[**2161-5-2**] 11:08PM TYPE-ART PO2-98 PCO2-48* PH-7.41 TOTAL
CO2-31* BASE XS-4

CT without contrast [**5-2**]
TECHNIQUE: Non-contrast head CT.

FINDINGS: There is a focal rounded area of hyperattenuation
measuring 2.5 x 2.3 cm in the left frontoparietal region
consistent with intraparenchymal hemorrhage, relatively
unchanged in appearance from the outside films. There is a thin
hypodense halo consistent with surrounding edema. There is no
evidence of mass effect, shift of normally midline structures or
hydrocephalus. The [**Doctor Last Name 352**]-white matter differentiation is
preserved. Note is made of extensive mucosal thickening within
the visualized maxillary and ethmoid sinuses bilaterally. The

mastoid air cells are well aerated. Bone windows demonstrate no evidence of acute fracture or osseous lesion.

IMPRESSION: 2.5 cm intraparenchymal hemorrhage within the left frontoparietal region with associated edema. No evidence of hydronephrosis, midline shift or mass effect. Extensive mucosal thickening within the visualized portions of the paranasal sinuses as described above.

CT with contrast [**5-2**]
CTA of the circle of [**Location (un) 431**] with multiplanar reformatted images.

PRELIMINARY REPORT: Exam is extremely technically limited by suboptimal contrast bolus. Within the limits of the study, the major vessels of the circle of [**Location (un) 431**] appear patent. There is a dominant left vertebral artery. Left intraparenchymal hemorrhage is again seen. Full [**Location (un) 1131**] to follow after post-processed images are acquired. Wet [**Location (un) 1131**] to CCC at 9:50 p.m. on [**2161-5-2**]. Dr. [**Last Name (STitle) **], pager [**Numeric Identifier 21129**].

FINDINGS: Study is extremely limited by suboptimal contrast bolus, which precludes evaluation of the intracranial circulation. No gross abnormalities are identified. There is a dominant left vertebral artery, with a possible posterior inferior cerebellar artery termination of the right vertebral artery. If clinically warranted, a repeat study could be performed for further evaluation.

IMPRESSION: Limted study secondary to suboptimal contrast bolus.

Grossly normal circle of [**Location (un) 431**] with no large aneurysm.

The study and the report were reviewed by the staff radiologist

[**5-2**] EKG:

Sinus bradycardia

Right bundle branch block

Lateral ST changes are nonspecific

No change from previous

[**5-2**] INITIAL CXR:

CHEST, SINGLE PORTABLE VIEW: Comparison is made to [**2159-10-25**], a CT and radiograph. The tip of the endotracheal tube lies

10 cm above the carina, above the thoracic inlet. The heart is

enlarged. The pulmonary artery is again prominent. A rounded

opacity in the right hilum most likely also represents a

pulmonary artery. There is opacity obscuring the left

hemidiaphragm, which may represent atelectasis. There is no

evidence of pleural effusion or pneumothorax. The left

cardiophrenic angle is excluded.

Old healed right rib fracture.

IMPRESSION:

1. More proximal than ideal positioning of endotracheal tube,

above the thoracic inlet. This finding was discussed with Dr.

[**Last Name (STitle) **] in the ER shortly after the study.

2. Likely left lower lobe atelectasis.

3. Cardiomegaly.

[**5-3**] MRI:

Multiplanar MRI imaging without and with gadolinium was performed. Sequences included axial T1, T2, FLAIR, gradient-echo images. Sagittal T1- weighted images were also obtained. After administration of gadolinium, sagittal, axial, and coronal T1-weighted images were obtained. MRA of the brain was also performed. Axial 3D multiplanar time-of-flight images were displayed.

MRI OF THE BRAIN WITHOUT AND WITH GADOLINIUM: There is again noted a left parietal hemorrhage, which measures 2.5 x 2.2 cm and is probably unchanged when compared to CT performed on the prior day. There is a moderate amount of edema around the hemorrhage. There is no evidence of shift of midline structures or herniations. After administration of gadolinium, there is no evidence of abnormal enhancement in the area to suggest underlying tumor. There are no other areas of susceptibility artifact present throughout the brain. No other obvious areas of hemorrhage, acute or chronic hemorrhages are seen. The ventricles are of normal size, which is unchanged when compared to prior study. There are again noted multiple areas of increased T2-weighted signal in the periventricular white matter, likely representing chronic microvascular infarcts.

There is again noted moderate-to-severe opacification of the bilateral maxillary sinuses with mucosal thickening likely a retention cyst in the right maxillary sinus. There is also moderate opacification of the ethmoid cells and mild mucosal thickening of the sphenoid sinuses. There is also mild mucosal thickening of the frontal sinuses bilaterally.

MRA of the circle of [**Location (un) 431**]: The major tributaries of the circle of [**Location (un) 431**] are patent. There is no area of significant stenosis or aneurysmal dilatation. Within the limits of coverage of this study, no sign of arteriovenous malformation is apparent.

IMPRESSION:

1. Intraparenchymal hemorrhage in the left upper lobe appears to be unchanged when compared to prior study. No evidence of abnormal enhancement to suggest an underlying tumor. Within the limits of coverage of the study, no sign of aneurysmal malformations apparent.

2. Normal circle of [**Location (un) 431**] MRA.

3. Sinus disease as described above.

EEG [**5-3**]:
FINDINGS:
ABNORMALITY #1: The background is low voltage and slow in the delta
frequency range with bursts of moderate voltage generalized slowing
bifrontally predominant with superimposed fast activity. There are
bursts of moderate slowing in the delta frequency range bifrontally
predominant.

BACKGROUND: As above.

HYPERVENTILATION: Could not be performed because the patient was

intubated.

INTERMITTENT PHOTIC STIMULATION: Was not performed because this was a

portable study.

SLEEP: Normal transitions of the sleep architecture were not seen.

CARDIAC MONITOR: Irregular bradycardia with a rate range between 36-48

bpm.

IMPRESSION: This is an abnormal routine EEG due to the presence of low

voltage and slow background activity in the delta frequency range with

bursts of generalized slowing bifrontally predominant. This finding

represents a severe encephalopathy most likely due to the medication

effect. There were no clear epileptiform discharges recorded. An

irregular bradycardia was noted.

REPEAT HEAD CT [**5-4**]:

COMPARISON: Head CT dated [**2161-5-4**].

TECHNIQUE: MDCT-acquired images of the head were obtained without IV contrast.

FINDINGS: Left temporal intraparenchymal hemorrhage with surrounding hypodensity of the brain parenchyma is not significantly changed compared to the previous study, measuring 24 x 25 mm. No definite new foci of hemorrhage are seen. The ventricles are stable in size. There is no midline shift. Basal cisterns appear patent. The osseous structures and sinuses are not significantly changed.

IMPRESSION: No significant interval change compared to the study performed eleven hours prior.

REPEAT CXR [**5-4**]:
FINDINGS: Patient is status post intubation, the ET tube is located 5.1 cm above the carina. Otherwise, the chest radiograph is unchanged. Dobbhoff overlies the stomach. The cardiac and mediastinal contours are stable. Patchy areas of increased opacification in the retrocardiac and right infrahilar region are unchanged.

IVC FILTER PLACED:
PROCEDURE AND DETAIL: The patient was brought into the interventional suite and placed in a supine position. After he was adequately sedated per nursing, he was prepped and draped in the normal sterile manner. Retrograde right common femoral venous access was obtained using a 19-gauge single wall puncture needle, a 0.035 starter wire, and a 4-French sheath. The tip of the 4 French sheath was placed into the femoral vein and an iliac venogram was obtained. Over the [**Last Name (un) 21130**] wire, the sheath

was then advanced into the iliac system after confirming there is no evidence of thrombus and an inferior vena cavogram was obtained.

At this time, the sheath was changed over a wire for a 6 FR sheath which was positioned 1.5 cm distal to the origin of the lowest renal vein. The vena cava was then measured on venogram and found to be ___ exactly 30 mm in diameter in its infrarenal portion. We chose the OptEase IVC filter at this time. It was loaded into the 6 French sheath and deployed atraumatically 1.5 cm distal to the renal veins. The sheath was pulled and a static view of the filter and its position was obtained. A venogram was then obtained following placement of the filter. It was in excellent position, without evidence of tilt.

At this time, all catheters, wires and sheaths were removed and the access site was sealed with direct pressure. The patient tolerated the procedure well and was taken to the recovery room in stable condition. Dr. [**Last Name (STitle) **] was present and scrubbed for the entire procedure and fluoroscopy was utilized.

VENOGRAPHIC FINDINGS: There is a widely patent right common iliac vein. There is some reflux into the left common iliac vein. There is brisk forward flow. There is a widely patent inferior vena cava that is approximately 30 mm in diameter in its infrarenal portion. There is no evidence of thrombus in the right iliac vein or the inferior vena cava. We clearly see the renal veins at the mid L2. We see deployment and atraumatic placement of an OptEase recoverable IVC filter 1.5 cm distal to

the lowest renal vein at L3.

DR. [**First Name11 (Name Pattern1) **] [**Initial (NamePattern1) **] [**Last Name (NamePattern4) **] [**2161-5-4**]

REPEAT CXR [**5-9**]:

There has been placement of a tracheostomy tube which terminates in the tracheal lumen at the thoracic inlet level. There is no pneumothorax or pneumomediastinum. Cardiac and mediastinal contours are stable. There is improving aeration at both lung bases with residual patchy and linear atelectasis. Gastric distention is observed in the imaged portion of the upper abdomen.

IMPRESSION: Satisfactory tracheostomy tube positioning. No pneumomediastinum or pneumothorax.

KUB [**5-12**]:

FINDINGS: There is evidence of dilated loops of large bowel. There is an unusual appearance to the bowel in the right upper quadrant, concerning for cecal bascule. Study is limited as the entire abdomen is not imaged. Repeat films with decubitus and upright films, including the entire abdomen would be helpful for further evaluation.

Findings discussed with Dr. [**First Name8 (NamePattern2) 21131**] [**Last Name (NamePattern1) 5740**] via phone on [**2161-5-12**], 2 p.m.

Brief Hospital Course:

75 year old right handed man with past medical history coronary artery disease status post inferior MI, status post cath [**10-19**] with mild LAD disease, history of pulmonary embolus, history of DVT on heparin SC so on lifelong coumadin, who presented with episode of non-sensical speech consistent with a Wernicke's type aphasia. Outside hospital imaging shows a left temporal hemorrhage, with etiology for hemorrhage considered either spontaneous bleed with no underlying pathology, related to coumadin, or amyloid angiopathy exacerbated by coumadin. There were no microhemorrhages suggestive of amyloid, but the location in the cortex suggested this diagnosis.

Hospital course:

1. Neuro:

-He was inbubated for airway protection and admitted to the ICU with q1hour neuro checks. As his exam stabilized (when examined off propofol), neuro checks were liberalized.

-He was reversed with FFP to achieve a goal INR<1.4; his platelets remained > 100, and hct> 30. Systolic blood pressure was kept within goal of 100-150 systolic.

-Imaging was performed to look for an underlying lesion; MRA was unrevealing of vascular anomaly, and MRI with gado showed no enhancement at the area of the bleed. He should have imaging repeated in [**5-21**] weeks from the date of admission.

-EEG was performed, which revealed encephalopathy, with no epileptiform activity.

-Although there were no clinical signs to suggest seizure, he had been dilantin loaded and maintained on dilantin for the

location of the bleed being cortical and potentially a seizure focus. After approximately ten days, with no seizure activity, this was weaned off.

-At ten days following the bleed, for both cardiac and neuro-protection ASA 81 mg was started.

-Exam remained stable when the patient was off propofol, but seemed to reveal some mild right hemiparesis in comparison to the left side; without passey-muir valve, speech and language was difficult to assess. However, his naming of both low- and high-frequency objects (patient mouthed words) seemed to be intact. Follows only midline commands

2. Heme:

-As he was no longer a coumadin candidate, an IVC filter was placed [**2161-5-4**]. He was continued on pneumoboots for the remainder of the hospitalization.

3. Cards:

-He ruled out for MI by enzyme, and cardiac telemetry monitoring was considered in the ICU.

-Echo was performed [**4-30**] and revealed some LVH, mild valvular disease, and normal EF; there was no clot seen in the heart.

4. Pulm:

-He had been intubated for airway protection initially; within 48 hours of intubation, extubation was attempted. Hours later, he was reintubated for hypercarbic respiratory failure off the vent, with metabolic acidosis (pH 7.09). He was succesful weaned off the ventilator [**5-20**] and has remained stable on trach

collar for the past two days

-To look for underlying cause of his respiratory failure, chest xray was performed which demonstrated pneumonia; bronchoscopy was also performed. BAL fluid gram stain showed:

2+ (1-5 per 1000X FIELD): POLYMORPHONUCLEAR LEUKOCYTES.

2+ (1-5 per 1000X FIELD): GRAM POSITIVE COCCI. IN PAIRS.

1+ (<1 per 1000X FIELD): GRAM POSITIVE ROD(S).

Culture eventually grew coag + staph sensitive to oxacillin, and haemophilus influenza.

-He was treated for pneumonia with vanco + levaquin and oxacillin; before seven days of therapy, vanco was discontinued and dicloxicillin had been started.

-He underwent tracheostomy placement [**5-8**].

5. Endo:

-RISS and QID finger stick blood glucose was continued while in the ICU.

6. ID:

-See above for pneumonia treatment.

-For abdominal distention, c-diff was sent and was negative.

7. GI:

-NGT was initiated for meds, and tube feeds were stated when the patient was stable. Prevacid was also initiated.

-He had a PEG tube placed [**5-8**] along with the trach.

-He had abdominal distention around [**5-12**]; abdominal xray showed

dilated large bowel loops and the questions of a cecal bascule.

8. FEN:

-Daily lytes, I=O followed while in house.

9. Code:

-Discussion was held with the patient's wife, and the patient
was kept full code.

Medications on Admission:

1. Lisinopril 2.5 mg po qd
2. Coumadin 5 mg po qod/7.5 mg po qod
3. Lovastatin 20 mg po qHS

Discharge Medications:

1. Acetaminophen 325 mg Tablet [**Month/Year (2) **]: 1-2 Tablets PO Q4-6H (every
4 to 6 hours) as needed.
2. Heparin (Porcine) 5,000 unit/mL Solution [**Month/Year (2) **]: 5000 (5000)
Units Injection [**Hospital1 **] (2 times a day).
3. Aspirin 81 mg Tablet, Chewable [**Hospital1 **]: One (1) Tablet, Chewable
PO DAILY (Daily).
4. Docusate Sodium 150 mg/15 mL Liquid [**Hospital1 **]: One [**Age over 90 1230**]y
(150) mg PO BID (2 times a day) as needed for constipation.
5. Bisacodyl 5 mg Tablet, Delayed Release (E.C.) [**Age over 90 **]: Two (2)
Tablet, Delayed Release (E.C.) PO DAILY (Daily) as needed for
constipation.
6. Nystatin 100,000 unit/mL Suspension [**Age over 90 **]: Five (5) ML PO QID
(4 times a day) as needed.
7. Magnesium Hydroxide 400 mg/5 mL Suspension [**Age over 90 **]: Thirty (30)

ML PO Q6H (every 6 hours) as needed.

8. Lisinopril 5 mg Tablet [**Age over 90 **]: One (1) Tablet PO DAILY (Daily).

9. Albuterol-Ipratropium 103-18 mcg/Actuation Aerosol [**Age over 90 **]: [**2-16**] Puffs Inhalation Q4H (every 4 hours).

10. Fluticasone 110 mcg/Actuation Aerosol [**Month/Day (2) **]: Two (2) Puff Inhalation [**Hospital1 **] (2 times a day).

11. Lansoprazole 30 mg Tablet,Rapid Dissolve, DR [**Last Name (STitle) **]: One (1) Tablet,Rapid Dissolve, DR [**Last Name (STitle) **] DAILY (Daily).

12. Quetiapine 25 mg Tablet [**Last Name (STitle) **]: One (1) Tablet PO QHS (once a day (at bedtime)).

13. Magnesium Sulfate 2 gm / 100 ml NS IV PRN mg<2.0

14. Calcium Gluconate 2 gm / 100 ml D5W IV PRN ca<1.15

15. Metoclopramide 10 mg IV Q6H ileus

Discharge Disposition:

Extended Care

Facility:

[**Hospital3 7**] & Rehab Center - [**Hospital1 8**]

Discharge Diagnosis:

Left temporal hemorrhage

Discharge Condition:

Stable

Discharge Instructions:

Continue medications

Please call for Neurology/Stroke follow-up [**Telephone/Fax (1) 21132**]

Speech therapy

Physical Therapy

Followup Instructions:

Continue medications

Please call for Neurology/Stroke follow-up [**Telephone/Fax (1) 21132**]

Speech therapy

Physical Therapy

[**First Name8 (NamePattern2) **] [**Name8 (MD) 162**] MD [**MD Number(2) 2575**]

"

"Sinus bradycardia with a 2.6 second sinus pause. Probable left atrial

abnormality. Right bundle-branch block. Prior inferior wall myocardial

infarction. Since the previous tracing of [**2161-5-2**] sinus pause is present.

"

"Sinus bradycardia

Right bundle branch block

Lateral ST changes are nonspecific

No change from previous

"

"[**2161-5-12**] 9:19 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 89312**]

Reason: increasing distention please eval

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with s/p CVA

REASON FOR THIS EXAMINATION:

increasing distention please eval

FINAL REPORT

INDICATION: Increasing distention.

COMPARISONS: None.

FINDINGS: There is evidence of dilated loops of large bowel. There is an unusual appearance to the bowel in the right upper quadrant, concerning for cecal bascule. Study is limited as the entire abdomen is not imaged. Repeat films with decubitus and upright films, including the entire abdomen would be helpful for further evaluation.

Findings discussed with Dr. [**First Name8 (NamePattern2) 89313**] [**Last Name (NamePattern1) 89314**] via phone on [**2161-5-12**], 2 p.m.

"

"[**2161-5-4**] 9:00 PM

CT HEAD W/O CONTRAST; -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 1**] # [**Clip Number (Radiology) 89904**]

Reason: eval progression of bleed

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75M s/p ICH, with minimal responsiveness

REASON FOR THIS EXAMINATION:

eval progression of bleed

No contraindications for IV contrast

FINAL REPORT

INDICATION: Minimal responsiveness, evaluate progression of bleed.

COMPARISON: Head CT dated [**2161-5-4**].

TECHNIQUE: MDCT-acquired images of the head were obtained without IV contrast.

FINDINGS: Left temporal intraparenchymal hemorrhage with surrounding hypodensity of the brain parenchyma is not significantly changed compared to the previous study, measuring 24 x 25 mm. No definite new foci of hemorrhage are seen. The ventricles are stable in size. There is no midline shift. Basal cisterns appear patent. The osseous structures and sinuses are not significantly changed.

IMPRESSION: No significant interval change compared to the study performed eleven hours prior.

"

"[**2161-5-2**] 5:56 PM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 89896**]

Reason: assess ICH, interval change (CD available from OSH)

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with expressive aphasia, txf at osh with reported

interparenchymal bleed

REASON FOR THIS EXAMINATION:

assess ICH, interval change (CD available from OSH)

No contraindications for IV contrast

FINAL REPORT

INDICATION: 75-year-old male with expressive aphasia, reported intraparenchymal bleed at outside hospital.

TECHNIQUE: Non-contrast head CT.

FINDINGS: There is a focal rounded area of hyperattenuation measuring 2.5 x 2.3 cm in the left frontoparietal region consistent with intraparenchymal hemorrhage, relatively unchanged in appearance from the outside films. There is a thin hypodense halo consistent with surrounding edema. There is no evidence of mass effect, shift of normally midline structures or hydrocephalus. The [**Doctor Last Name **]-white matter differentiation is preserved. Note is made of extensive mucosal thickening within the visualized maxillary and ethmoid sinuses bilaterally. The mastoid air cells are well aerated. Bone windows demonstrate no evidence of acute fracture or osseous lesion.

IMPRESSION: 2.5 cm intraparenchymal hemorrhage within the left frontoparietal region with associated edema. No evidence of hydronephrosis, midline shift or mass effect. Extensive mucosal thickening within the visualized portions of the paranasal sinuses as described above.

These findings were discussed with Dr. [**First Name4 (NamePattern1) **] [**Last Name (NamePattern1) 18936**] at the time of dictation.

"

"[**2161-5-4**] 3:54 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 65891**]

Reason: eval dobhoff position

Admitting Diagnosis: STROKE/TIA

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

eval dobhoff position

FINAL REPORT

PORTABLE CHEST, [**2161-5-4**]

COMPARISON: [**2161-5-2**].

INDICATION: Dobbhoff tube placement.

A Dobhoff tube is in place, with the distal radiodense tip terminating at the expected thoracoabdominal junction, and should be advanced for more optimal placement. Cardiac and mediastinal contours are stable allowing for differences in technique between the two studies. There are patchy areas of increased opacity in the right infrahilar and left retrocardiac regions, as well as probable small bilateral pleural effusions.

IMPRESSION: Proximal location of feeding tube, which should be advanced for

more optimal placement as communicated by telephone to Dr. [**Last Name (STitle) 1924**] on [**5-4**], [**2161**].

"

"[**2161-5-5**] 11:38 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 90054**]

Reason: s/p bronch eval

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

s/p bronch eval

FINAL REPORT

INDICATION: ICH, intubated status post bronch evaluation.

PORTABLE AP CHEST.

COMPARISON: [**2161-5-4**].

FINDINGS: The ET tube and Dobbhoff tube are in good position. The

cardiomediastinal silhouette is stable. The left lower lobe atelectasis and

right basilar atelectasis persist. No pneumothorax.

IMPRESSION: Persistent left lower lobe and right basilar atelectasis.

"

"[**2161-5-4**] 3:29 PM

IVC GRAM/FILTER Clip # [**Clip Number (Radiology) 89902**]

Reason: dr [**Last Name (STitle) 275**] to place filter

Admitting Diagnosis: STROKE/TIA

Contrast: OPTIRAY Amt: 80

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

* [**Numeric Identifier 4421**] INTERUP IVC [**Numeric Identifier 4119**] INTRO CATH SVC/IVC *

* -51 MULTI-PROCEDURE SAME DAY [**Numeric Identifier 4422**] PERC PLCMT IVC FILTER *

* C1769 GUID WIRES INCL INF C1880 VENA CAVA FILTER *

* C1894 INT.SHTH NOT/GUID,EP,NONLASER *

****

[**Hospital 3**] MEDICAL CONDITION:

75M on chronic coumadin with recent hemorrhagic stroke

REASON FOR THIS EXAMINATION:

dr [**Last Name (STitle) 275**] to place filter

FINAL REPORT

PREOPERATIVE DIAGNOSIS: History of DVT and PE with a hemorrhagic CVA and contraindication to anticoagulation.

POSTOPERATIVE DIAGNOSIS: History of DVT and PE with a hemorrhagic CVA and contraindication to anticoagulation.

PROCEDURE: A diagnostic venogram with placement of an OptEase IVC filter,

completion arteriogram.

SURGEON: [**First Name8 (NamePattern2) 276**] [**Last Name (NamePattern1) **]

ASSISTANT: [**First Name4 (NamePattern1) 2914**] [**Last Name (NamePattern1) 264**]

ANESTHESIA: Local with sedation.

PROCEDURE AND DETAIL: The patient was brought into the interventional suite and placed in a supine position. After he was adequately sedated per nursing, he was prepped and draped in the normal sterile manner. Retrograde right common femoral venous access was obtained using a 19-gauge single wall puncture needle, a 0.035 starter wire, and a 4-French sheath. The tip of the 4 French sheath was placed into the femoral vein and an iliac venogram was obtained. Over the [**Last Name (un) 9205**] wire, the sheath was then advanced into the iliac system after confirming there is no evidence of thrombus and an inferior vena cavogram was obtained.

At this time, the sheath was changed over a wire for a 6 FR sheath which was positioned 1.5 cm distal to the origin of the lowest renal vein. The vena cava was then measured on venogram and found to be ___ exactly 30 mm in diameter in its infrarenal portion. We chose the OptEase IVC filter at this time. It was loaded into the 6 French sheath and deployed atraumatically 1.5 cm distal to the renal veins. The sheath was pulled and a static view of the filter and its position was obtained. A venogram was then obtained following placement of the filter. It was in excellent position, without evidence of tilt.

(Over)

[**2161-5-4**] 3:29 PM

IVC GRAM/FILTER Clip # [**Clip Number (Radiology) 89902**]

Reason: dr [**Last Name (STitle) 275**] to place filter

Admitting Diagnosis: STROKE/TIA

Contrast: OPTIRAY Amt: 80

FINAL REPORT

(Cont)

At this time, all catheters, wires and sheaths were removed and the access site was sealed with direct pressure. The patient tolerated the procedure well and was taken to the recovery room in stable condition. Dr. [**Last Name (STitle) **] was present and scrubbed for the entire procedure and fluoroscopy was utilized.

VENOGRAPHIC FINDINGS: There is a widely patent right common iliac vein. There is some reflux into the left common iliac vein. There is brisk forward flow. There is a widely patent inferior vena cava that is approximately 30 mm in diameter in its infrarenal portion. There is no evidence of thrombus in the right iliac vein or the inferior vena cava. We clearly see the renal veins at the mid L2. We see deployment and atraumatic placement of an OptEase recoverable IVC filter 1.5 cm distal to the lowest renal vein at L3.

"

"[**2161-5-4**] 7:49 PM

CHEST (PORTABLE AP); -76 BY SAME PHYSICIAN [**Name Initial (PRE) 1**] # [**Clip Number (Radiology) 89996**]

Reason: s/p intubation

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

s/p intubation

FINAL REPORT

PORTABLE AP CHEST

INDICATION: 75-year-old man with ICH, intubated, status post intubation.

COMPARISON: [**2161-5-4**] at 19:02.

FINDINGS: Patient is status post intubation, the ET tube is located 5.1 cm above the carina. Otherwise, the chest radiograph is unchanged. Dobbhoff overlies the stomach. The cardiac and mediastinal contours are stable. Patchy areas of increased opacification in the retrocardiac and right infrahilar region are unchanged.

"

"[**2161-5-2**] 8:08 PM

CT HEAD W/ & W/O CONTRAST; CT 100CC NON IONIC CONTRAST Clip # [**Clip Number (Radiology) 65886**]

Reason: assess for aneursym, other vascular anomaly

Admitting Diagnosis: STROKE/TIA

Contrast: OPTIRAY Amt: 90

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with left temporal lobar hemorrhage

REASON FOR THIS EXAMINATION:

assess for aneursym, other vascular anomaly

No contraindications for IV contrast

WET READ: JJMl SAT [**2161-5-2**] 9:54 PM

exam is extremely technically limited by a suboptimal contrast bolus. within the limits of this study, the major tributaries of the circle of [**Location (un) **] appear patent. there is a dominant left vertebral artery. left intraparenchymal hemorrhage is again seen. Full [**Location (un) 464**] to follow after post-processed images are acquired.

FINAL REPORT

INDICATION: Left temporal lobar hemorrhage, assess for aneurysm or other vascular anomaly.

COMPARISON: CT head without contrast performed two hours earlier the same day.

TECHNIQUE: CTA of the circle of [**Location (un) **] with multiplanar reformatted images.

PRELIMINARY REPORT: Exam is extremely technically limited by suboptimal contrast bolus. Within the limits of the study, the major vessels of the circle of [**Location (un) **] appear patent. There is a dominant left vertebral artery. Left intraparenchymal hemorrhage is again seen. Full [**Location (un) 464**] to follow after post-processed images are acquired. Wet [**Location (un) 464**] to CCC at 9:50 p.m. on [**2161-5-2**]. Dr. [**Last Name (STitle) 236**], pager [**Numeric Identifier 65887**].

FINDINGS: Study is extremely limited by suboptimal contrast bolus, which precludes evaluation of the intracranial circulation. No gross abnormalities are identified. There is a dominant left vertebral artery, with a possible posterior inferior cerebellar artery termination of the right vertebral artery. If clinically warranted, a repeat study could be performed for further evaluation.

IMPRESSION: Limted study secondary to suboptimal contrast bolus. Grossly normal circle of [**Location (un) **] with no large aneurysm.

"

"[**2161-5-13**] 5:49 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 89906**]

Reason: ?pna

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with ICH w/ fever.

REASON FOR THIS EXAMINATION:

?pna

FINAL REPORT

INDICATION: Fever.

CHEST AP: The tracheostomy tube appears to be tipped horizontally. There is no pneumothorax. Cardiac and mediastinal silhouettes are stable. There is interval worsening of the left lower lobe atelectasis. The right lower zone pneumonia appears to be worse.

There is interval increase in the intraperitoneal free air.

IMPRESSION: Interval worsening of left lower lobe atelectasis and right lower zone pneumonia. Interval increase in the free intraperitoneal air which could be secondary to a continued air leak in the PEG tube.

These findings were discussed with Dr. [**First Name8 (NamePattern2) 89313**] [**Last Name (NamePattern1) 89314**] at the time of interpretation of this study.

"

"[**2161-5-16**] 1:31 PM

G/GJ TUBE CHECK Clip # [**Clip Number (Radiology) 89371**]

Reason: NOT TOLERATING TUBE FEEDS

Admitting Diagnosis: STROKE/TIA

FINAL REPORT

INDICATION: Not tolerating tube feeds.

No comparison studies.

GASTRIC TUBE CHECK:

Under fluoroscopic guidance, approximately 100 cc of Gastrografin was injected to the gastric tube. Scout imaging demonstrated predominantly distended loops of large bowel. The stomach filled with Gastrografin, and within two minutes, contrast was seen extending through the duodenum into the jejunum. There is no evidence of obstruction or leak. Of note, contrast was seen refluxing up

the esophagus.

IMPRESSION: No evidence of obstruction. Contrast is seen extending into the jejunum. Recommend followup KUB to follow contrast column. Gastroesophageal reflux.

"

"[**2161-5-18**] 10:58 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 65485**]

Reason: eval for dilated bowel loops

Admitting Diagnosis: STROKE/TIA

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with colonic ileus , rectal tube/g-tube , not tolerating advancement of tube feeds.

REASON FOR THIS EXAMINATION:

eval for dilated bowel loops

FINAL REPORT

HISTORY: 75-year-old male with colonic ileus status post rectal and G-tube placement not tolerating tube feed advancement.

COMPARISON: Multiple prior abdominal radiographs from [**5-12**] to [**2161-5-17**] are available.

A single AP supine abdominal radiograph was obtained. Overall, there has been no significant change compared to [**2161-5-17**]. Again seen are loops of severely distended colon. Contrast [**Doctor Last Name 66**] is present in the transverse and descending colon. There remains evidence of pneumoperitoneum, which has been present at least since [**2161-5-12**]. A gastrostomy tube projects over the stomach. There

is an IVC filter in appropriate position projecting over the L3 and L4
vertebral bodies.

IMPRESSION: No significant change from [**2161-5-17**].

"

"[**2161-5-17**] 1:08 PM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 89430**]

Reason: please eval if any residual contrast to assess motility

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with colonic ileus , rectal tube/g-tube , not tolerating
advancement of tube feeds.

REASON FOR THIS EXAMINATION:

please eval if any residual contrast to assess motility

FINAL REPORT

AP CHEST, 1:08 P.M., [**5-17**].

HISTORY: Colonic ileus. Not tolerating advancement of tube feeds.

IMPRESSION: AP abdomen compared to [**2161-5-14**]:

Colon is severely distended with air. Pneumoperitoneum is present.
Gastrostomy tube projects over the stomach. Pneumoperitoneum has been present
since at least [**2161-5-12**], when a CT of the abdomen was performed.
Contrast [**Doctor Last Name 426**] is seen in the ascending and descending colon primarily, not in
the small bowel or stomach. Findings were discussed with Dr. [**Last Name (STitle) 15812**] by

telephone at the time of dictation.

"

"[**2161-5-13**] 5:49 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 65377**]

Reason: please eval

Admitting Diagnosis: STROKE/TIA

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with s/p CVA w/ abd distention s/p rectal tube placement.

REASON FOR THIS EXAMINATION:

please eval

FINAL REPORT

INDICATION: Abdominal distention, status post rectal tube placement.

COMPARISON: [**2161-5-12**].

There has been interval placement of a rectal tube. Again seen are dilated loops of large bowel with persistent dilatation of the cecum. Again seen are IVC filter and clips within the pelvis.

"

"[**2161-5-2**] 4:36 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 65884**]

Reason: ETT placement, cardpulm eval

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

ETT placement, cardpulm eval

FINAL REPORT

INDICATIONS: 75-year-old man with cranial hemorrhage, status post intubation. ET tube placement assessment requested.

CHEST, SINGLE PORTABLE VIEW: Comparison is made to [**2159-10-25**], a CT and radiograph. The tip of the endotracheal tube lies 10 cm above the carina, above the thoracic inlet. The heart is enlarged. The pulmonary artery is again prominent. A rounded opacity in the right hilum most likely also represents a pulmonary artery. There is opacity obscuring the left hemidiaphragm, which may represent atelectasis. There is no evidence of pleural effusion or pneumothorax. The left cardiophrenic angle is excluded. Old healed right rib fracture.

IMPRESSION:

1. More proximal than ideal positioning of endotracheal tube, above the thoracic inlet. This finding was discussed with Dr. [**Last Name (STitle) 18840**] in the ER shortly after the study.
2. Likely left lower lobe atelectasis.
3. Cardiomegaly.

"

"[**2161-5-9**] 6:30 AM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 89237**]

Reason: eval trach position

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

eval trach position

FINAL REPORT

PORTABLE SEMI-UPRIGHT CHEST, [**2161-5-9**]

COMPARISON: [**2160-5-5**].

INDICATION: Tracheostomy tube.

There has been placement of a tracheostomy tube which terminates in the tracheal lumen at the thoracic inlet level. There is no pneumothorax or pneumomediastinum. Cardiac and mediastinal contours are stable. There is improving aeration at both lung bases with residual patchy and linear atelectasis. Gastric distention is observed in the imaged portion of the upper abdomen.

IMPRESSION: Satisfactory tracheostomy tube positioning. No pneumomediastinum or pneumothorax.

"

"[**2161-5-4**] 6:54 PM

CHEST (PORTABLE AP); -77 BY DIFFERENT PHYSICIAN [**Name Initial (PRE) 1**] # [**Clip Number (Radiology) 89945**]

Reason: eval CXR

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with ICH, intubated

REASON FOR THIS EXAMINATION:

eval CXR

FINAL REPORT

PORTABLE AP CHEST

INDICATION: 75-year-old man with intracranial hemorrhage, intubated, please evaluate chest x-ray.

COMPARISON: [**2161-5-4**] at 15:47:44.

A Dobbhoff tip has been advanced and now lies overlying the stomach. Otherwise, the exam is unchanged. The cardiac and mediastinal contours are stable. Patchy areas of increased opacity in retrocardiac and right infrahilar are unchanged.

"

"[**2161-5-3**] 12:28 PM

MR HEAD W & W/O CONTRAST; MR CONTRAST GADOLIN Clip # [**Clip Number (Radiology) 65888**]

MRA BRAIN W/O CONTRAST

Reason: pls do MRI/MRA/post contrast/susceptability

Admitting Diagnosis: STROKE/TIA

Contrast: MAGNEVIST Amt: 20

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with left temporal lobar hemorrhage. ?due to underlying

vascular lesion, mass lesion, aneurysm

REASON FOR THIS EXAMINATION:

pls do MRI/MRA/post contrast/susceptability

No contraindications for IV contrast

WET READ: FKh SUN [**2161-5-3**] 6:36 PM

No cause for hemorrhage identified.

FINAL REPORT

INDICATION: 75-year-old male with left temporal lobe hemorrhage. Rule out underlying mass or aneurysm.

COMPARISONS: Comparison is made to CT scan from [**2161-5-2**].

TECHNIQUE: Multiplanar MRI imaging without and with gadolinium was performed. Sequences included axial T1, T2, FLAIR, gradient-echo images. Sagittal T1-weighted images were also obtained. After administration of gadolinium, sagittal, axial, and coronal T1-weighted images were obtained. MRA of the brain was also performed. Axial 3D multiplanar time-of-flight images were displayed.

MRI OF THE BRAIN WITHOUT AND WITH GADOLINIUM: There is again noted a left

parietal hemorrhage, which measures 2.5 x 2.2 cm and is probably unchanged when compared to CT performed on the prior day. There is a moderate amount of edema around the hemorrhage. There is no evidence of shift of midline structures or herniations. After administration of gadolinium, there is no evidence of abnormal enhancement in the area to suggest underlying tumor. There are no other areas of susceptibility artifact present throughout the brain. No other obvious areas of hemorrhage, acute or chronic hemorrhages are seen. The ventricles are of normal size, which is unchanged when compared to prior study. There are again noted multiple areas of increased T2-weighted signal in the periventricular white matter, likely representing chronic microvascular infarcts.

There is again noted moderate-to-severe opacification of the bilateral maxillary sinuses with mucosal thickening likely a retention cyst in the right maxillary sinus. There is also moderate opacification of the ethmoid cells and mild mucosal thickening of the sphenoid sinuses. There is also mild mucosal thickening of the frontal sinuses bilaterally.

MRA of the circle of [**Location (un) **]: The major tributaries of the circle of [**Location (un) **] are patent. There is no area of significant stenosis or aneurysmal dilatation. Within the limits of coverage of this study, no sign of arteriovenous malformation is apparent.

(Over)

[**2161-5-3**] 12:28 PM

MR HEAD W & W/O CONTRAST; MR CONTRAST GADOLIN Clip # [**Clip Number (Radiology) 65888**]

MRA BRAIN W/O CONTRAST

Reason: pls do MRI/MRA/post contrast/susceptability

Admitting Diagnosis: STROKE/TIA

Contrast: MAGNEVIST Amt: 20

FINAL REPORT

(Cont)

IMPRESSION:

1. Intraparenchymal hemorrhage in the left upper lobe appears to be unchanged when compared to prior study. No evidence of abnormal enhancement to suggest an underlying tumor. Within the limits of coverage of the study, no sign of aneurysmal malformations apparent.

2. Normal circle of [**Location (un) **] MRA.

3. Sinus disease as described above.

"

"[**2161-5-4**] 10:36 AM

CT HEAD W/O CONTRAST Clip # [**Clip Number (Radiology) 65889**]

Reason: eval for interval change

Admitting Diagnosis: STROKE/TIA

[**Hospital 2**] MEDICAL CONDITION:

75M s/p head bleed

REASON FOR THIS EXAMINATION:

eval for interval change

No contraindications for IV contrast

FINAL REPORT

INDICATION: Evaluate for interval change of hemorrhage.

COMPARISON: [**2161-5-2**].

NONCONTRAST HEAD CT SCAN.

FINDINGS: Again seen is a focal rounded area of hyperattenuation, measuring approximately 2.6 x 2.4 cm in the left temporal region, consistent with parenchymal hemorrhage, unchanged from prior study. Thin hypodense halo representing vasogenic edema also appears unchanged. Mass effect from this hemorrhage is unchanged. There is no shift of normally midline structures. No new hemorrhage is identified. Intracranial carotid calcifications are again seen. Previously described extensive chronic sinus disease also appears unchanged.

IMPRESSION: Essentially unchanged from prior study with stable appearance of left temporal parenchymal hemorrhage with small zone of surrounding vasogenic edema. No evidence of new hemorrhage.

"

"[**2161-5-15**] 11:26 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 65895**]

Reason: please eval

Admitting Diagnosis: STROKE/TIA

[**Hospital 2**] MEDICAL CONDITION:

75 year old man with decreased o2 sats.

REASON FOR THIS EXAMINATION:

please eval

FINAL REPORT

HISTORY: Decreased oxygen saturations.

COMPARISON: Abdominal radiograph from [**2161-5-14**] and chest radiograph from [**2161-5-13**].

UPRIGHT AP VIEW OF THE CHEST: Cardiac and mediastinal contours are unchanged. Tracheostomy tube remains in stable position. There is continued left basilar atelectasis. Pulmonary vascularity is within normal limits. There is no pneumothorax, new focal consolidation, or definite pleural effusions, however, the right costophrenic angle is excluded from the study. Dilated loops of bowel are seen under the diaphragm. A curvilinear lucency is seen inferior to the right hemidiaphragm, consistent with pneumoperitoneum.

IMPRESSION:

1. Stable left basilar atelectasis.
2. Dilated loops of bowel with associated pneumoperitoneum.

DFDdp

"

"[**2161-5-14**] 9:20 AM

PORTABLE ABDOMEN Clip # [**Clip Number (Radiology) 89370**]

Reason: please re-eval

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with colonic ileus , rectal tube/g-tube

REASON FOR THIS EXAMINATION:

please re-eval

FINAL REPORT

INDICATION: Colonic ileus, status post rectal and G-tube placement.

COMPARISON: [**2161-5-13**].

Rectal tube, clips within the pelvis, and IVC filter are again seen. Loops of large bowel appear less dilated compared to prior study. There is no evidence of the previously described free air within the abdomen (CT dated [**2161-5-12**]) on today's study, although the right upper quadrant and hemidiaphragms are not visualized. There is possible thickening of the haustra of the transverse colon, although no evidence of bowel abnormality was seen on prior CT.

"

"[**2161-5-18**] 9:42 PM

CHEST (PORTABLE AP) Clip # [**Clip Number (Radiology) 89432**]

Reason: eval trach position

Admitting Diagnosis: STROKE/TIA

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with decreased o2 sats.

REASON FOR THIS EXAMINATION:

eval trach position

FINAL REPORT

REASON FOR EXAMINATION: Evaluation of the tracheostome position.

A portable upright chest x-ray was compared to the previous film from [**5-15**], [**2161**].

The patient is status tracheostomy with stable satisfactory position of tracheostome.

Small amount of pneumoperitoneum is again noted grossly unchanged in comparison to the previous film.

The heart size is enlarged unchanged in comparison to the previous film. Low lung volumes are demonstrated with no evidence of focal consolidation or congestive heart failure. No significant amount of pleural effusion or pneumothorax is seen.

Dilated stomach and small bowel are again present.

IMPRESSION:

1. Stable position of tracheostome.
2. No evidence of acute cardiopulmonary process.
3. Small amount of pneumoperitoneum.

4. Dilated stomach and small bowel.

"

"[**2161-5-12**] 4:55 PM

CT ABDOMEN W/CONTRAST; CT PELVIS W/CONTRAST Clip # [**Clip Number (Radiology) 89905**]

CT 150CC NONIONIC CONTRAST

Reason: eval cecal volvulus

Admitting Diagnosis: STROKE/TIA

Contrast: OPTIRAY Amt: 110

[**Hospital 3**] MEDICAL CONDITION:

75 year old man with abdominal distention. ? cecal volvulus.

REASON FOR THIS EXAMINATION:

eval cecal volvulus

No contraindications for IV contrast

FINAL REPORT (REVISED)

INDICATION: Evaluate for cecal volvulus.

TECHNIQUE: MDCT-acquired axial images from the lung bases to the pubic symphysis were acquired with intravenous contrast and displayed with 5-mm slice thickness. Multiplanar reformations were performed.

CT OF THE ABDOMEN WITH INTRAVENOUS CONTRAST: There is bibasilar atelectasis. The liver and gallbladder, spleen, pancreas, and adrenal glands are unremarkable. The right kidney contains a cyst. An IVC filter is seen in place. The aorta and the major arterial tributaries appear patent. There are

atherosclerotic calcifications along the aorta and iliac vessels. The stomach is fluid filled and the small bowel is decompressed.

The entire colon is air filled and most of the loops are dilated. There is no evidence for a cecal volvulus with the cecum being in its normal location. Fecal material is seen in the cecum. There is no definite evidence for pneumatosis to suggest bowel ischemia. THe SMA and SMV are well opacifidied with no evidense of occlusive ischemia.

There is copious free intraabdominal air. There is a PEG tube which was, according to the surgical team, recently placed and likely explain the free air, with the tube located at the epicenter of peritoneal air collection. No free fluid is seen in the abdomen. No mesenteric or retroperitoneal lymphadenopathy is seen.

CT OF THE PELVIS WITH INTRAVENOUS CONTRAST: There is a caliber change of the dilated descending colon at the transition to the sigmoid colon but no definite obstruction can be seen and there is fluid and air in the rectum. No free pelvic fluid is seen. No pelvic lymphadenopathy is seen. The bladder is unremarkable, containing a Foley catheter. The prostate is not clearly visualized. Note is made of some high density material in some of the colonic loops which may represent old contrast material.

BONE WINDOWS: There are degenerative changes in the lumbar spine and the sacrum. No suspicious lytic or sclerotic lesions are seen.

IMPRESSION:

1. Dilated colon and particularly dilated cecum and ascending colon filled with loose fecal material (>12 cm) without evidence of cecal volvulus or direct evidence of ischemia.
2. Free intraabdominal air, likely due to the recently placed PEG tube.

(Over)

[**2161-5-12**] 4:55 PM

CT ABDOMEN W/CONTRAST; CT PELVIS W/CONTRAST Clip # [**Clip Number (Radiology) 89905**]

CT 150CC NONIONIC CONTRAST

Reason: eval cecal volvulus

Admitting Diagnosis: STROKE/TIA

Contrast: OPTIRAY Amt: 110

FINAL REPORT (REVISED)

(Cont)

3. No pneumatosis or bowel wall thickening to suggest bowel ischemia. The

colonic dilatation may represent an ileus.

4. Simple cyst in right kidney.

RECOMENDATION: Follow up CT in [**7-27**] hours.

"

"[**2161-11-9**] 11:00 AM

MR HEAD W & W/O CONTRAST; MRA BRAIN W/O CONTRAST Clip # [**Clip Number (Radiology) 89433**]

Reason: Rule out mass, vascular malformation

Contrast: MAGNEVIST Amt: 15

[**Hospital 3**] MEDICAL CONDITION:

76 year old man with left temporal hge. Please repat scan to rule out

underlying mass, vascular anomaly

REASON FOR THIS EXAMINATION:

Rule out mass, vascular malformation

FINAL REPORT

MR HEAD

HISTORY: 76-year-old male with left temporal hemorrhage. Please assess for underlying lesions.

MRI BRAIN:

TECHNIQUE: Sagittal pre- and post-gadolinium T1; axial post- gadolinium T1, T2, FLAIR, GRE; and coronal post-gadolinium T1-weighted images were obtained. Axial DWI images were also obtained.

Since [**2161-5-3**], the previously seen left temporal hemorrhage has largely resolved with minimal linear hemosiderin deposition predominantly in the subcortical white matter region. No underlying masses, abnormal enhancement, or vascular malformations are seen.

Again seen are moderate amount of periventricular and subcortical white matter T2 hyperintensities, which likely represent small vessel ischemic changes.

There is also prominence of the ventricles, sulci, and basal cisterns, which likely represent atrophy.

The previously seen soft tissue change of the paranasal sinuses have improved significantly, with some minimal residual within the right maxillary sinus and

the posterior ethmoid air cells.

Prosthetic lenses are seen within the globes bilaterally as before.

No osseous abnormalities are seen.

MRA HEAD:

TECHNIQUE: 3D time-of-flight MRA of the head was performed with maximal intensity projection 3D reconstructions.

FINDINGS: No aneurysms, stenoses, occlusions, or vascular lesions are seen. Note is made of a small right vertebral artery, as before, which is a normal variant.

IMPRESSION: Since [**2161-5-3**], near complete resolution of left temporal hemorrhage with minimal hemosiderin remaining. No underlying masses or

(Over)

[**2161-11-9**] 11:00 AM

MR HEAD W & W/O CONTRAST; MRA BRAIN W/O CONTRAST Clip # [**Clip Number (Radiology) 89433**]

Reason: Rule out mass, vascular malformation

Contrast: MAGNEVIST Amt: 15

FINAL REPORT

(Cont)

vascular malformations. Stable moderate small vessel ischemic changes and mild atrophy.

"

"Resp Care Note:

Pt cont intub upon transferring from ER and placed on mech vent as per Carevue. Lung sounds ess clear suct sm th white sput. ABGs stable on present vent settings. Cont mech vent.

"

"NURSING PROGRESS AND ADMISSION NOTE 2200-0700

REPORT RECEIVED FROM [**Name (NI) **] PT TRANSFERRED TO MICU 685 VIA STRETCHER WITH NO UNTOWARD INCIDENCES. ALL ALARMS ON MONITOR AND VENTILATOR ARE FUNCTIONING PROPERLY. PT'S ENVIRONMENT SECURED FOR SAFETY.

THIS IS A 75 Y/O M PT WITH PMH SIGNIFICANT FOR CAD S/P IMI, CATH IN [**10-19**], HX OF PE, DVT WHILE ON HEPARIN- NOW ON LIFELONG COUMADIN, STREP PNA MENINGITIS ON [**12-19**] WITH ACUTE SYMPTOMATIC SEIZURES THAT PRESENTED TO THE [**Hospital1 95**] ED ON [**2161-5-2**] AT 5PM AS A TRANSFER FROM [**Hospital **] HOSPITAL FOR EVALUATION OF LEFT TEMPORAL INTRAPARENCHYMAL HEMORRAGE. PT HAD BEEN IN HIS USUAL STATE OF HEALTH PRIOR TO THE INCIDENT AND HAD JUST RETURNED FROM HAVING A HAIRCUT WHEN HIS WIFE NOTED THAT HE WAS TALKING GIBBERISH- SPEECH WAS NOT SLURRED, HOWEVER WORD ASSOCIATION WAS [**Name (NI) 11127**] PT WALKED INTO [**Hospital1 **] OF HIS OWN [**Location (un) **]- HEAD CT SIGNIFICANT FOR LT TEMPORAL LOBAR BLEED. ON ARRIVAL TO [**Hospital1 95**] [**Name (NI) **] PT NOTED TO HAVE BRADYCARDIA TO THE 30'S AAND SBP IN THE 200'S. BOLUSED WITH PROPOFOL AND GTT STARTED- DILANTIN LOAD- TX TO MICU FOR AS TSICU BORDER.

NEURO: RECEIVED PT SEDATED ON 60MCG/KG/MIN OF PROPOFOL GTT- ABLE TO WEAN DOWN TO 20MCG/KG/MIN- WILL SWITCH PROPOFOL TO PRECEDEX GTT FOR EASY WEAN OFF OF SEDATION- HOPING FOR QUICK EXTUBATION. PERRLA, 3/BRISK. PT WILL GET VERY AGITATED WHEN SEDATION LIGHTENED- NORMAL STRENGTH NOTED TO ALL EXTREMITIES. BRISK MOVEMENTS WHEN STIMULATED. DOES NOT FOLLOW COMMANDS NOR OPEN EYES SPONTANEOUSLY. LOW GRADE TEMPS OF 100F. NO SEIZURE ACTIVITY NOTED. DILANTIN DOSING INITIATED. PT TO HAVE MRI/A TODAY.

RR: INTUBATED. OETT IS SECURE AND PATENT. PT TO REMAIN INTUBATED AND SEDATED FOR MRI. BBS= ESSENTIALLY COARSE TO ALL LUNG FIELDS. STRONG COUGH EFFORT AND GAG. CURRENT VENT SETTINGS ARE AC/12/600/500/50%. SP02 > OR = TO 95%. SUCTIONING FOR SCANT CLEAR TO WHITE SECRETIONS.

CV: S1 AND S2 AS PER AUSCULTATION. PT HAS BEEN BRADYCARDIC MOST OF SHIFT- WILL DROP HR TO THE LOW 30'S- ACCORDING TO HIS WIFE0 THIS IS HIS NORM- HOWEVER, WHEN STIMULATED- HR STAYS IN THE 60-80'S. NO SIGNS OF ECTOPY NOTED. SBP > OR = TO 100- WOULD LIKE SBP < 140- TREATING WITH Q6 HOUR HYDRALIZINE WITH THERAPEUTIC EFFECT. RT RADIAL ALINE INSERTION WITH NO UNTOWARD INCIDENT. REZEROED AND RECALIBRATED DURING THE SHIFT. PT HAS 3 #18PIVS- ALL ARE SECURE AND PATENT. ELECTROLYTE REPLETION- CURRENTLY RECEIVING 40MEQ K AND RECEIVED 2 GMS OF MAG. GOAL IS FOR INR < 1.4- RECEIVED TOTAL OF 10MG OF VITAMIN K AND 4U FFP. NO BLOOD TRANSFUSION REACTION NOTED.

GI: ABD IS SOFT, DISTENDED. BS X 4 QUADRANTS. PASSING FLATUS. NO BM THIS SHIFT. NPO.

GU: INDWELLING FOLEY CATHETER IS SECURE AND PATENT. CLEAR, AMBER URINE NOTED IN ADEQUATE AMOUNTS.

INTEG: GROSSLY INTACT.

SOCIAL: WIFE IN TO VISIT AND SPOKE TO NEURO TEAM AT LENGTH. NO ISSUES.

PLAN:

EEG

Q 1-2 HOUR NEURO CHECKS.

INR < 1.4, PLT > 100, HCT > 30.

GOAL SBP < 140-150.

MRI/MRA WITH CONTRAST TO R/O UNDERLYING VASCULAR ANOMALY, ANEURISM.

QUICK EXTUBATION- WILL NEED TO SWITCH PROPOFOL TO PRECEDEX.

FULL CODE.

PLEA

"

"Respiratory Care Mote:

Pt was on med conc mask and ABG showed CO2 ~110's. WE tried spont mask ventilation, but PT aws apneic. He was intubated with No complications. We are sxtn mod to copious of thick tan to bloody secretions from EET. Plan: Continue present ICU monitoring and wean as tolerate.

.

"

"assessment as noted

res: with co2 >130 last night, was reintubated at [**2155**] to ventilate.down to cpap this am, suctioned for large amnt thick tan-culture was sent.

neuro: obtunded and [**Year (4 digits) **] last night, became mre and more awake after was intubated. when pco2 was <50 pt started follow commands and move all extremeties , went to ct head last night which was unchanged

cv:sick sinus syndrome persist stable with rare pvcs, kphos 30 meq was started this am, did not get any more lasix, ++pulses, no edema

gi: t feeding was started shortly after intubation, tol well, no stool, + bs, soft abdomen

social: ho talked to pt wife after intubation and informed her

plan: wean off vent, monitor co2, pulm toilet, ?rehab screening

"

"T-SICu Nsg note

This am, pt alert, looking at speaker, mouthing words, following commands. Pt was on CPAP all morning. Bronchoscopy done. Pt cont. with strong prod cough and copious sptum - tan, thick blood tinged. Pt more lethargic toward noon. O2 sats falling to 88-90%. PEEP increased and O2 sats improved. Pt continued to be lethargic and more difficult to arouse, would not open eyes, nor follow commands. ABG sent with PaCO2 63, so pt placed on IMV with improved alertness. Diminished breath sounds at bases, coarse anteriorly.

[**Name (NI) 15**] wife in this am to visit, but pt lethargic at that time and not very interactive.

Advancing TF toward goal of 80cc/hr. Pt has had liquid stools.

Continues with short sinus pauses that monitor calculates as HR < 40.

A: Pt back on IMV for hypoventilation. More alert with improved ventilation.

P hold TF at MN for possible extubation [**5-6**].

"

"TSICU NPN 1500-1900

Pt opening eyes to command, inconsistantly following commands, mouthing words. Vital signs stable with improved ABG. Continue to advance TF as tolerated.

"

"res: remains on SIMV with abg wnl, sedated overnight on prppofol which was stopped 0630am.suctioned for thick tan sputum mod amnts. extubation is planned for today

gi: tf was stopped midnight, stooling liquid brown, m/r cath was inserted

cv: in sr/s.brady, bp asymptomatic, a/lone positional

neuro: aggitated and combative when off sedation, follows simple commands, mae, +gag, +cough

gu: dark 50-100/h

plan: try to wean off vent/extubate, monitor cv, neuro

"

"Respiratoey Care Note:

Pt remain orally intubated on vent support and got sedated last night due to agitation. No vent changes done. We are sxtn for mod amt of thick tan secretions from ETT. Plan: Continue present ICU monitoring. Will follow.

"

"Resp Care:

Patient weaned from SIMV to PSV for several hours. Changed to MMV with back up of 4.8 lpm due to periods of apnea. See Carevue flowsheet for details.

"

"TSICU NPN 0700-1900

REVIEW OF SYSTEMS:

NEURO: Pt remains sedated on Propofol, increased to 20-30mcg/kg/min. When called by name, pt sometimes opens eyes and mouths words. Moves all four extremities on bed. Does not follow commands. Withdraws to painful stimuli. Pupils 5mm, briskly reactive.

CV: SR 50-70's with occasional PVC's. SBP ranging 120-130's. Lisinopril started today. P-boots intact. Right radial arterial line positional at times.

RESP: Remains orally intubated, placed on CPAP this afternoon. Due to apenic events, placed on MMV this evening. ABG pending at this time. Suctioned for moderate amts thick tan secretions. Bloody sputum this am, which has now resolved. LS coarse, diminished at bases.

ID: TMAX 100.1. Levaquin for abx coverage.

GI: Abd soft, slightly distended. Positive BS. TF infusing via dophoff tube. Currently at 50cc/hr, goal 80cc/hr. Mushroom cath draining liquid stool.

SKIN: Left hand swollen due to old IV infiltrate. Backside intact.

SOCIAL: Wife into visit today, update given.

PLAN: ? trach later in week. Advance TF, Wean vent as tolerated.

"

"Resp care Note

Pt was unable to maintain adequate ventilation on MMV to prevent resp acidosis. SIMV was resumed at previous settings, AGB now showing compensated resp acidosis with Pco2 @ baseline. Current settings are 600 x 14, 40%, ps 10 / + 10 peep.

"

"resp care

Pt initially ventilated on psv10/peep8 and 40%. Pt essentially stopped breathing and was just getting backup ventilation. Abg revealed resp acidosis. Pt placed on imv 600x14 40% 8peep/10psv. Morning abg revealed resp alkalosis-rate reduced to 10. Will cont to follow and place back on psv this am.

"

"T/SICU Shift Report 1900-0730

75 Year Old Male NKA FULL CODE Univeral Precautions

Admission [**2161-5-2**] - L Temporal Hemorrhage

PMH - CAD

Sick Sinus Syndrome

Pneumonia

Obstructive sleep apnea

Mild Pulomonary hypertension

PE ([**2153**])

DVT

R Rotator cuff repair

Patient admitted to T/SICU following L temporal stroke, with consequent failure to wean from ventilation. Scheduled for Trach/PEG today.

Review of Systems:

Resp - Fully ventilated on SIMV/PS PEEP 8 PS 10 10x500 FiO2 40%. Acidotic on MMV at beginning of shift. 0200 abg on SIMV pH 7.55, PaCO2 40, PaO2 147. RR reduced to 10x500, abg pending. Breath sounds clear to coarse throughout, with copious thick yellow secretions on ETT suction, also has copious volumes of thick offensive secretions from mouth.

CVS - Sinus bradycardia HR 50-70bpm, SBP 110-130, Tmax 100.3. Peripherally warm/well perfused/strong palpable pulses. 0200 labs, HCT down to 35.9%, Hb down to 11.9, WCC down to 5.0, lactate 0.6. Coags WNL. Continues on vancomycin (random level sent 0200).

Renal - UO 80-180ml/hr, 24hour balance +1150. BUN/Creatinine WNL. K+ 3.7 (after repletion with 80mEq PO), Mg 1.8, Ion Ca 1.18. Maintenance fluid 80ml/hr NS whilst NPO for OR.

Neuro - GCS 10 (e3v1m6), only able to show tongue to command, withdraws extremities to noxious stimuli. Unable to assess orientation due to ETT. Pupils 3mm/3mm reactive. Making purposeful movements towards the ETT, MAE. Mildly sedated with 15mcg/kg/min. No evidence of pain.

GI - TF stopped from midnight for OR, currently NPO. Abdomen soft/nontender/+ve bowel sounds. Mushroom catheter in situ with minimal liquid brown stool overnight. Blood glucose stable without insulin.

Skin - Full bed bath this am, tolerating 4 hourly turns. Pressure areas intact.

Access - Aline patent, taped to board with good effect. 2xperipheral cannula patent.

Family - Wife called overnight for an update, will visit pre-op at 11am, will call before coming in.

PLAN - OR for Trach/PEG

Attempt to place back on PS ventilation

Replete Mg

Replete K

"

"Respiratory Care Note:

Patient received a #8 Portex percutaneous trach today. He tolerated procedure well. BS=bilat. Suctioned for small amount of blood tinged sputum. He remains on SIMV at this time. Will wean as tolerated.

"

"nursing progress note

events: bedside trach, peg placed today by surgery team w/ no incident. pt tolerated procedures well, see flowsheet for vs trends during each. o2 sats stable since trach placement, pt overbreathing vent to 20s.

neuro: moving all extrem well, good strength noted to all, slightly weaker to right side. note right side neglect ongoing, cough intact, gag, swallow impaired. perrla, 3mm. [** 3247**] intact. following commands well, nods and shakes head to questions.

resp: simv+ps continued, peep weaned to 5 this pm. trach tolerated well thus far, sx mod amts thick bloody secretions since insertion. o2 sats stable, rr high teens to 20s w/ stimulus. ls clear, intermittently coarse to upper fields, clearing w/ sx.

cv: bp stable, sinus brady, rate down to high 30s transiently, self limiting. occas. pac's noted w/ episodes. ppp to all extrem, warm.

gi: peg patent for meds since insertion, pt tol well. scant amt bloody drainage to site, dsd intact. belly soft/round, bs present. +flatus, no bm today. mushroom cath pulled by pt this am, no further stools.

gu: foley patent clear green tinged urine, adeq volumes.

id: tmax 99.7, levaquin, vanco dosing continued. vanco level this am 13.4.

endo: bg's stable, no sliding scale coverage needed.

skin: no issues.

social: wife in to visit today, all ques answered, support offered ongoing.

a/p: s/p trach, peg placement, ventilatory status remains adequate post trach. peep weaned this pm, will monitor abg. plan to restart tf tonight, more aggressive vent, sedation weaning if tolerated. initiate rehab screening when able.

"

"T/SICU Nursing Progress Note

S:

O: Review of systems

Neuro: sedated on low dose propofol. Very quiet when undisturbed. When propofol off, pt moves all extremities equally and purposefully. Will open eyes to name but does not follow commands. Begins coughing on ET tube becomes red in face then purple very quickly. Continues on dilantin. No seizures noted.

CVS: sinus brady with occ pvd. BP stable. Peripheral pulses present

RESP; orally intubated. Changed to SIMV 14X600 50% 10 peep. Suctioned for thick blood tinged secretions. Decrease breath sounds in bases. CXR from [**5-5**] shows LL lobe atelectasis, and R basiliar lobe atelectasis. ABG shows CO2 49/O2 115/7.46/+10.

RENAL: adequate urine output, normal BUN/Cr. K+ low at 3.2, received 40 meq per feeding tube at 5am.

GI: on fs promote currently at 70/hr, last increased at 4am. Goal is 90cc/hr to be increased by 10cc q 6 hours. Belly soft with bowel sounds. On lanzoprazole for prophylaxis. Mushroom catheter in place with very water diarrhea.

ENDO: on SSRI, last bs 115.

Heme; IVC filter placed earlier in week, on sq heparin, pneumoboots, hct 36.1, nl inr.

ID: on levoquin, vanco for Gram + cocci and gram neg rods in sputum. WBC 5.3. T max 100.3

SKIN: Keeps head turned to left. Has continuous oral secretions which can pool on L shoulder. Some stasis changed to lower legs. Probably oral thrush. Other skin intact.

LINES: new 20G angio place L hand. Also has 18g angio L antecubital. L radial art line in place.

SOCIAL: no calls from wife tonight.

A: s/p intercranial hemorrhage with decreased mental status and inability to maintain airway.

P: continue to advance tube feedings to goal. ??send stool for c diff.

continue current antibiotics. ??need for trach. Wean propofol as tolerated. Support family with information.

"

"Respiratory Care Note:

Patient weaned to MMV with back up of 4.8lpm, breathing spontaneously at times with little support from vent and other times the vent takes over. See trends on [**Last Name (un) **] screen. ET tube resecured. bS coarse at times bilat. Suctioned for thick yellowish secretions. Heated circuit placed on vent for added humidification. Plan for tracheotomy [**5-8**]. Will continue monitoring and providing supportive care.

"

"NPN 2p-7p

neuro- pt opens eyes, moves all ext, puropesful movement , but no movement to command. lightly sedated on propofol. PERL. 3=. + cough and gag. cont on dialntin, no sz activity.

cv- SR-SB, sbp 100's. maps in 70's. + peripheral pedal pulses. cont on po lisinopril. A-line wnl.

resp- lung sounds coarse to clear. cont to be vented,MMV 40% spont rate 11-17 TV 750 MV6.5. peep decreased to 8 from 10. tol well pao2 at 93. PS cont at 10. + cough thick yellow sputum. cpoeous oral and nasal secreations.

renal- marginal u/o + 1 liter today. lytes monitored . K to be replaced. IVF hl.

GI- cont clear-brown liquid stool. spec sent for c-diff. abd large but soft + BS. mushroom cath in. post pyloric tube for feeding. promote with fiber at 80/hr. goal 90/hr. 100cc residual at 4pm. tf held x 2 hrs. restarted at 6pm.

endo- bs monitored no s/s coverage needed.

ID- t-max 100.4 cont on levoflox.

soc- wife in to visit.

plan- trach tommorrow at 1pm. conscents not yet signed by wife. NPO after mid. cont to attempt to wean vent to prepare for trach.

2 more stools needed for c-diff spec.

"

"TSICU NPN

O: ros

Neuro: pt is lethargic and slow to respond at times but mae and consistently follows commands. Nodding appropriately and attempts to mouth words. pearl 3mm bilat. Strong cough but gag remains weak. Remains sedated on low dose propofol. Increased to 30 mcg/kg/hr d/t increased restlessness and climbing oob. Easily arousable on this dose.

CV: hr 40's nsb and upto 70's nsr w/ stimulation. No ectopy. Stable bp overnoc. (see carevue)

Resp: vented on simv/ps initially 600x10, 40% and 5peep. Pt does not overbreathe when asleep. pc02 rising and rate increased to 13. Pt initially plugging with thick secretions and coarse bs throughout. Desat to 88% despite pulm toilet. 02sat lower with L side down. Peep increased to 8 with improvement.

Renal: Adequate u/o via foley. Lytes repleted. ivf maintainance at 80cc. Body balance sl positive.

GI: PEG in place and tf restarted and at 60cc/hr with residuals of 10cc. Abd soft-distended. +bs, -flatus. Denies nausea,

ENDO: No SS insulin required.

Heme: stable

ID: Cont on abx. levoquin dose increased. Tmax 100.

Skin: Intact

A: Hemodynamically stable w/ bradycardia. No change in nvs. Altered pulm status, failure to wean.

P: cont to monitor and support systems. Vigorous pulm toilet. Wean as tolerated. Cont to monitor nvs. Abx. Pt ready for rehab screening.

"

"Resp Care Note:

Pt cont trached and on mech vent as per Carevue. Lung sounds coarse suct sm th tan sput. Most currnt ABGs stable after RR increaesd. Cont mech vent support.

"

"S/P Stroke

Pt alert, mouthing words occasionally, follows commands. He gets restless and attempts to climb out of bed. Low dose Propofol with good effect.

SB with PVCs. Aline is postional but BP stable. IVF@KVO. Pneumoboots on.

Attempted to wean IMV but CO2 rising. Suctioned for thick yellow sputum. Strong cough. Trach site looks good. Breath sounds clear, diminished in bases. O2 sats 93-97% on FiO2 50%. Sats lower when left side down.

Pt tolerating tube feeds at goal without residual. Abd. soft and distended. No stool.

Urine output good.

[**Name (NI) 15**] wife visited and updated. She appears to be well informed.

Plan: Attempt vent wean tomorrow; increase rehab as tolerated.

"

"ASSESSMENT AS NOTED IN CAREVUE

RES: REMAINS ON SIMV, PCO2 IN 50S, ON PROPOFOL OVERNIGHT, LS CLEAR/COARSE, STRONG CONGESTED COUGH, SUCTIONED FOR SM AMNT TAN SPUTUM, DROOLING A LOT

CV:IN S.BRADY MOST OF THE NIGHT, BP STABLE, NO EDEMA, + PULSES

NEURO: MAE WHEN AWAKE OFF SEDATION, +FOLLOWS SIMPLE COMMANDS, IMPARED GAG.NO SEIZURES, CONT ON DILANTIN [**Last Name (un) 11128**]

GI: TOL TF WELL AT THE GOAL 90/H, STOOLING Q2-Q3H [**Male First Name (un) 714**] LIKE LOOSE

DENIES NAUSEA

SKIN: INTACT, DIAPHORETIC A T TIMES, BECOMES FLUSHED FACED WHEN COUGHING-PURPLE

ID: VANCO LEVEL WAS SEND, CONT ON DOXYCILLIN, LOW GRADE TEMP 99+ ORALY

PLAN: REHAB SCREENING, TRY TO WEAN VENT SETTINGS, PULM TOILET

"

"RESPIRATORY CARE:

Pt remains intubated, vent supported. No changes overnight. BS's diminished, sxing small amount bloody secretions. See flowsheet for further pt data. Will follow.

"

"p/s cont plan: stool for c-diff, to chair

"

"Resp. care note - Pt. remaines trached and vented weaned to PSV tol ok at this time.

"

"T/SICU NPN

Brief ROS:

[**Name (NI) **] Pt. is unable to communicate with trach in place but he attempts by mouthing words almost constantly. He nods appropriately to questions but he also continues to mouth words after nurse has explained difficulty in [**Location (un) **] lips. He is alert all shift today, no naps. Pt. moves all

extremities, requires soft restarints to arms. Rt arm is somewhat weaker than the left arm but gd strength. Both legs move all about in bed, over rails etc.. Follows commands with moving extremities, tries to help with turns. Cooperative and mostly appropriate but has been restless all day. Rcv'd 2mg morphine for pain earlier today and may recieve ativan 1mg for anxiety if needed. Sml amt of propofol continues, 20mcg, less effective in quieting pt. today.

CV- Stable BP and HR. HR remains slow, sinus brady wit rare to occ pvc's. He recieved po KCl (60 meq) for K+ 3.5. Skin warm and dry. Palpable periph pulses, pale.

Resp- Has tolerated CPAP today, peep 10 and ps of 8. Gd sats throughout and a gd abg. Suctioning occ for scant amts of secretions. RR20's Breath sounds vary, between coarse to clear. Trach site clean and dry.

GI- Tolerates tube feeds at goal. Belly soft and slightly distended. Attempted a BM today, no luck as yet. No BM's this shift, waiting to obtain sample to send for c diff etc..

GU- Adequate u/o via foley. Dark urine.

Heme/ID- Pneumo boots on. No heme issues. Afeb

Endo- FS BS not requiring insulin coverage.

Skin- Generally intact throughout. Slightly rashy looking back, only mild.

"

"FUll CODE NKDA Universal Precautions

Neuro: Awake, alert, mouthing words - difficult to understand him - ?orientation. MAEx4 spont/command. Stood and Pivoted to get BTB this afternoon w/ fairly good strength. Assists to turn

and push himself up in the bed. Continues to be a bit squirmy in the bed/chair - propofol was d/'d this am and started on haldol po prn.

CV: HR=50-60s, NSR, occ PVCs. Occ drops HR to 30s for a few beats and comes right back up to 50-60s. BP=110-120/50s. Lopressor 25mg po BID started. Periph pulses +, extrems warm, no edema.

Resp: CPAP/PS 50% 8/8 this am and tol ok - ABG 7.54/28/150/25. Diamox started. Will attempt trach mask this afternoon. Lungs coarse, but clears w/ coughing/sductioning. Great cough effort producing thick yellow sputum. RR=18-26.

GI/GU: abd large, distended/firm. +BS, no BM. Started on bowel regime - colace [**Hospital1 **], biscodyl prn (not gieven yet) and a one time dose of mag citrate - given this afternoon after pt got BTB. He has hemorrhoid at anus which has a small clot that's been oozing a bit thru the day. Dr. [**First Name (STitle) 1076**] assessed this before I gave the Mag Citrate. P t also needs a c-dif spec. Pt also has FS Promote w/ Fiber via PEG at 75cc/hr (goal) - decreased from 90cc/hr. Resids minimal. Foley cath w/ dark amber/brown urine - responded to diamox. - Want him 1-2 liters neg - may add lasix.

Pain: Pt denies pain.

Skin: intact

ID: 98.9 - on dicloxacillin and levaquin.

Endo: FS covered w/ RISS

Social: Wife in today - Spoke w/ [**First Name4 (NamePattern1) 975**] [**Last Name (NamePattern1) 1351**] (case management) about rehab.

Plan: Wean to trach collar if tol. Pulm toilet. Diuresis as ordered. Bowel regime - send c-diff spec when obtained. Monitor resp/neuro/cardiac status.

"

"Attempted trach collar 50% and pt tol x1 hour, then 02sat to mid 80s, RR 30s. Placed back on CPAP/PS [**9-22**] 50%.

"

"Respiratory Care

Pt weaned on PSV and at 1800 trialing on 50% trach mask. Plan to continue trachmask wean as tol.

"

"RESPIRATORY CARE:

Pt remains trached, vent supported. Vent support changed overnight to AC for periods of apnea. BS's diminished, sxing small amts tan secretions. See flowsheet for further pt data.

Plan: Back to PSV as tolerated. Will follow.

"

"t-sicu nsg note:

neuro- slept well following haldol, easily arousable, following commands, nods and smiles approp. moves all extrems w/ gd strength.

resp- sxn for mod amts thick yellow creamy secretions, sao2 94-98%, back on rate to rest overnight d/t periods of apnea.

cvs- tm 99.6po, sbp 120's-130's, hr 60's-70's nsr w/ occ-.freq pvc depending on K+level at the time, 80meq po kcl given over night. pt had 1 episode of hr~20 w/ resultant sbp 80's. prior to being placed back on vent.

gi- tol promote w/ fiber @ goal rate of 75cc/hr via gtube. abd very distended and firm, pt passed lg amt of watery clear mucus w/ brb streaks from hemorrhoid. +bs, no flatus.

gu- diureses well following diamox dose. clear amber urine.

skin- intact.

endo- bs covered w/ riss.

a: pt slept well, alert and smiling this am. ? need for KUB

p: monitor cvs/nvs per routine, enc ^ mobility and arom, reorient frequently, oob to chair as tol. assess bowel status. aggressive pulmonary hygiene, trach collar trial.

"

"resp care

Pt initially on 10psv/8peep but was switched back to imv after sedation. Currentl;y pt is on imv 600x12 50% 10psv and 8peep. Suct for thick tan sput. Will change back to psv when more awake.

"

"cv:hr 57-71 sb to nsr occasional pvc. bp 100-155/55-80.

neuro: pt restless. moving all around . placing legs over sssside rails. propophol at 20 mics/kg/min. requiring occasional bolus to turn patient. dr [**Last Name (STitle) **] and one time dose of ativan 1 mg iv given with good effect.. pt slept for ~ 3 hours.

gi: gtube feeding promote with fiber at 90 cc/hr. abdomen very distended. much gas via gtube. some mucoid drainage from rectum..very foul fishy7 smell. ? very large hemmoroid in anal canal.moderate sanguinous drainage at rectum and several small clots at rectum. no stool available as of yet for c difficile. if stool please send spec for c diff. dr [**Last Name (STitle) **] notified of abd distension and rectal bleeding and ?? hemorroid.hct is stable.

gu: foley draining yellow urine in adequated amounts 50-100 cc/hr

resp: rested on rate overnoc secondary to decrease resp rate after ativan. this a.m. awake so placed back on pressure support and doing well. see careview for abg which was drawn on resting vent settings.

suctioned for thick tan via trach.

"

"TSICU NPN 0700-1900

EVENTS: Pt's abd remains distended. KUB obtained this am which showed bowel full of stool. Soap suds enema given with little effect. Mag citrate, colace and milk of mag given with no effect. Surgery team c/s due to increased distention. To abd CT at 1700 which showed dialated bowel throughout. GI team to be

c/s - ? decompression of abd. TF on hold. G-tube to gravity, draining total of 750cc this shift. Lactate 0.6 at this time.

REVIEW OF SYSTEMS:

NEURO: Pt very alert, appropriate. Answers questions by mouthing words/nodding head. Less anxious today. OOB to chair X 1 1/2 hours this afternoon. Moves all extremities, follows commands.

CV: SR/SB 50-60's with occasional PVC's. At times pt's HR down to low 30's with coughing. EP c/s this am, feel no pacemaker needed at this time. SBP ranging 110-130's. Right arterial line dampens at times, positional. Potassium repleted. P-boots intact.

RESP: Placed on Trach collar with high flow neb at 1100, pt tolerating well. SATS 91-98%. LS coarse, diminished at bases. Suctioned for thick yellow sputum. Last ABG with metabolic acidosis 7.28/60/210/29/0. Currently on 60% FIO2.

ENDO: No coverage needed per RISS.

GI: Abd firmly distended. NPO. G-tube to gravity. Positive BS. See above events.

GU: Foley draining clear yellow urine. Diamox and Lasix given for diuresis.

SKIN: Skin intact.

SOCIAL: Wife called this am. Did not visit today, as she travels 70 miles/day when visiting. Will be in tomorrow.

PLAN: Monitor abd. ? GI decompress abd. Transfer to rehab when ready. (pt currently being screened for [**Hospital1 **]).

"

"Respiratory CARE

Pt weaned to High flow trach mask 40-60%, Pt with increased belly size and abd pain, to cat-scan. Last abg on 60% 728/60/210/29/0/94 .

"

"TSICU NPN 0700-1900

REVIEW OF SYSTEMS:

NEURO: Alert, very appropriate, nodding yes and no/mouthing words to communicate. Moves all extremities. Follows commands.

CV: SB 40-60's with rare PVC's/PAC's. SBP ranging 120-140's. Right radial arterial line dampens at times, positional. D5 1/2 NS with 20 K@ 125cc/hr. Potassium repleted.

RESP: Placed on Trach collar with high flow mask, 50% FIO2 this am. Pt tolerating well with ABG 7.40/47/106/30/2. SATS 94-99%. LS clear, diminished at bases. Coughs up thick white secretions on own.

ID: TMAX 99.3. Abx coverage finished today.

ENDO: No coverage needed per [** 1874**].

GI: Abd slihgtly distended, much improved since yesterday. Positive BS. Remains NPO. Rectal tube intact, draining 700cc brown liquid stool this shift.

GU: Foley draining clear yellow urine. Adequate UO.

ACTIVITY: OOB to chair X 2 assist. In chair X 4 hours.

SKIN: Red heat rash noted to back, intact.

SOCIAL: Wife into visit today. Pleased with pt's progress. Currently being screened for vent rehab.

PLAN: ? rest on vent overnight, ? re-start TF tomorrow, currently being screened for rehab at cape.

"

"REspiratory care

Pt spent all day on 50% aerosol without any desats 740/[**Numeric Identifier 11129**]/30/2. Plan to place pt on [**6-19**] mmv overnight to deal with apnea spells and allow pt a good night sleep.

"

"assessment as noted in carevue

res: on trach mask 50% overnight, a/line out - no abg drawn, maintains so2>95, + strong prod cough - yellow thick sputum. trach intact, ls clear

cv: stable bp by cuff in nsr, + pulses, no edema

gi: mushroom cath in and draining liq stool, g/tube to gravity, +bs, abd soft

neuro: was confused and aggitated last night and was restrained , fell asleep later and was more cooperative. grossly intact, mouthtalks

labs: got mag, k, phos

id: temp 99-98,

plan: pulm toilet, rehab, ?to start feeding

"

"TSICU NPN 0700-1900

REVIEW OF SYSTEMS:

EVENTS: Pt very alert this am, passy [**Last Name (un) **] valve placed and pt speaking, yet not making sense at times. Expressive aphasia noted. Pt then placed on trach mask. Pt became less responsive and not easily arousable. Later placed on AC mode, pt then became very appropriate - following commands and interacting with wife and this RN.

NEURO: At times pt alert and very appropriate. Other times, pt less responsive- grimices to sternal rub - yet not opening eyes. Moves all extremities with good strength. Follows commands. Pupils equal and reactive.

RESP: Currently on AC mode 600X12, 8 PEEP, 50% FIO2 with SATS 94-97%. LS clear, diminished at bases. Suctioned for thick tan secretions.

CV: SB 40-60's with occasional PVC's noted. SBP ranging 100-130's. D2 with 40K @ 125cc/hr. TMAX 100.3.

ENDO: No coverage needed per [**Last Name (un) 1874**].

GI: Abd soft, slightly distended. Rectal tube DC'd. No stool since. TF started, advancing Q4/hr. Currently at 30cc/hr. No residuals noted.

GU: Foley draining clear yellow urine. Adequate UO.

SKIN: Multiple brusies noted to bilteral upper extremities.

SOCIAL: Wife into visit today. Discouraged with pt confused at times.

PLAN: Transfer to rehab when bed ready. Wean from vent as tolerated.

"

"NPN

NO Majot events FULL Code universal precautions

Neuro: somnalent during noc w/ long spells of apne, requiring retiun to vent, Follows commands, MAE.

CV: SR, freq VEA; 50-80. MAP>60, even during relative brady of 40.

Pulse palpable throughour; 1+ anasarca.

Pulm: BS course throughout; dim bases. Thick yellow secretions. Long periods of apnea during noc, requiring return to vent. CO2 climbed to 87, but reruned to pt baseline, 57.

GI: mushroom cath placed w/ large volume(>1000cc) liquid brown stool and large amt flatus. Abd softly distended now w/ hypoactive BS. G-tube remains to gravity, draining bile. NPO

GU: F/C urine clear amber, 20-50cc/hr. Diuretics d/c'd

Skeletal: skin grossly intact. G-tube site pink. A-line red at site, dampened.

Endo: [**Last Name (LF) 1874**], [**First Name3 (LF) **] requirements

ID: Tmax 99.4, po. Pan cx per surgery request. Cdif and O/P stool sent. Cont on po dicloxicillin.

P: cont decompression of bowel w/ rectal tube. Switch to IV antbx until TF resumes. Trach mask, OOB.

"

"S: The patient is trached and reports feeling anxious at times.

O:

General: Ill-appearing 75 yo male in NAD lying in supine position in bed, confused in restraints.

Neuro: Oriented to self only. Obeys commands. Medicated with Haldol.

CV: Bradycardic to high 40s-low 50s in sinus rhythm. Hypertensive to 160s/60s intermitently. Qtc 0.43 while on Haldol.

Resp: Received on trach collar. Patient somulent and difficult to arouse. ABG revealed PCO2 70. Returned to C-PAP 5/5 with resolution of MS change. LSCTA b/l. Performed trach care.

PV: No edema. Pneumosleeves intact. +3 pedal pulses b/l. Nail beds pink with prompt cap refill. Access:(2) L PIV clean, dry and intact.

GI/GU: Rounded abdomen. Soft with +BS. G-tube to gravity, dressing is clean, dry and intact. Maintenance fluid of D5W infusing at 125/cc/hr. Voiding amber urine via foley catheter. Mushroom catheter draining dark brown liquid stool.

Skin: Pale in color with some areas of ecchymosis on forearms. No lesions. MM moist. Turned patient Q2H to promote skin integrity.

Musk: MAE.

Endo: SSRI per FS BS.

A:

Impaired gas exchange R/T hypercarbia.

Ineffective airway clearance R/T trach

Anxiety and powerlessness R/T disease process.

Risk for impaired skin integrity R/T immobility.

Risk for falls R/T restlessness

P:

Wean from the vent as tolerated and maintain hemodynamic status.

Provide emotional support to patient and family.

Maintain patient safety.

Assess pt's mental status.

Provide medication to relieve anxiety as ordered.

"

"ADdendum:

Speech up to evaluate pt-passey-muir in place. Tolerating well thus far. Clear voice. Cuff deflated.

"

"Resp Care

Pt is now on AC, pt becomes somulent and acidotic on TM. Pt also has prolong periods of apnea on PSV. Plan to continue resp support.

"

"T/SICU NPN: 1500-2300

S/O: System Review:

Neuro: mental status waxing/[**Doctor Last Name 704**] periods of wakefulness--alert

moving all extremities to command although RLL with less movement

answering questions with nodding head yes/no or mouthing words

TO periods of less responsive--sternal rub>>>+facial grimacing although not consistently opening eyes and moving extremities UE>LE

PERRL 3-4mm brisk reaction intact [**Doctor Last Name 3247**] intact gag/cough

CVS: HR 40-60's NSB to NSR with PAC's and PVC's SBP 90-160's

BP on higher side with increased wakefulness +palpable pedal pulses

Respiratory: remains trached @ 1545 Sao2 alarming for 85% Pt with respiratory effort on trach mask with passe-muir valve on

pt with minimal responsiveness passe-muir valve removed/trach cuff inflated suctioned for minimal secretions T/SICU md notified

placed back on ventilator--psv ps=5 RR low teens tv's initially 200's and then slowly climbed to 500's continued issues with sao2--hovering around low 90's% peep increased to 8 sa02 eventually settling out in high 90's% pt still with minimal responsiveness

ABG: 96-64-7.34-36+5 at this time

@1730 pt ventilator alarming for apnea>>>apena ventilation

T/SICU md notified pt placed on AC [**Medical Record Number 8598**]%

@[**2155**] pt awoke placed back on psv ps=5 RR high teens to low 20's with tv's 500-600's sao2 high 90's % doing well until ~2230 ventilator ringing off for apnea/apnea ventilation again with falling sats to high 80's to low 90's% and minimal responsiveness

T/SICU MD notified placed back on AC [**Medical Record Number 8598**]%

breath sounds diminished to clear suctioned for thick white secretions

Renal: foley patent and draining clear yellow urine u/o 30-220cc/hr

K+ 3.0 received total 20meq kcl(plus 10meq the prior shift) K+ 3.3 received another 10meq kcl iv and 40meq kcl added to ivf

GI: abdomen: soft +bs + stool mushroom catheter in place with liquid brown stool--100cc per shift on pepcid remains NPO

g-tube to gravity--draining light green fluid--300cc per shift

D5W with 40meq kcl at 125cc/hr

Endocrine: [**2155**] blood sugar 114 no insulin required

Heme: on asa on heparin on pneumoboots

ID: tmax 100.6 on no antibiotics

Skin: back/buttocks intact with no redness

Psychosocial: wife called updated on clinical situation questions answered wife plans to visit tomorrow

A: issues with apnea and responsiveness

P: continue to monitor above parameters keep on assist control overnight

"

"RESPIRATORY CARE 1900-0700

PT REMAINS [**Name (NI) 76**] ON VENT SUPPORT. PT KEPT HAVING PERIODS OF DESATURATION IN MID 80'S AND PERIODS OF APNEA > 20 SEC ON CPAP+PS, SWITCHED TO AC MODE, TOLERATING THIS MODE WELL. PT SX FOR MODERATE AMT OF THICK WHITE SECRETIONS.

"

"T/SICU RN Progress Note

Patient transferred from SICU at 1030, transfered from PACU to SICU at 0630.

Neuro: Alert, aphasic, confused, speaking with Passy Muir valve. Following commands.

CV: HR 40-60's SB with some ectopy noted. ABP systolic 140-160. P-boots, SQ Heparin, ASA.

Resp: SIMV vent support and trach mask toleraing well. Lungs clear suctioned for some blood tinged secretions.

GU/GI: Foley with clear yellow urine. NPO, PEG started wtih Promote with fiber at 20cc/hr not to advance, reglan, pepcid, colace, no BM.

Skin/Mobility: Skin grossly intact, OOB stand/walk/pivot to chair up for about 2hrs tolerated well.

ID: Afebrile

Social: Wife in updated and support given.

Plan: Vent wean, monitor GI function, cont to monitor and support.

"

"resp care

pt received from sicu this shift. alternating simv mode with trach mask/high flow neb with PMV in place while on tc. able to speak clearly,very strong cough. nard. did place back on simv when pt very sleepy due to hx of central sleep apnea. in pm. with bld tinged secretions of unclear origin. seems to be decreasing in amt. c/w above. mdi's per order.

"

"Resp Care

Pt remains [** **] with #8 portex DIC with patent trach site and new inner cannula in place. Pt placed back on vent psv 5/5 due to increase periods of apnea and unarousable state. BS course anteriorly sxing for mod to large amts of thick yellow secretions. Pt also expectorating most secretions on own during trach collar wean. Bronchodilators given Q4 with good aeration noted. Will cont with vent support and reassess for further trach collar weans as tol.

"

"T-SICU NPN 0700-1900

Please see carvue for specifics.

ROS:

Neuro: Lethargic most of shift (medicated overnoc, more alert in early afternoon; on trach mask in afternoon, became more lethargic, ? CO2 climbing, now back on vent). Opens eyes to verbal/tactile stimulation, pupils equal and reactive. +gag and cough, follows commands inconsistently, MAE's. Able to point to nose, ceiling, floor; does not appear to be oriented to time, place or situation. Denies pain, tolerates activity well. Activity: OOB to chair, 2 person pivot, for 5hrs today, able to pivot back to bed.

CV: HR 50's SB with occ. PVC's, BP 90-100's/40's. Skin warm, dry. Pedal pulses palpable. sc heparin and PB's for prophylaxis. IVC filter in place. Access: 18g PIV x1 wnl.

Resp: LS coarse->clear with suctioning. Pt with strong, productive cough, able to expectorate mod. amts. thick yellow secretions. Tol. trach mask for few hours as above, placed back on vent this afternoon d/t lethargy. Please see carevue for labs/vent changes/resp. notes. Trach site with scant yellow drainage.

GI: abd softly distended, NT, BS present, tol. promote with fiber at 80cc/hr (advance to goal 90cc/hr at [**2155**]) with scant residuals. Inc. large, liquid, brown BM this am. Prevacid for GI prophylaxis.

GU: foley patent draining borderline 15-50cc/hr concentrated amber urine, team aware.

Endo: BS 128, 101, covered per ss.

ID: tmax 99.6; wbc 8.2 No abx coverage.

Skin: back/buttocks intact, no breakdown. PEG and trach sites wnl, dsgs changed.

Psych/social: pt's wife in this afternoon. Asking appropriate questions about vent, rehab, mental status. Questions answered, support provided.

A: s/p L temporal lobe hemorrhage, hemodynamically stable, lethargic today, tol. trach mask x few hours

P: Monitor VS, I/O, labs, mental status. Cont. aggressive pulmonary hygiene/skin care. Increase activity/trach mask use as tolerated. ?d/c to [**Hospital1 29**] this week when bed available. Teams aware of need for pg 1,2,3 and d/c summary. Cont. ongoing open communication, comfort and support to pt and family.

"

"npn

Neuro: lethargic all night, mouthing words, doesn't maintain information when reoriented to place, time. inconsistent with following commands. perrla 3 to 4mm

Cardiac: BP 90-100s/40-50s, Bradycardic in 50s with PVC's. Hct: 35.5.

Resp: MMV 5 peep/5 ps @ 50% FI02. MV set @ 3.6. LS very diminished. Strong productive cough. Able to expectorate large amounts of tan/yellow thick secretions. Trach site with scant yellow drainage. O2 sat 98-100%.

GI: incontinent of 1 liquid stool around 0400. Tube feeding increased from 80 to 90 with <5cc residual. Nauseous around 0200, checked residual - <5cc. given MOM prn. Passed flatus. Turned tube feeding off for about an hour. Restarted at 90, tolerating well.

GU: 120 to 25cc/hr of clear amberish urine. output of 25cc/hr via [**Name8 (MD) **], MD notified. K 4.5, Phos 2.6.

Endo: no SSI coverage needed. FS 116-126

ID: max temp 100.0

skin: intact, warm and dry. face sweaty.

Plan: Monitor VS, I/Os, Labs. Assess pain/comfort. Speech + swallow tomorrow. Provide emotional support to family. Reorient patient to surroundings, date as needed.

"

"RESPIRATORY CARE:

Pt remains [** **], vent supported on manditory minute ventilation secondary to persistent apneas. BS's coarse. Administering Combivent MDI's in line with vent. Sxing large amts thick yellow secretions from trache. RSBI=200 this am. See flowsheet for further pt data. Will follow.

"

"assessment as noted

res:on cmv to prevent apnea, maintains so2>98, no abg were drawn-has no a/line, trong prod cough, suctioned for sm.mod amnt thick yellow sputum,

cv: in s/brady or 1st deg av block, bp asymptomatic, + pulses, no edema

neuro: lethargic but easily arousable and follows simple commands

mae, +cough, +gag, mouthwords

gi: still oozing liquid stool although in less amnts, +bs, npo as of now.

skin: intact, trach benign

id: temp 99+,

plan: ? to start tube feedings, , wean off a/c to cpap

"

"npn

neruo: alert on eves , has been sleeping off and on since around 11pm, easily arousable, responds to name calling. will attempt to communicate by mouthing words, follows commands, perrla at 3mm,moves all exts.

pain: denies pain when asked.

cad hr sick sinus syndrome with rate 40 to 50's with rare pvc's, abp 109/52 to 145/66, aline tracing waveform is not sharp probable due to slow hr, no issues overnight. hct 32.9

resp remains on simv5/5at 50%fio2x600tv with 560 to 600 seen and rr one to 3 breaths over occass. sats 98%, repeated coughing on eves with thin bloody secretions with some clots present, coughing has diminished as evening progressed, is able to clear secretions, has strong cough, am abg 7.46/47/128.

gi bs + abd soft but distened no increasing distention noted, no bm this shift, tf promote with fimber has remained at 20cc/hr, [** **]. resid. noted,<10cc, no flatus noted,

gu: foley patent for clear yellow urine 140 to 65cc/hr pt + 1 liter at mn for last 24 hours,

id: temp max 99.0, no issues

endo bs 127 and 119 no ssi coverage needed.

plan: pt to be weaned from vent, increase activity as tolerated, if bleeding from trach persists pt maybe bronched, cont to monitor gi , abd distention and bowel regime,

"

"RESPIRATORY CARE 1900-0700

PT [**Name (NI) 76**] ON SIMV+PS. NO CHANGES MADE TO VENT DURING SHIFT. BS COARSE, CLEAR WITH SX. SX FOR BLOODY SECRETIONS. MDIS GIVEN AS ORDERED. SEE CAREVUE FOR FURTHER DETAILS.

PLAN: VENT SUPPORT AND WEAN AS ABLE.

"

"T-SICU NPN 0700-1900

Please see carevue for specifics.

ROS:

Neuro: Alert, oriented to self, occ. ""hospital, [**Location (un) 124**]"", able to write ""[**Hospital3 **]"" once this am, oriented to self, not to time (""[**2159-6-9**]"") or situation. Requesting to call his wife consistently, writing random, non-sensical words at times. Cooperative with care. MAE's, L arm noted to be slightly weaker than R. Follows commands, able to point to window, floor, ceiling, and show

thumbs up bilaterally. Pupils equal and reactive. +gag, strong productive cough. Denies pain throughout day. Activity: OOB to chair x4hours this am; 2person pivot and few steps taken, tolerated well.

CV: HR 40-50'sSB with occ. PVC's, BP 110-140's/50-80's. Conts. lopressor as ordered. Skin warm, dry. Pedal pulses palpable. sc heparin and PB's for DVT prophylaxis. Heme: hct 32.9 this am.

Access: 20g PIV and R. radial a-line wnl.

Resp: LS coarse, suctioned/coughs up large amts. thick blood tinged secretions, team aware (?r/t trauma from suctioning). +strong productive cough. Attempted CPAP this am, pt apneic. Currently tol. CPAP, please see carevue for labs/vent. changes/ resp. notes.

GI: abd softly distended, BS present, NT, no stool this shift. Promote with fiber at 40cc/hr (advance to goal 90cc/hr) with sm. residuals. Pepcid dc'd, to start prevacid. Conts. reglan as ordered.

GU: foley patent draining clear, yellow urine in adequate amts.

Endo: BS wnl, no coverage per ss.

ID: tmax 99.6, wbc 8.4 No current abx coverage.

Skin: back/buttocks intact. PEG and trach sites wnl, dsgs changed.

Psych/social: pt's wife called this am, pt's nephew in to visit this afternoon; affect/questions appropriate, questions answered, support provided.

Dispo: pt being screened by [**Hospital1 29**]; per screener, currently no vent. beds available; she will return Wed. to re-evaluate pt and his progress.

A: s/p L temporal lobe hemorrhage, failure to wean from vent

P: Monitor VS, I/O, labs, neuro status. Cont. aggressive pulmonary hygiene/skin care. OOB to chair with assist. Continue ongoing open communication, comfort and support to pt and family. Wean vent as tolerated, cont. rehab. screening, will need pg 1,2+3 and d/c summary.

"

"RESPIRATORY CARE:

Pt remains [** **], vent supported. Event overnight, pt pulled out trache. Trache replaced with #8.0 Portex without difficulty. Pt remained on trache mask for several hours after episode. Placed back on vent for apnea. Administering Combivent MDI inline with vent. BS's coarse at times. See flowsheet for further pt data. Will follow.

"

"npn

add: pt has thrush in oral cavity

"

"T/SICU NURSING PROGRESS NOTE 0700-1900

RESP--SX FOR COPIOUS AMTS OF THICK WHITE,CLEAR, TAN SPUTUM. AT ONSET OF SHIFT, PT VERY [**Name (NI) 1213**]. ABG SHOWED RESP. ACIDOSIS WITH COMPENSATION. INCREASED VENT SETTINGS AND THEN PLACED ON TRACH MASK AT 0930. AWAKE ALL DAY. NOT [**Name (NI) 1213**]. SPONT RESP 16-28. SAO2 97-99%. CLEARING AIRWAYS WITH STRONG PRODUCTIVE COUGH. PT HAS NOT NEEDED DEEP SUCTIONING.

NEURO--PASSE MUIR VALVE ON AND PT IS VERY CONFUSED. DOES NOT COMPLETE SENTENCES. ASKED TO WRITE. HANDWRITING IS CLEAR AT TIMES BUT THOUGHT PROCESS IS INCOMPLETE AND NOT WRITTEN IN FULL SENTENCES.

IT IS GIBBERISH. ABLE TO STAND AND PIVOT WITH ASSIST. HAND GRASPS EQUAL. PEARL AT 3-4MM.

CARDIAC--HR SB/SR WITH RARE PVC'S. SBP >100.

GI--TOL. TUBE FEEDS VIA PEG AT GOAL OF 90CC. STOOL X2. DENIES PAIN.

GU--FOLEY CATH PATENT DRAINING >30 CC HR OF AMBER URINE.

ENDO--BS COVERED WITH SSRI.

SKIN--INTACT. BUTTOCKS WITHOUT BREAKDOWN.

ID--AFEBRILE. NOT ON ABX.

PAIN--DENIES PAIN WHEN ASKED.

COPING--WIFE PHONED AND WILL BE IN TOMORROW OR WILL CALL FIRST TO SEE IF PT HAS TRANSFERRED. PT IS ASKING FOR WIFE. [**Name (NI) **] IN TO SCREEN PT TODAY.

DISPO-FULL CODE.

PLAN--TX TO REHAB WHEN BED AVAIL. CON'T TO MONITOR. REDIRECT AND REORIENT AS NEEDED.

"

"npn

events: at 2130 pt pulled out his trach, new 8 portex trach inserted and pt maintain ed on trach collar at 50 to 60% most of shift at 4 am noted sats to 89% with shallow breathing noted, pt placed back on vent at cpap5/5 at 50%.

neuro: very confused and agitated on eves with pulling out of trach and subsequent reinsertion, pt needed to have restraints applied bilat to prevent further injury, pt repeatedly reoriented to place, time and situation but he is unable to remember, perrla at 3mm, received 5mg im haldol at 2130 and 1 mg total of ivp ativan at 10pm does follw commands, seems to become very agitated iwth male staff as compared to female staff.

resp: ls dim. bases with clear to coarse upper lobes, sats 100% on cpap5/5 rr in the teens while on vent had been mid 20 to 30 while ontrach collar.

cad : hr 60 to90's with pvc's , b/p 93/45 to 129/77 range, hct 36.9

gi: bs+ one large liquid brown stool overnight, tf at 50 with [** **]. resid.

gu: uo 40 to 380 cc/hr K= 4.1, mag 1.9 and phos 5.4

endo: no coverage needed

id temp max 100.1,

plan: screen for rehab, maintain resp status as tolerated,cont. to monitor neuro status, vs and labs

"

"Respiratory Care

Pt continues [** **]. Placed on a trach collar and tolerating well. Per attending... only to be placed on vent if he is in distress. Will continue to follow closely.

"

"T/SICU Shift Report - 1900-0730

75 Year Old Male NKA FULL CODE Universal Precautions

Admission - [**2161-5-2**] - Head Bleed

PMH - CAD/Sick Sinus Syndrome/Mild Pulmonary Hypertension

PE (98)

Pneumonia

Rotator cuff repair

Patient admitted to T/SICU following stroke, difficult wean from ventilation. Trach/PEG, weaned to trach mask, ready for rehabilitation. Has a possible bed at [**Hospital1 **] rehabiliation center today.

Review of Systems:

Resp - SV via trach on trach mask ventilation since 10am [**2161-5-20**] FiO2 60%, no episodes of apnea overnight. RR 10-27bpm, SpO2 98% (desaturation to 90% without FiO2). Breath sounds clear to coarse in the upper lobes, diminished at the bases. Trach care done. Coughing and clearing copious amounts of thick yellow sputum with strong cough. No deep suction required. Cuff done.

CVS - Sinus rhythm with periods of profound bradycardia to 40s, occasional-frequent PVCs witnessed. HR 55-75, SBP 90-130, MAP 60-88, Tmax 98.8. Peripherally warma and well perfused, with positive pedal pulses. No labs taken this morning.

Renal - UO 20-100ml/hr, +ve 700ml/24hours. 90ml/hr TF. No labs taken this am.

Neuro - Alert/slightly agitated at times, arousable to voice. Unable to assess orientation as passe muir valve is not currently in situ. GCS 14 (e4v4m6), patient able to say some words whilst the cuff is down. MAE, obeying commands, normal strength with all four limbs.

GI - TF continue at goal rate of 90ml/hr with minimal residuals. BMx2 small soft stool. Abdomen soft/distended/+ve bowel sounds. Blood glucose controlled with ISS.

Skin - Given full bed bath prior to settling. Skin grossly intact. Turned Q4, mouth care Q2.

Access - 1xperipheral IV, patent, dressing intact.

Family - No contact overnight.

PLAN - Possible transfer to rehabilitation ([**Hospital1 877**]) today

Wean FiO2 on trach mask

Encourage patient cough and clear secretrions

OOB to Chair

Page two updated

"

"NURSING PROGRESS AND ADMISSION NOTE 2200-0700

(Continued)

SE SEE FLOW SHEET AS NEEDED FOR ADDITIONAL INFORMATION. THANK YOU!

"

"MICU WEST Nursing Progress Note for 7a-3p: Full Code

T/SICU BORDER PT:

Events: HR ranging from 33-40's (SB) and T/SICU TEAM is aware. MRI w/ contrast of HEAD this afternoon. No report/read at present. Required moderate amount of sedation for agitation (a total of 6mg ATIVAN IV while in MRI) and rec'd Precedex boluses x 3 w/ conts gtt at 0.7mcg/kg/hr (17.2cc/hr). [**Initials (NamePattern4) **] [**Last Name (NamePattern4) **] of 4 units of FFP given while at

[**Hospital1 95**] (grand total of FFP from OSH and here is 8 units FFP). Vitamin K SC given to obtain goal INR of less than 1.5.

Neuro: Adequately sedated at present. Prior to MRI, pt. responded to stimuli by becoming extremely agitated, pulling at restraints and reaching to ETT. Currently, he is arousable to sternal rub by localizing. PERLA at present. No seizure activity. On dilantin IV. EEG done this AM (no read at present). MAE. Neurology seen and evaluated.

PULM: Orally intubated on A/C 12, TV 600, FIO2 .50%, 5. Stable O2 saturations. Lung sounds coarse throughout. Min. secretions. Intubated at OSH for airway protection. RR regular and unlabored.

CV: Conts. w/ low HR to 33. Normal HR per chart is 40's at rest. Cardiology consult in place, but haven't seen. BP stable. Palp. peripherial pulses x 4. Low grade fever to 100.3 max. No edema noted.

GI/GU: + BS noted. Abd is soft, NT, ND. No BM at present. ? need for NGT for long term nutrition. Foley in place w/ dark amber UO in adequate amts.

Social: Wife here and needs to be updated by team.

Plan: Cont. w/ current plan of care. Monitor per protocol. Repleting electrolytes as needed. Extubation in near future per T/SICU team. Cont. w/ Q2hr neur checks

"

"Addendum to previous note: Precedex gtt infusing at 0.5mcg/kg/hr.

"

"Respiratory Care

Pt recieved from MICU on a/c settings without changes, No abg's at this time, will continue support as ordered.

"

"NURSING PROGRESS NOTE 1600-1900 HOURS:

** ACCEPTED PT IN TRANSFER FROM MICU WEST

ADDENDUM:

** FULL CODE

** NKDA

** ACCESS: 3 PIV'S PATENT.

PLEASE SEE DAYSHIFT NURSING NOTE.

IN BRIEF: PT IS A 75YO MALE WITH PMH: CAD, S/P MI, CATH IN 04' LAD DISEASE, STREP PNA MENINGITIS, OBSTRUCTIVE SLEEP APNEA, RIGHT ROTATOR CUFF REPAIR, PE'S, DVT'S (EVEN WHILE ON HEPARIN SO PT ON LIFELONG COUMADIN), MILD PULM HTN, PULM NODULES, SSS (WITH BASELINE HR IN 30'S PER WIFE)

ADMIT TO [**Hospital **] HOSP FOR EVAL AFTER WAS IN USOH-WENT TO GET HAIRCUT-CAME BACK AND SPOUSE NOTICED THAT PTS WORDS WERE GIBBERISH AND HE WAS SAYING THINGS THAT WERE INAPPROPRIATE. HED CT REVEALED LEFT TEMPORAL HEMORRAGE. HE WAS BRADY AND HTN AT THE TIME. TX'D TO [**Hospital1 95**] FOR TREATMENT.

NEURO: PT RECEIVED ON PRECEDEX GTT AT 0.5 MCG/KG/HR-INITIAL ASSESSMENT-PT [**Name (NI) **]. NO GAG, NO COUGH, NOT OPENING EYES TO STERNAL RUB, NO SPOT MOVEMENT-DOES WITHDRAW TO PAINFUL NAILBED PRESSURE. + [**Last Name (LF) **], [**First Name3 (LF) 684**]-SLUGGISH AT 3MM. PRECEDEX GTT DOSE IN HALF-MD MADE AWARE-APPROX ONE HOUR LATER-PRECEDEX GTT DC'D IN ATTEMPT TO WAKE PT AND ASSESS NEUROS. PT [**Name (NI) 57**] 6MG ATIVAN EARLIER FOR REPORTED AGITATION...?? STILL SEDATE FROM THAT. PT UNDERWENT MRI TODAY WITH RESULTS PENDING.

CARDIAC: SB WITH HR 30'S-40'S. UNABLE TO ASSESS SYMPTOMATIC OR NOT. APPARENTLY THIS IS PT'S BASELINE WITH SSS HX AND NEVER ANY TALK OF PACEMAKER PER SPOUSE. ABP NOW >100 WITH MAP OF 63-WAS IN 90'S SINCE ARRIVAL. HYDRALAZINE HELD. COMPRESSION STOCKINGS PLACED FOR DVT PROHYLZXIS. RECEIVING 2U FFP FOR INR OF 1.5.

RESP: INTUBATED/SEDATED. ETT #8.0/25. VENT SETTINGS: 50%/TV 600/ R 12/P 5. NOT INITIATING BREATHS ABOVE SET RATE. POX 95% AND ABOVE. LUNGS WITH SCATTERED RHONCHI AND DIMINSHED AT BASES. NO SECRETIONS.

GI/GU: ABD SOFTLY DISTENDED, POS BS. NO BM. NO FEEDING AT THIS TIME. FOLEY IN PLACE-UO >25CC/HR PER FLOWSHEET-AMBER, CLEAR.

ENDO: FS Q 6 AS ORDERED WITH S.S.

SKIN: INTACT-NO ISSUES.

PSYCHOSOCIAL: WIFE IN TO VISIT -UPDATED ON ALL POC'S-CELL NUMBER AT BEDSIDE. SHE SPOKE WITH NEURO WHO TOLD HER THAT THEY WOULD HAVE MRI RESULTS FOR HER TOMORROW. WIFE GOING TO STAY WITH FAMILY-HAS BEEN HERE SINCE LAST NIGHT-PLS CALL WITH ANY CHANGES.

DISPO: FULL CODE-INTUBATED. ASSESS Q 1 HOUR NEUROS. NO [**Doctor First Name 102**] INTERVENTION AT THIS TIME FOR HEAD BLEED-CONT TO ASSESS. MED REGIMEN, AND ICU SUPPORTIVE CARE. ATTEMPT TO WAKE UP TO ASSESS NEURO STATUS.

"

"Respiratory Care:

Patient switched from A/C to CPAP/PSV. No abg results at this time.

RSBI = 58.1.

Plan is to wean to extubation.

"

"1900-0700

PT RECEIVED INTO MY CARE VENTILATED AND SEDATED ON PRECEDEX.

CV: PT BRADYCARDIC 30-43. THIS IS PTS NORMAL ACCORDING TO WIFE. R RADIAL ARTERIAL LINE IN PLACE. BP STABLE 98-140 SYSTOLIC. HYDRALAZINE 10MG IV GIVEN AS ORDERED TO MAINTAIN SYSTOLIC <140. RARE PVC'S.

RESP: VENT SETTINGS CHANGED FROM CMV TO PS 8 PEEP 5 FIO2 50% @ 0430HRS. RISBI BY RT 58.1. ABG SENT @ 0640. RESULTS PENDING. AIMING TO EXTUBATE THIS AM. CREAM/TAN SECRETIONS EXPECTORATED INTO ETT THIS AM. NIL GAINED FROM SUCTION. BRIGHT RED BLOOD X 1 CATHETER LENGTH NOTED WHEN RT SUCTIONED PT THIS AM. SINCE CLEARED. VSS.

NEURO: PT SEDATED ON PRECEDEX. TURNED OFF @ 0100 FOR WAKE-UP. PT NOT RESPONDING AFTER 1.5HRS SO PRECEDEX LEFT OFF. NO SEDATIVE MEDICATION GIVEN SINCE. PT STARTED MAE @ 0500. OPENED EYES BRIEFLY ONCE. HAS NOT DONE ANYTHING TO COMMAND. FACIAL GRIMACING AND WITHDRAWS WITH NAILBED STIMULI. PERL. WERE SLUGGISH BUT BRISK IN LAST 2HOURS.

GI: BOWEL SOUNDS PRESENT. NO BOWEL MOVEMENT. NO FEEDING TUBE. IV MEDS GIVEN AND SALINE AT KVO. ON SLIDING SCALE. SUGARS 134+119.

GU: URINE DARK. YIELDING 30-50MLPH.

LABS: PT ON LIFELONG COUMADIN FOR HISTORY OF DVT WHILST ON HEPARIN. INR GOAL <1.4. FFP X 2 UNITS GIVEN OVERNIGHT. TOTAL 6 UNITS @ [**Hospital1 95**]. TOTAL 2 DOSES VIT K 10MG GIVEN S/C. AM INR 1.4.

SKIN: NO IMPAIRMENTS NOTED.

SOCIAL: WIFE CALLED LAST NIGHT. TOLD PT STABLE. WILL VISIT TODAY.

PLAN: AIM TO EXTUBATE.

Q1HR NEURO CHECKS.

MONITOR VS.

AWAIT MD ROUND FOR REVIEW.

"

"T/SICU RN Progress Note

Neuro: Patient goes between slightly alert and following some simple commands to lethargic and localizing to pain. Pupils equal and reactive, + gag/cough, though not strong cough at all times. Remains on dilantin. Repeat head CT done.

CV: HR 80-100 SR with PVC's. ABP systolic 120-140's. P-boots, SQ Heparin.

Resp: Extubated at 1300, on 70% face tent, lungs coarse, NT suctioned for thick tan secretions. RR 20's with sats 92-97%.

GU/GI: Foley with clear yellow urine, lasix 20mg given X1. Abd soft + bowel sounds, pedi-tube placed, PPI, NPO.

Skin/Mobility: Skin grossly intact, no breakdown noted. OOB to chair via [**Doctor Last Name 43**] lift, tolerated well.

Endo/Lytes: RISS coverage as needed, K and Mg repleated

Social: Wife in to visit updated by this RN, HO [**Doctor Last Name 2981**], N-med, and V-[**Doctor First Name **].

Plan: IVC filter placement, aggressive pulmonary hygeine, monitor neuro status, cont to monitor and support, follow plan of care.

"

"Adendum

During IVC filter placement patient noted with HR 110's, with multiple runs of ectopy. Once in T/SICU given 5mg lopressor, 4gm magnesium, 10meq KCL IV, 60meq PO KCL, and 2gm Ca. EKG done, patient currently in ST/SR with occasional PVC's. Lytes, enzymes cycled, and abg sent. HO [**Doctor Last Name 2981**] aware.

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