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11/24/1994 12:00:00 AM
Discharge Summary
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Admission Date :
11/24/1994
Report Status :
Signed
Discharge Date :
PRINCIPAL DIAGNOSIS :
1) RIGHT LOWER EXTREMITY PSEUDOMONAS CELLULITIS .
2) PAROXYSMAL ATRIAL FIBRILLATION .
3) CORD COMPRESSION .
4) STEROID INDUCED DIABETES MELLITUS .
5) PLASMACYTOMA .
6) POOR NUTRITIONAL STATUS .
7) THROMBOCYTOPENIA STATUS POST BONE MARROW TRANSPLANT .
8) MULTIPLE MYELOMA .
HISTORY OF PRESENT ILLNESS :
This is a 59-year-old white male .
The patient has had multiple myeloma since 1990 .
He underwent an autologous bone marrow transplant in 10/92 at Petersly Hospital And Medical Center .
At that time he received total body irradiation of 1400 cGy .
This bone marrow transplant did not produce remission and then he was treated with three cycles of VAD subsequently .
In 08/94 , the patient developed lower back pain .
A workup done in DE is not available at the time of this dictation .
According to her scanty records , an MRI of the spine showed diffuse spinal column involvement with lesions in T4 and T8 with no cord compression at that time .

He was then treated with radiation therapy from T3 to T9 receiving 2500 cGy from 08/94 to 09/94 .
He has been on Decadron since 08/94 .
About two weeks prior to admission the patient developed mid back pain , burning in nature with radiation around the right lower ribs .
He also began to develop noticeably increasing bilateral lower extremity weakness and possibly numbness in the lower extremities .
He stated that he had difficulty rising from a chair .
An MRI without gadolinium done on 11/20/94 of the spine showed a right posterior lateral epidural mass extending from T9 to T12 .
There was evidence of cord compression .
The patient 's Decadron dose was increased to 12 mg q day and he was also started on MS Contin and radiation therapy was being planned and arranged at the Petersly Hospital And Medical Center .
However , one day prior to admission the patient developed right lower extremity pain and could not walk secondary to the pain .
Over the next 12 hours while in transit to the hospital , the patient 's right lower extremity became red , swollen , and increasingly painful .
He has had chronic bilateral lower extremity swelling since his transplant but the right lower extremity swelling was noticeably increased .
He also complained of some fecal incontinence the day prior to admission without urinary incontinence .
At the time of presentation the patient denied headache , arm weakness , changes in vision , dysarthria , abdominal pain , nausea or vomiting , chest pain or shortness of breath .

He was taken to Huyychestleme Health Of in Scoo , Utah where he had a temperatur e of 99.9 , blood pressure 90/50 , heart rate 128 , and O2 sat of 91% on room ai r .
Blood cultures , urine culture , and UA were all done .
Blood cultures drawn on admission subsequently grew Pseudomonas aeruginosa .
He was treated with Ceftazidime , gentamicin , and Vancomycin and also was start ed on a Dopamine drip for treatment of his sepsis .
A Swan was placed and initial readings were CVP of 6 , wedge pressure of 10 to 1 2 , cardiac index of 4.7 , and SVR of 438 all consistent with a Pseudomonas seps is picture .
He was given stress steroids and was subsequently transferred to Lorough Medical Center 's Intensive Care Unit for further management .
PAST MEDICAL HISTORY :
1) Multiple myeloma .
2) Paroxysmal atrial fibrillation .
3) Plasmacytoma of T9 through T12 .
4) Chronic renal insufficiency .
5) Chronically low platelet count .
6) Failed autologous bone marrow transplant in 10/92 .
7) Hypothyroidism .
FAMILY HISTORY :
Positive for diabetes mellitus .
SOCIAL HISTORY :
Married to a very supportive wife .
ALLERGIES :
Question of penicillin and sulfa drugs leading to a rash .
MEDICATIONS :
On transfer include Vancomycin , Ceftazidime , gentamicin , Solu Cortef 100 mg q 8h , Lasix , Synthroid , insulin , MS Contin 60 mg b.i.d. , MSO4 2 mg p.r.n. pai n IV , Dopamine 12 mcg per minute .
PHYSICAL EXAMINATION :
On admission showed a non-toxic appearing male with temperature 99.5 , blood pre ssure 82/50 , heart rate 118 , respiratory rate 15 .
HEENT exam atraumatic , no oral lesions .
Neck supple , carotids without bruits .
Cardiac exam was regular S1 and S2 , no murmur .
Chest clear to auscultation with a few fine crackles at the left base .
Abdomen non-distended , positive bowel sounds , soft , non-tender , no hepatospl enomegaly or masses .
Rectal normal tone , guaiac positive brown stool , no perirectal lesions or eryt hema .
Extremities reveal the right lower extremity was tense , purple-red , swollen , and was warm from the knee to the ankle and extremely tender .
There was pitting edema of both lower extremities but no evidence of cellulitis of the left lower extremity .
Neurological exam on admission revealed he was drowsy but easily arousable to vo ice , oriented to person , Retelk County Medical Center , and date , able to say no but mildly inattentive during examination .
Cranial nerves intact .
Motor exam normal tone , positive asterixis , no drift .
Strength was decreased in both lower extremities .
Coordination was normal with good finger to nose , gait was not tested .
Deep tendon reflexes were 2+ in the upper extremities , 1+ in the patella reflex es , no reflexes at the ankles , upgoing Babinski toes bilaterally .
LABORATORY DATA :
On admission revealed white blood cell count 4.2 , Hct 27 , platelet count 28 .
Glucose 191 .
PT 17.6 , PTT 48.7 , fibrinogen 686 , TT 39.2 .
Magnesium 1.7 .
UA showed no white blood cells , positive granular casts .

Chest x-ray was without infiltrates , wand in good position .
An MRI was performed upon admission and showed an epidural mass at the right pos terior lateral T9 to T12 area invading the neural foramina .
There was no CSF density .
These findings were consistent with the cord compression .
HOSPITAL COURSE :
By problems -
1) INFECTIOUS DISEASE / CELLULITIS :
The patient 's clinical situation was most consistent with a Pseudomonas ce llulitis and subsequent sepsis .
Blood cultures drawn at the outside hospital grew out Pseudomonas that was sensi tive to Imipenem and Tobramycin .
There were cultures obtained seeping from the wound at Retelk County Medical Cen ter and those also grew out Pseudomonas aeruginosa .
The organism grown at this institution was sensitive to Imipenem , Ceftazidime , Amikacin , gentamicin , Ciprofloxacin , Tobramycin but was resistant to Cefotet an , Ceftriaxone , Mezlocillin , Bactrim , Ampicillin , chloramphenicol , and su lbactam .
He was treated initially with Ceftazidime and gentamicin but there was a questio n about the organism 's susceptibility from lab studies done at the outside hospital .
He was subsequently switched to Imipenem and Tobramycin and was maintained on th ose medications throughout the hospital course .
The Tobramycin and Imipenem were started on 11/25/94 .
In addition , the patient received a five day course of intravenous IgG to impro ve infection control .
Vancomycin was also added to his regimen on 11/28/94 and this was primarily to p rovide improved MRSA coverage as he continued to have erythema along the lateral right lower extremity .
He was evaluated by the Surgery Department and it is there feeling that there is no indication for surgical intervention / amputation at this time .
He is being maintained with twice daily Xeroform with Betadine changes .
These dressing changes are applied by applying the Xeroform on Betadine initiall y and then changing it with sterile dry bandages .
Of note , the patient has extreme pain with these dressing changes and requires parenteral morphine sulfate for pain control during dressing changes .
The plan is to complete a full course of Imipenem and Tobramycin for his Pseudom onas cellulitis .
As mentioned earlier he continues to have erythema tracking up his leg and up to his lateral thigh .
The cause of this erythema is not know at this time but has not shown extensive progression .
2) CARDIOVASCULAR :
The patient was initially treated with Dopamine which was subsequently weaned of f after his sepsis improved .
He was noted to be in rapid AF on several episodes receiving 5 mg IV Lopressor e ach time with improvement .
He has been in and out of atrial fibrillation and normal sinus rhythm .
An echocardiogram performed at the outside hospital while he was septic showed d ecreased global EF .
The patient is being maintained on Digoxin for his paroxysmal atrial fibrillatio n .
He has had no significant episode of tachycardia or blood pressure alteration du ring the final days of hospitalization .
The plan is to continue the Digoxin and to recheck an echocardiogram to assess h is ejection fraction when he is clinically better .
3) ONCOLOGY :
The patient has a plasmacytoma affecting the spine .
He has been receiving radiation therapy to that area during the hospital stay .
The plan is to complete a full course of XRT to the spinal region for the plasma

cytoma .
The patient 's lesion compressing his thoracic spine was never biopsied , h
owever , the MRI appearance does not seem to be infectious and is most consisten
t with plasmacytoma for which he is receiving the radiation therapy .
4) NEUROLOGIC :
As mentioned above he has a cord compression and is on steroids .
He was initially treated with IV Decadron 10 mg up front and then 6 mg q6h.
His neurological exam remained stable with no evidence of increasing lower extre
mity edema .
His Decadron dose was titrated down to 5 mg IV q6h on 12/3/94 .
His Decadron dose will be slowly titrated down over time following his neurologi
cal exam closely .
5) BLOOD SUGARS :
The patient has steroid induced diabetes mellitus .
He has been on increasing doses of insulin receiving NPH in the morning and nigh
t in addition to a CZI sliding scale on a q6h basis .
The plan is to continue the supplemental insulin while he is on steroids and whi
le his sugars remain high .
6) RESPIRATORY :
He initially required a face mask to keep his saturation above 90% .
However , with increasing diuresis and improving septic pictures his O2 saturati
ons have improved and he is now on nasal cannula and will be maintained on nasal
 cannula to keep his sat above 93% .
He can be given intravenous Lasix as needed for any evidence of respiratory comp
romise or increasing pulmonary edema .
7) NUTRITION :
The patient has a poor nutritional status with hypoalbuminemia .
He has been maintained on tube feeds and that should be continued .
He should also be encouraged to eat as much as possible orally in addition to th
is tube feeds and aspiration precaution should be maintained .
8) ELEVATED PT and PTT :
Both of these responded to three day course of vitamin K 10 mg each day .
His PT and PTT are now normal , however , he continues to run a low platelet cou
nt .
This has been evident since the time of his bone marrow transplant .
We have been transfusing him with platelets to keep his counts above 20,000 to r
educe his bleeding risk .
He also received several blood transfusions while here to maintain his Hct aroun
d 30 .
Thrombocytopenic inducing drugs should be avoided if possible on this patient .
DISPOSITION :
DISCHARGE MEDICATIONS :
Tylenol 650 mg po q4h p.r.n. , Dulcolax 10 mg per rectum b.i.d. p.r.n. , Decadro
n 5 mg IV q6h , Digoxin 0.25 mg po q day , Colace 100 mg po t.i.d. , Florinef 0.
1 mg po q day for presumed adrenal insufficiency , Imipenem 500 mg IV q6h , insu
lin NPH 60 units subcu q a.m. , insulin NPH 20 units subcu q p.m. , insulin CZI
sliding scale regular , Synthroid 125 mcg po q day , magnesium sliding scale , p
otassium sliding scale today , morphine sulfate IV p.r.n. dressing changes and b
reakthrough pain , Carafate 1 gm po q.i.d. , Tobramycin 200 mg IV q30h , Vancomy
in 1 mg IV q18h.
Dicatated By :
LAYMIE WHITE , M.D. WE01
Attending :
TAMYRCLEO N. BACK , M.D. GP0 EA855/4665
Batch :
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