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FIH
2044357
81841/8e23
715555
4/9/1992 12:00:00 AM
Discharge Summary
Unsigned
DIS
Report Status :
Unsigned
ADMISSION DATE :
04-09-92
DISCHARGE DATE :
04-20-92
HISTORY OF PRESENT ILLNESS :
Mr. Kacholera Junk was a 34 year old gentleman with no significant past medical history except for a history of of intravenous drug abuse .
He was status post a rehabilitation hospitalization at the Raya Ma Den Erinmarg Hospital with a recent recrudescence of his drug abuse .
He was admitted to the Sephsandpot Center on the morning of 4/9 and was subseque ntly transferred to the Fairm of Ijordcompmac Hospital for further care .
The patient was apparently well until one day prior to admission .
His family reports that he had worked that day .
He relates using large doses of Cocaine and Heroin early in the morning on the d ay of admission .
At 3:00 a.m. on the day of admission he was found by the emergency medical techn icians " crawling on all fours " , confused , and combative outside hi s home .
He gave an equivocal history of fevers and chills on the days prior to admission .
Bystanders report that he was assaulted about 20 minutes earlier and the nature of the assault was not known .
He was taken to the Sephsandpot Center where he was hypotensive with a blood pre ssure of 105/85 , tachycardic with a heart rate to 186 , aneuric , hyperthermic , with a temperature to 105 degrees F , and progressively more confused .
His chest x-ray was clear .
He was treated with Dopamine for hypertension and Inderal for tachycardia .
He received two amps of Narcan .
He received one gram of Ceftriaxone intravenously after blood cultures were draw n .
His initial arterial blood gas at the Sephsandpot Center revealed a p02 of 76 , pC02 14 , and a pH of 7.44 on room air .
He was then transferred via Med Flight to the Fairm of Ijordcompmac Hospital .
He denied any history of recent travel .
Toxicology screen at Sephsandpot Center revealed Cocaine and Quinine .
Shortly after his arrival to that hospital he had been intubated for a respirato ry rate of 60 .
He required medical paralysis for this .
He was reported to have a seizure , although the nature of this was unclear , an d received Valium for this .
PAST MEDICAL HISTORY :
None .
PAST SURGICAL HISTORY :
He is status post recent left knee surgery , status post left carpal tunnel rele ase .
MEDICATIONS ON ADMISSION :
His meds on transfer to FIH were Levophed , Dopamine , and Ceftriaxone .
FAMILY HISTORY :
The patient is divorced with no children .

His mother and father are alive and well .
SOCIAL HISTORY :
The patient works as a welder .
He has a history of intravenous drug abuse , no alcohol abuse or tobacco abuse .

PHYSICAL EXAMINATION :
Revealed an obtunded white muscular man who was intubated and sedated .
The vital signs showed a blood pressure of 69 , pulse 80 , respirations 14 , and temperature 99.8 .
There is a contusion over the right eye but no laceration , abrasion of her left shoulder , no flank discoloration , blanching papules over the knees bilaterally without central necrosis .
He had multiple tattoos .
Lymphatic-he had shotty cervical adenopathy .
The head , eyes , ears , nose , throat exam was normocephalic , with trauma as described , pupils were 2 mm bilaterally which were minimally reactive , fundi was not seen , conjunctivae without erythema , sclerae anicteric , positive corneal reflexes noted .
Ears-the tympanic membranes were clear with no hemorrhage at the time of admission .
Nose-no sinus discharge , no hemorrhage .
The oropharynx was intubated .
Lungs-clear with good air movement bilaterally .
He had scattered wheezes following a 3 liter bolus for hypotension .
No effusion or rub was heard .
The cardiac exam showed point of maximal impulse was not displaced , regular rate and rhythm with normal S1 , S2 , no S3 or S4 , a grade II / VI systolic murmur was heard at the left upper sternal border without radiation , likely representing a flow murmur .
No peripheral edema was noted .
The jugular venous pressure was not assessed secondary to cervical collar being in place .
The carotid pulses were brisk bilaterally .
The vascular exam showed normal pulses bilaterally without bruits .
The abdomen was soft , bowel sounds of normal character , and there was mild percussion tenderness and tenderness to modest palpation in all four quadrants .
It was unclear whether this was due to superficial tenderness or abdominal tenderness .
He had marked voluntary guarding without rigidity and no masses were felt .
The genitourinary exam showed normal penis with normal testicles which were nontender .
There was no urethritis , no balinitis , normal prostate , nontender .
There was tan guaiac positive stool with no masses .
The musculoskeletal exam showed well developed , symmetrical muscular development with no fasciculations , no joint erythema , no effusions .
Neuro exam-the Mental Status Exam was variable , intermittently responsive , unable to follow commands .
He nods appropriately and was able to confirm known history .
The cranial nerves II-XII grossly intact , bilaterally symmetric .
The motor exam-moves all four extremities easily and on command .
The sensory exam revealed no focal deficits to limited exam .
Reflexes were trace in the upper extremities and absent in the knees with downgoing toes bilaterally .
LABORATORY DATA :
On admission the sodium was 144 , potassium 2.6 , chloride 114 , bicarbonate 12.3 , BUN 30 , creatinine 4.0 , glucose 89 .
The SGOT was 994 , LDH 1,888 , alkaline phosphatase 92 , total bilirubin 2.9 and direct bilirubin 11.2 .
Lactate was 6.3 , acetone negative , ammonia 26 , uric acids 26.9 , albumin 4.0 , globulin 3.0 , amylase 259 , lipase 34 , magnesium 3.5 , phosphorus 1.9 , calc

ium 9.4. The white blood count was 19.7 with 89% polys , 7% bands , 4% lymphs , with toxic granulations .
Hematocrit was 45.2 with a platelet count of 132,000 , falling rapidly to 24,000 .
The MCV is 88 .
The prothrombin time is 27.7 , partial thromboplastin time is greater than 100 .

The urinalysis revealed a specific gravity of 1.15 , pH 5.0 , and 4+ albumin , positive occult blood , with 0-5 granular casts and 5-10 RBCs and 3-5 WBCs .
The CK was 17,890 with 0.6% MB .
The urine sodium was 147 .
The serum toxicology was positive for Cocaine on admission to the Fairm of Ijord compmac Hospital as well as the Sephsandpot Center .
The electrocardiogram revealed normal sinus rhythm at 85 with a prolonged QT at 0.572 .
An I-head CT revealed left sphenoid and left maxillary sinusitis with mild cerebral edema and no focal hemorrhages .
The abdominal CT revealed mesenteric adenopathy , normal bowels , hepatosplenomegaly , and ? fatty liver .
Chest x-ray revealed early interstitial edema .
HOSPITAL COURSE :
The patient was admitted with the diagnosis of Cocaine induced rhabdomyolysis , renal failure , disseminated intravascular coagulation , shock , hepatic failure , pancreatitis , and thrombocytopenia in the setting of Cocaine intoxication .
He was accepted at the Vo Yd Burgsygu Hospital Center Intensive Care Unit and his hospital course will be reviewed by problems .
1-Rhabdomyolysis .
The patient had massive Cocaine induced rhabdomyolysis .
This resulted in tremendous third spacing of fluid and persistent intervascular hypovolemia .
The patient 's creatinine _____ kinase peaked at 56,160 with negative MB percentages .
The aldolase was positive at 142 .
This was further complicated by hypocalcemia which resulted in mild electrocardiographic abnormalities .
The patient 's urine was alkalinized with intravenous bicarbonate to maximize the myoglobin secretion .
The patient 's urine output was further augmented by adding Dopamine .
Nevertheless , the patient 's renal failure continued to progress .
Over the course of the hospitalization his CK fell in the serum .
Much of his diffuse pain was felt to be due to this massive rhabdomyolysis .
2-Renal failure .
The creatinine was 4.4 on admission and peaked at 10.5 on the 15th .
The urinalysis revealed 4+ albumin with marked occult blood .
Peritoneal dialysis was instituted on 4/11 after a Tenckhoff catheter was placed by Drs. Freierm , Le , and Round .
Subsequently his creatinine rose for three days and then stabilized at 10 .
He continued to make minimal urine throughout the hospitalization .
3-Disseminated intravascular coagulation .
On admission the patient 's prothrombin time was 27.7 with a partial thromboplastin time of greater than 100 and a d-dimer positive at 8 with a fibrinogen of 69 .
He went on to develop profound thrombocytopenia complicated by hemorrhage .
The patient was supported with abundant use of fresh frozen plasma , cryoprecipitate , platelets , and packed red blood cells .
His DIC was further complicated by hepatic failure which resulted in poor endogenous production of clotting factors and he remained fresh frozen plasma dependent .
4-Septic shock .
The patient remained pressor dependent throughout his hospitalization .

He was maintained variously on Levophed , Dobutamine , Dopamine , and ultimately Epinephrine for blood pressure support .
Hemodynamic monitoring revealed low systemic vascular resistance and high cardiac output .
He had multiple sources of infection including his sinuses , lungs , and multiple lines .
This will be discussed below .
Further he had massive muscle necrosis and hepatic failure .
An echocardiogram on 4/12 revealed a dilated left ventricle which was diffusely mildly hypokinetic with no vegetations .
His ejection fraction was 55% .
On 4/16 the pulmonary artery catheter was placed which revealed a wedge pressure of 8 , cardiac index of 4.5 , and an SVR of 5.8 .
5-Hepatic failure .
His SGPT on admission was 2,520 with a peak at 7,680 on hospital day two .
He had complete loss of synthetic and conjugation function of the liver with rising bilirubin and falling albumin with dependence on transfusion for support of his prothrombin time .
He was seen in consultation by the GI Service and the Liver Transplantation Service .
Given his multiple other medical problems , the direness of his situation , and his ongoing substance abuse at the time of admission he was deemed not to be a candidate for a liver transplantation .
6-Cocaine intoxication .
Serum Cocaine was positive 6-12 hours ingestion at the Fairm of Ijordcompmac Hospital .
Further , at Ceanotsit Ortgold Center his serum toxicology screens were positive .
This is thought to be the insighting cause of his massive rhabdomyolysis and hepatic failure .
7-Pneumonia .
The patient developed two pneumonias with two separate organisms .
The first was Acinetobacter calcoaceticus subspecies anitratus , treated with Ciprofloxacin and Gentamicin .
He subsequently developed a staphylococcus aureus pneumonia which was treated with Vancomycin , dosed to levels appropriate for his renal failure .
He was seen in consultation by the Infectious Disease Service who advised us on antibiotic choices daily .
8-Pancreatitis .
The amylase on admission was 279 with a lipase of 161 .
Although not fully this may have contributed to his hypocalcemia and volume requirements .
9-Catheter tip infections .
The patient grew out coagulase negative staphylococcus from the femoral lines which were placed during his profound hypertension .
These were treated with Vancomycin .
10-Anemia .
The patient 's hematocrit was 33% on admission and fell to 28 requiring 4 units of packed red blood cells over the course of his hospitalization .
11-Coma .
The patient , although initially minimally responsive , went on to develop a deep comatose state .
A CT scan on admission revealed no evidence of hemorrhage though he did have sphenoid sinusitis .
The lumbar puncture and sinus exploration were unable to be performed given the patient 's persistent coagulopathy .
The patient was treated empirically with Nafcillin and Ceftriaxone for meningitis and sinusitis .
Further complicating this was his profound liver failure with rising ammonias and hepatic encephalopathy .

Despite maximal supports the patient continued to be hypotensive .
Mid-way through his hospital course he developed trilobar pneumonia and this was probably complicated further by adult respiratory distress syndrome and the multi-organ system failure syndrome .
The patient remained mechanically ventilated throughout his hospitalization .
Nevertheless , he developed refractory hypoxemia , hypotension , and ultimately the patient died despite total life support .
DISCHARGE DIAGNOSIS :
Cocaine intoxication , rhabdomyolysis , renal failure , disseminated intravascular coagulation , septic shock , hepatic failure , pneumonia , pancreatitis , catheter tip infection , anemia , coma .
PRINCIPAL PROCEDURE :
Peritoneal dialysis catheter placement , peritoneal dialysis , arterial catheterization , venous catheterization , continuous mechanical ventilation , and parenteral nutrition .
COMPLICATIONS DURING ADMISSION :
Neck hematoma secondary to pulmonary artery line placement requiring transfusion , catheter tip infection .
MEDICATIONS ON DISCHARGE :
None .
CONDITION ON DISCHARGE :
The patient was discharged to Samfer Street with no autopsy .
LENNI HEAD , M.D.
TR :
be / bmot
DD :
09-05-92
TD :
09/07/92
CC :
[report_end]