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Discharge Summary
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Admission Date :
02/03/1991
Report Status :
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Discharge Date :
02/21/1991
DIAGNOSIS :
ISCHEMIC CARDIOMYOPATHY AND CONGESTIVE HEART FAILURE .
HISTORY OF CORONARY ARTERY DISEASE .
SKIN RASH .
VENTRICULAR FIBRILLATION .
HISTORY OF PRESENT ILLNESS :
The patient had a history of chronic atrial fibrillation , coronary artery disea se and congestive heart failure , who actually underwent a right breast biopsy a nd was off Coumadin for 5 days .
However , the patient denied any periods of prolonged inactivity .
At baseline the patient has occasional dyspnea on exertion while walking up stai rs , able to walk indefinitely on normal ground and when his feet swell up his d yspnea on exertion gets worse .
The patient sleeps on 2 pillows for neck comfort only , and denied orthopnea and paroxysmal nocturnal dyspnea .
The patient gave a history of atypical angina and exertion brings on left scapul ar pain without radiation .
This is also associated with nausea and diaphoresis .
The pain resolved spontaneously with rest .
The patient denied ever taking sublingual nitroglycerin .
Over the past day , the patient developed progressively increasing lower extremi ty edema and abdominal girth , accompanied by dyspnea on exertion , but no short ness of breath at rest .
He had one or two episodes of left scapular pain over the past week , both of wh ich lasted 30 seconds and resolved spontaneously .
The patient denied acute shortness of breath , pleuritic chest pain , cough , wh eeze .
He had weight gain of approximately 23 pounds over the last 7 days , associated with leg edema and he had also developed scrotal edema and had mild difficulty u rinating .
He talked to Dr. Collea R. Douetscarv yesterday on the phone , who instructed th e patient to take 60 milligrams of Lasix on the morning of admission , his usual dose was 40 .
The patient experienced no symptomatic relief .
He was seen in clinic by Dr. Stisie H. Pain , who felt he had congestive heart f ailure exacerbation , although myocardial infarction , pulmonary embolism , infe rior vena cava obstruction could not be totally ruled out .
PAST MEDICAL HISTORY was remarkable for coronary artery disease .
The patient had an exercise tolerance test with thallium in 11-90 , and stopped after 7 minutes secondary to fatigue , shortness of breath , maximum heart rate 170 , and there were ST changes which were nondiagnostic .
He was in rapid atrial fibrillation , there were unifocal premature ventricular contractions .
This was consistent with , but not diagnostic of , ischemia .
The patient had positive reversal defect in inferior and septal wall .
The electrocardiogram was difficult to interpret secondary to rapid atrial fibri

llation .
The patient was status post an anteroseptal myocardial infarction in 1989 , he had chronic atrial fibrillation since 09-90 .
Cardioversion was attempted , but the patient failed and reverted back to atrial fibrillation .
His congestive heart failure most recently he had an ejection fraction of 30% , per Dr. Pain .
The patient also had a history of iron-deficiency anemia , status post cold polypectomy , he had abnormal liver function tests with rising glucose tolerance test since 01-91 .
Ultrasound in 10-90 , showed a single gallstone , and the gallbladder otherwise was negative .
The patient was status post appendectomy .
MEDICATIONS ON ADMISSION were potassium 20 mEq per day , captopril 12.5 milligrams by mouth 3 times a day , Lasix 20 milligrams by mouth each morning , 40 milligrams by mouth in the evening , digoxin 0.25 milligrams by mouth per day , Cardene 20 milligrams by mouth twice a day , Coumadin 2.5 milligrams by mouth per day .
ALLERGIES are no known drug allergies .
PHYSICAL EXAMINATION :
The patient was a pleasant gentleman in no acute distress .
Temperature was 97.6 , blood pressure 132/80 , heart rate was between 100 and 120 and irregular , respiratory rate 17 .
He had 97% oxygen saturation on room air , and weight was 73.1 kilograms .
Head , eyes , ears , nose and throat examination was unremarkable , he was nonicteric .
Neck was supple , there was a right SCV scar , there was jugular venous distention up to the angle of the jaw .
Lungs were negative .
Skin showed multiple excoriated papules and pustules , diffusely distributed over the trunk , they were erythematous and hyperpigmented , and they were pruritic .
Lungs were clear to auscultation , there were no wheezes or rales .
Cardiac examination was irregularly irregular with S1 , S2 , question of a gallop .
Abdomen was benign , soft , nontender , mildly distended , liver was 12 centimeters by percussion , edge was 2 centimeters below the right costal margin and slightly tender , no spleen tip , no masses .
The genitourinary examination showed positive scrotal edema , testes were palpable bilaterally and equal in size , there was no inguinal hernia .
Rectal examination showed external hemorrhoids , normal tone , prostate was within normal limits .
Guaiac was negative .
Extremity examination showed 3+ pitting edema to the knees , 1+ pitting edema to the thighs .
Neurologic examination was nonfocal .
LABORATORY EXAMINATION :
Sodium was 137 , potassium 4.0 , chloride 97 , bicarbonate 26 , blood urea nitrogen 28 , creatinine 1.3 , glucose 80 , ALT 35 , AST 30 , alkaline phosphatase 210 , LDH 147 , total bilirubin 1.4 , direct bilirubin 0.7 , calcium 8.9 , albumin 3.8 , digoxin 0.8 .
His white count was 7.83 thousand , hematocrit 39 , mean corpuscular volume 78.9 , platelet count 295,000 .
His prothrombin time was 16.9 .
Urinalysis was uremarkable .
The electrocardiogram showed atrial fibrillation at 100 beats per minute , QRS was 0.08 , QTC 0.30 , axis +60 degrees , there was T-wave inversion in V4 through V6 , flat T-waves in I , II , III and AVL , no changes compared to the previous electrocardiogram on 9-8-90 .
Chest x-ray showed cardiomegaly , pulmonary vascular redistribution , no effusio

ns , no Kerley lines , and no change compared to a previous film on 1-24-91 .
HOSPITAL COURSE :
The patient was treated with increased diuretics , captopril was increased to 25 milligrams by mouth 3 times a day , and then to 37 milligrams by mouth 3 times a day as tolerated .
The patient 's dose of Lasix was increased slowly over the course of this hospitalization in order to effect diuresis .
The patient 's digoxin was changed to 0.375 milligrams by mouth per day on 2-7-91 .
The patient was placed on intravenous Lasix 80 milligrams each morning and 40 milligrams intravenously each evening on 2-5-91 .
The patient required potassium oral supplements throughout his hospitalization secondary to effective diuresis .
The patient was placed on Corgard 10 milligrams by mouth twice a day beginning on 02-10-91 , and started on procainamide , which induced normal sinus rhythm on 02-18-91 , but which was thought to lead to lethargy in the patient .
The patient was then started on Quinaglute at 324 milligrams 4 times a day , and remained in sinus rhythm for the duration of his hospitalization .
The patient 's elevated GGT was explored by ultrasound , which found a normal liver , no dilated biliary ducts and a single gallstone in the gallbladder . This will be followed up further by Dr. Stisie H. Pain as an outpatient .
The patient 's congestive heart failure was markedly better by the time of discharge .
His weight had decreased to 68.1 kilograms at the time of discharge , and edema was significantly reduced .
DISPOSITION :
The patient was discharged to home .
MEDICATIONS ON DISCHARGE were Quinaglute 324 milligrams by mouth 4 times a day , digoxin 0.125 milligrams by mouth per day , Coumadin 1.25 milligrams by mouth every Monday , Wednesday and Friday and 2.5 milligrams every Tuesday , Thursday , Saturday and Sunday , Corgard 10 milligrams by mouth twice a day , potassium supplement 50 mEq by mouth per day , Atarax 25 milligrams by mouth every 4 hours as needed for itching , captopril 37.5 milligrams by mouth 3 times a day , Zaroxolyn 2.5 milligrams by mouth per day , Lasix 80 milligrams by mouth twice a day .

The patient will have FOLLOW-UP with Dr. Collea R. Douetscarv , Dr. Stisie H. Pain .
CONDITION ON DISCHARGE was fair to good .
His disability will be limited by his congestive heart failure and may be moderate to severe at times .
WH968/1141 STISIE H. MEIGS , M.D. CX1
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Report :
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03/17/91
Dicatated By :
SHONDMAGSHAO M. H. PAIN , M.D.
cc :
COLLEA R. NOSE , M.D.
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