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1/17/1998 12:00:00 AM
CONGESTIVE HEART FAILURE .
Unsigned
DIS
Report Status :
Unsigned
DISCHARGE SUMMARY
NAME :
CLOZ , NBURT R
UNIT NUMBER :
085-77-41
ADMISSION DATE :
01/17/98
DISCHARGE DATE :
02/03/98
PRINCIPAL DIAGNOSIS :
Congestive heart failure .
ASSOCIATED DIAGNOSIS :
Coronary artery disease .
PRINCIPAL PROCEDURE :
Echocardiogram .
HISTORY OF PRESENT ILLNESS :
The patient is a 101-year-old man with a history of severe ischemic cardiomyopat
hy who presents with weight gain and some shortness of breath .
The patient has a long history of coronary disease starting in 1946 with his fir
st myocardial infarction .
He underwent a CABG for four vessels in 1980 and did well until 1992 when he beg
an to experience episodic chest pain .
He continued to have episodes of angina for the subsequent several years .
He subsequently went to cath in 1994 which showed a native three vessel disease
, patent saphenous vein grafts to his diagonal and to his obtuse marginal and di
ffusely diseased saphenous vein grafts to his RCA .
He had an echo at this time which showed an ejection fraction of 20% with infero
lateral akinesis , septal akinesis and diffuse hypokinesis of the LV .
He had severe mitral regurgitation and moderate tricuspid regurgitation at this
time .
He subsequently has been managed at a nursing home medically .
He had been doing fairly well on PO medications and has had intermittent admissi
ons for dobutamine holidays with IV diuresis .
The last of such admissions took place in 1997 in July when he was admitted and
placed on dobutamine and diuresed to a dry weight of 115 pounds .
He now presents with at least 10 pound weight gain in spite of doses of increasi
ng diuretics .
He also has been complaining of abdominal bloating and reports increased size of
 his abdomen .
He denies any fevers , chills , sweats , nausea , vomiting , diarrhea , chest pa
in and only mild shortness of breath .
PAST MEDICAL HISTORY :
Coronary disease with ischemic cardiomyopathy as above , hypertension , urinary
retention with a chronic indwelling Foley , gout , peripheral vascular disease ,
 basal cell carcinoma , chronic renal insufficiency .
MEDICATIONS ON ADMISSION :
Zaroxolyn 2.5 mg. Monday , Wednesday and Friday which recently had been increase
d to 5 mg. PO BID , Ampicillin 250 mg. PO QD , Cipro 750 mg. PO QD , Hydralazine
 25 mg. PO QID , Nitro-patch .6 mg. per hour every 24 hours , digoxin .125 mg. P

O QD , aspirin 81 mg. PO QD , Mevacor 20 mg. PO QD , Hydrin 2 mg. PO QHS , iron sulfate 325 mg. PO TID , Cimetidine 400 mg. PO QD , Ativan .5 mg. PO TID , Allop urinol 150 mg. PO QD .
ALLERGIES :
No known drug allergies .
In the past , ACE inhibitors have caused a cough .
SOCIAL HISTORY :
He is a retired Roman Catholic priest who lives in Lupe Frankcinevirg Asma Ein H ealth Care .
PHYSICAL EXAMINATION :
He is a cachectic and fatigued appearing white male upon admission .
His blood pressure was 98/60 .
His heart rate was 75 .
Respirations of 12 and he was afebrile .
HEENT is notable for extraocular movements being intact , for equal round and re active pupils and for a clear oropharynx .
Neck :
His JVP was up to his angle of his jaw .
He had soft bilateral bruits versus a trasmissable murmur in his neck .
Lungs :
He had crackles a third of the way up at the bases with poor air movement .
Cardiovascular :
He had an irregularly irregular S1 and S2 with a Grade III / VI holosystolic mur mur at the apex and a Grade II / VI systolic ejection murmur at the base with mi ld radiation to this carotids bilaterally .
He had a positive hepatojugular reflux .
Abdomen :
He had positive bowel sounds .
It was soft .
It was mildly distended with a fluid wave and shifting dullness .
Extremities had 1+ non-pitting pedal edema bilaterally and diffuse ecchymoses an d thinned skin .
LABORATORY DATA :
Sodium of 139 , potassium of 3.2 , chloride of 96 , bicarb of 32.1 , BUN of 79 , creatinine of 3.4 , glucose of 129 , magnesium of 2.2 and albumin of 3.2 , bili rubins of .4/.9 , alkaline phosphatase of 126 , SGOT of 27 , hematocrit of 27.6 , white count of 4.7 , PT of 13.4 , PTT of 26.5 .
His EKG showed atrial fibrillation versus frequent PVC 's and no acute ST-T wave changes indicative of ischemia .
His chest x-ray showed mild cephalization of vessels but no evidence of overwhel ming congestive heart failure and no air space disease .
HOSPITAL COURSE AND TREATMENT :
The patient was admitted to the hospital and the following issues were addressed :
1. Cardiovascular :
The patient was admitted and placed on IV dobutamine and also IV Lasix for diure sis .
He was also placed on varying vasodilator regimens .
It was thought that his Hydralazine had caused a drug induced lupus .
Initially , he was changed to Cozaar .
His creatinine then began to increase at this time and the patient became hypote nsive .
He was then started on amlodipine up to 10 mg. PO QD with more stable blood pres sure .
A few days prior to discharge , he was also begun back on his prazosin and curre ntly is at 2 mg. PO QD .
He was aggressively diuresed with a goal dry weight of 121 pounds .
At the time of discharge , he was down to 123 pounds .
This is approximately 10 pounds less than his admission weight .
His dobutamine was discontinued approximately 2 days prior to discharge .

He continued to have a good urine output to a regimen of PO diuresis including B umex 4 mg. PO BID , aldactone 50 mg. PO BID and Zaroxolyn 5 mg. PO BID .
2. Renal :
The patient has baseline chronic renal insufficiency .
With optimization of his cardiac output and volume status , his creatinine impro ved to his baseline of 2.0 .
He continues to have approximately 500-700 cc. of urine output every eight hours .
He is fluid restricted to 1 liter of free water .
He should also follow a strict diet including 2 gram salt restriction per day .
3. GU :
The patient has had a Foley in place for several months for urinary retention an d BPH .
He has failed a trial of Hydrin after discontinuation of his Foley .
Urology felt that this time that the only other option would be a suprapubic tub e which would not decrease the risk of infection .
In consultation with the patient , it was decided to leave the Foley in place an d to place him on daily Cipro for UTI prophylaxis .
4. Hematologic :
The patient has mild baseline pancytopenia .
He occasionally has a transfusion .
He was transfused 1 unit of packed red blood cells the day before discharge for a hematocrit of 25 .
His hematocrit at the time of discharge is 30 .
DISPOSITION :
The patient is now discharged stably with a weight of 123 pounds to Lupe Frankci nevirg Asma Ein Health Care for further management .
CONDITION ON DISCHARGE :
Stable .
MEDICATIONS ON DISCHARGE :
Gentamicin ointment to the left eye QHS , Ativan .5 mg. PO TID , Zaroxolyn 5 mg. PO BID , Colace 100 mg. PO TID , Ciprofloxacin 250 mg. PO QD , amlodipine 10 mg . PO QD , Mevacor 20 mg. PO QD , Nitro-patch .6 mg. per hour once a day , digoxi n .125 mg. PO QD , iron sulfate 325 mg. PO TID , Cardura 2 mg. PO QHS , aldacton e 50 mg. PO BID , and Bumex 4 mg. PO BID .
FOLLOW UP :
The patient is to follow up in Cardiology Clinic with Dr. Sta Husband .
LUPEVICKETTE L. TRUE , M.D.
DICTATING FOR :
TRUE G. MCARDLE , M.D.
TR :
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TRUE G MCARDLE , M.D. LUPEVICKETTE LONIE TRUE , M.D. / Sta Husband , M.D. STAT
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