



DEATH SUMMARY REPORT

PATIENT MRN: 63081838

PATIENT DOB: 1979-12-28

PATIENT NAME: Sherry Small

DATE OF ADMISSION: 12/04/2021

DATE OF EXPIRATION: 12/18/2021

DISCHARGE DIAGNOSES:

1. Cardiac arrest.
2. Anoxic encephalopathy.
3. Aspiration pneumonia.
4. Congestive heart failure.
5. Alcohol withdrawal syndrome.

OPERATIONS: None.

HISTORY OF PRESENT ILLNESS: The patient was a 42-year-old female who was brought to the hospital after suffering a seizure at home. His medical history includes Crohn's disease, kidney stones, and prostate cancer. He had been drinking heavily, and on the day of admission, he was showing evidence of being unsteady on his feet, fell, and suffered a laceration to his left eyebrow and other soft tissue trauma to the left side of the face. The patient was found on the ground at home and appears to have suffered a grand mal seizure while waiting for the ambulance to arrive. On arrival at the hospital, the patient was intubated for airway protection. He had been taking Demerol, Flomax, and several other pain medications.

PHYSICAL EXAMINATION: Initial examination showed a temperature of 101.2 degrees with a heart rate of 126 and a blood pressure of 152/94. The patient was in general thin and malnourished and appeared chronically ill. He was not responding to verbal or tactile stimulation on admission. Head and neck demonstrated no abnormalities. Heart sounds were normal. Breath sounds were loud bilaterally without wheezing or rales. Abdomen was soft without any masses. Neurologic assessment could not be performed because the patient had been sedated.

DIAGNOSTIC AND LABORATORY DATA: The chest radiograph demonstrated no definite infiltrates or effusions. The electrocardiogram showed sinus tachycardia with right axis deviation and right bundle branch block. Arterial blood gases demonstrated pH of 7.46, PCO2 of 38, and PO2 of 72 on 40% oxygen and controlled ventilation. There was an

elevated lactate level of 1.78. The white blood cell count was 12,200 and hematocrit was 42. Electrolytes were largely within normal limits with a potassium of 3.7.

HOSPITAL COURSE: The patient was admitted to the intensive care unit and maintained on mechanical ventilation. He was evaluated by Dr. John Doe because of an elevated troponin level. However, it was felt the patient did not suffer a myocardial infarction. He was treated with antibiotics for possible pneumonitis, and over the next several days, the patient did develop bilateral infiltrates. He was able to be weaned from mechanical ventilation two days after admission and was showing some mild tremor, which was treated with Valium and Librium. He remained in a stable condition with gradually improving mental status but then had a sudden episode of bradycardia followed by respiratory arrest. The patient was placed on mechanical ventilation again and needed resuscitation with atropine and epinephrine in order to restore a normal heart rhythm and blood pressure. His sputum culture did show evidence of *Klebsiella oxytoca*. It was felt that the patient had probably suffered aspiration, which resulted in respiratory arrest. His condition was again stabilized, and he was able to be weaned from the respirator once again after several days. He then showed evidence of congestive heart failure with significant hypoxemia and fluid overload. He was given diuretics, which did result in some improvement, but again, the patient developed a respiratory arrest and bradycardia and subsequently developed pulseless electrical activity. He was intubated, and it took extended period of time to restore satisfactory blood pressure. Following this episode, the patient remained flaccid and unresponsive and did not regain consciousness. After further discussion with the family, it was determined that the patient would not benefit from additional medical treatment, and he was removed from life support and was allowed to die naturally.