**MEDICAL DISCHARGE SUMMARY**

**NAME:** Taihlah S Vick **MRN:** 20518475 **DOB:** 11/25/1994

**ADMIT Date:** 12/5/2019 5:50 PM **D/C Date:** 12/09/19

**Attending of Record**: Jean-Louis, Gerty, MD

**Admitting Physician**: Gerty Jean-Louis, MD

**Discharge Physician:** Anish Shah, MD, Gerty Jean-Louis, MD

**Outpatient PCP:** No primary care provider on file.

**Principal and Secondary Diagnoses:**

#. Opioid Withdrawal

#. Opioid abuse/addiction

#. Persistent/intractable nausea/vomiting

**Diagnostic Tests:**

No significant testing

**Brief Presenting History:**

TAIHLAH S VICK is a 25 y.o. female h|o opioid use disorder, who presents with symptoms of opioid withdrawal. She explains that she consumes 13x30 tabs of oxycodone and a daily basis and has been doing so over the past month. She also endorses the use fentanyl via nasal insuflationspray about 3-6 times per day,  for the last 3 years. Her last dose of opiates was 3 days ago. She endorsed persistent nausea/vomiting for almost 48 hours with diaphoresis and runny nose. She also complains of generalized myalgias and joint pain,  irritability, and restlessness, chills, rhinorrhea, abdominal cramping with nausea with NBNB emesis and loose stools, feels tremulousness and  Anxious. She is requesting detox at this time.

She was seen by toxicology and was started on suboxone and has outpatient follow up instructions. The plan was to keep her in the CDU for observation. Unfortunately her nausea and vomiting has proven to be intractable despite adequate antiemetic coverage. Medicine is askde to admit the patient for further management. She currently on complains of the above symptoms.

Denies IVDU or any co-ingestants including benzos and heavy alcohol use. No CP, SOB, headache, neck stiffness, syncope, focal abdominal pain, urinary sx. Denies pregnancy.

**Hospital Course by Problem List:**

#. Opioid Withdrawal

- pt presented with abd pain, n/v, tachycardia, diarrhea, all c/w opioid withdrawal

- pt was given supportive care c- significant improvement

- toxicology was consulted and suboxone therapy was started to aid in mgmt

- she improved significantly, and has a OP f/u c- toxicology for further mgmt on Wednesday after DC

#. Opioid abuse/addiction

- counseled about this problem significantly

- pt endorsed undrestanding and will attempt OP detox

#. Persistent/intractable nausea/vomiting

- persisted even after other opioid sx improved

- unclear etiology, but no sx of liver/gi or nutrition issues

- will DC c- antiemetics and f/u

The remainder of the patient's medical problems were chronic and stable without any further intervention this admission. The patient will continue the current treatments and medications.

**Discharge Condition:**

BP (!) 136/92 | Pulse 57 | Temp 37 °C (98.6 °F) (Oral) | Resp 16 | Ht 1.803 m (5' 11") | Wt 77.1 kg (170 lb) | LMP (LMP Unknown) | SpO2 100% | BMI 23.71 kg/m²

Laying in bed, sleepy

NAD, AOx4, although endorsing nausea

ABd soft, nontender

Easy WOB

NRRR, +2 radial, warm ext

**Discharge To:**

home

**Discharge Medication Reconcilitation:**

|  |  |  |
| --- | --- | --- |
| **Current Discharge Medication List** | | |
|  | | |
| **START taking these medications** | | |
|  | | Details |
| **ondansetron ODT (ZOFRAN) 4 mg disintegrating tablet** | | Place 1 tablet (4 mg total) under the tongue every 6 hours as needed for Nausea.  *Qty:* 20 tablet, *Refills:* 0 |
|  | | |
| **famotidine (PEPCID) 20 MG tablet** | | Take 1 tablet (20 mg total) by mouth 2 times every day.  *Qty:* 60 tablet, *Refills:* 11 |
|  | | |
| **buprenorphine-naloxone (SUBOXONE) 8-2 MG SL tablet** | | Place 1 tablet under the tongue 2 times every day.  *Qty:* 5 tablet, *Refills:* 0 |
|  | *Comments:* M Yeh XY8366735. Start taking on 12/7/2019 | |
|  | | |
| **naloxone (NARCAN) 4 MG/0.1 ML LIQD nasal spray** | | 1 spray by Nasal route use as needed.  *Qty:* 1 each, *Refills:* 0 |
|  | | |
|  | | |
| **CONTINUE these medications which have NOT CHANGED** | | |
|  | | Details |
| **ibuprofen (MOTRIN) 800 mg tablet** | | Take 1 tablet (800 mg total) by mouth every 8 hours as needed for Pain.  *Qty:* 20 tablet, *Refills:* 0 |
|  | | |
| **acetaminophen (TYLENOL) 325 MG tablet** | | Take 2 tablets (650 mg total) by mouth every 4 hours as needed for Pain.  *Qty:* 30 tablet, *Refills:* 0 |
|  | | |
|  | | |

**Discharge Instructions:**

The patient was educated on warning signs regarding the current medical conditions. If any of these issues were to arise or worsen, the patient was instructed to contact the PCP or seek further medical evaluation in the emergency room.

**Test Pending/Items to Follow Up:**

- f/u c- toxicology on Wednesday per DC instructions

**Follow-up Appointment Date and Time:**

No future appointments.

Greater than 30 minutes were spent in coordinating this discharge plan.

Anish Shah, MD

12/9/2019

2:14 PM

**MEDICAL DISCHARGE SUMMARY**

**NAME:** Alexander Clark **MRN:** 100372613 **DOB:** 3/24/1959

**ADMIT Date:** 11/17/2019 10:51 AM **D/C Date:** 12/09/19

**Attending of Record**: Merid, Obsinet, MD

**Admitting Physician**: Aarti Duggal, MD

**Discharge Physician:** Anish Shah, MD, Aarti Duggal, MD

**Outpatient PCP:** Park, Jung, MD

**Principal and Secondary Diagnoses:**

#. Placement

#. Cardiometabolic syndrome, obesity

**Diagnostic Tests:**

|  |
| --- |
| CT Dissection Protocol |
| **Final Result** |
| IMPRESSION: |
| 1.    Interval enlargement of infrarenal abdominal aortic aneurysm with associated mural thrombus/soft plaque measures up to 4.3 x 4.1 cm, previously 4.0 x 3.8 cm. |
| 2.    Interval enlargement of the right internal iliac artery aneurysm measures 2.9 x 3.0 cm, previously 2.8 x 2.5 cm. Unchanged aneurysmal dilatation of the left internal iliac artery measures 2.5 x 2.5 cm. Redemonstrated occlusion of the distal |
| internal iliac arteries. |
| 3.    Up to 75% stenosis of the tortuous left common iliac artery. |
| 4.    Mild to moderate focal stenosis of the right superficial femoral artery. |
| 5.    Dilated main pulmonary artery may reflect underlying pulmonary hypertension. |
|  |
| Preliminary findings were published to the electronic medical record by Dr. Ross Christopher. |
|  |
| The images were reviewed and interpreted by Eugene Berkowitz, MD. |
|  |
| CT Dissection Protocol    (Results Pending) |

**MRI L spine 10/11/18:**

IMPRESSION:

1.    Status post T11-T12 and L2-L4 posterior spinal interbody fusion and posterior decompression.

2.    Multilevel degenerative changes of the lumbar spine with canal stenosis most prominent at L4-L5 where it is moderate to severe. Multilevel high-grade neural foramina stenosis most pronounced at L4-L5 where it is severe bilaterally. Severe bilateral

 neural foramina stenosis at T11-T12 and L1-L2.

3.    No abnormal enhancement.

**Brief Presenting History:**

Alexander Clark is a 60 y.o. male with a medical history significant for CAD (remote stent), HFrEF (EF 20-25%), Afib/Aflutter, HTN, AAA (4 cm infrarenal aneurysm), GERD, CKD, left heel ulcer (chronic), severe spinal stenosis, and morbid obesity who presented to the hospital with increasing lower back pain with concomitant right groin pain. States his lower back pain has been ongoing for almost 14 years now, after his first back surgery. Groin pain also started around this time, and pain in both areas have been increasing since. Now, he is at a point where he cannot walk. He also feels numbness in his hands and feet. Also endorsing severe right hip pain.

He has had difficulty walking for a "while" now and previously used ambulatory assist devices (canes, walkers) to walk. He was incarcerated for about 30 days and was recently released from jail. His assist devices were not recovered (they were "torn up" by another individual). He has been extensively worked up for his chronic pain issues, seen by PM&R and neurosurgery. Last NSGY visit (03/2019) concerning for possible cord compression but cites likely high operative risk. He has since gotten a CT myelogram without evidence of cord compression and seen PM&R. Last PM&R visit cites pain in right hip that may be contributing to groin pain. Indeed, there is severe OA of his hip per XR imaging.

Per ED, he tried to ambulate to bathroom today but just "fell to the ground." Has since been unable to ambulate more than a few steps 2/2 pain. Per ED personnel report, DRE done and good anal tone note. No saddle numbness. Admitted to medicine for inability to ambulate and PT/OT.

**Hospital Course by Problem List:**

**#Severe low back pain w/ radiculopathy**

**#Severe right hip pain**

**#Severe right-sided groin pain 2/2 R hip OA**

**#Likely neurogenic claudication**

**-**All chronic issues that have increased in severity, resulting in inability to ambulate. Per chart review, has history of difficulty ambulating but has been able to do so with assist devices in past. Low suspicion for cauda equina given reported good anal tone. CT myelogram from 05/2019 without overt evidence of cord compression, per NSGY there is no acute intervention or suspicion for cord compression. They will continue to follow as outpatient.

-pain management with PO percocet, lidocaine patch. Pt has pain clinic appt on 1/14/20 and PM&R visit on 2/26/20.

-lidocaine patches

-Received CST hip injection under fluoro by PM&R on 11/22 by Dr. Hinrichs

-cont home gabapentin 1.2g TID

-cont cymbalta 20 mg daily, increased to 30 mg po daily for neuropathic pain.

-Per PT/OT rec SNF, discussed with NCM, appreciate assistance. Submitted name to CMU team.

**#HFrEF (EF 20-25%)**

-Euvolumic

-cont coreg, hydralazine, isordil, lisinopril, torsemide

-Card appt on 1/6/20

**#AFib**

**-**sinus rhythm

-cont home coreg, eliquis

**#Infrarenal AAA**

**#BLT internal iliac aneurysms**

**-**still smoking. No evidence of rupture on CT dissection, some expansion of both from prior.

-counseled on smoking cessation

-Vascular surgery saw pt and planning to see the patient in clinic in 3 months with repeat CT dissection protocol to monitor growth of infrarenal AAA and bilateral internal iliac artery aneurysms and CTM thereafter.

-Pt has appt on 2/26/20.

**#HTN**

**#CAD**

**Plan:**

-Cont home atorvastatin, asa

-Cont home coreg, hydralazine, isordil, lisinopril, torsemide

**#GERD**

**Plan:**

-cont home nexium

The remainder of the patient's medical problems were chronic and stable without any further intervention this admission. The patient will continue the current treatments and medications.

**Discharge Condition:**

BP 121/48 | Pulse 76 | Temp 36.9 °C (98.4 °F) (Oral) | Resp 18 | SpO2 95%

No acute distress, laying in bed

Obese abdomen

Easy WOB

Wamr ext, no edema

Mood/affect congruent

**Discharge To:**

Transfer to dekalb medical center

**Discharge Medication Reconcilitation:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Discharge Medication List** | | | |
|  | | | |
| **CONTINUE these medications which have NOT CHANGED** | | | |
|  | | Details | |
| **baclofen (LIORESAL) 10 mg tablet** | | Take a half tablet as needle twice a day for muscle spasms. May increase to a whole tablet twice a day as needed if tolerated well.  *Qty:* 60 tablet, *Refills:* 2 | |
|  | | | |
| **apixaban (ELIQUIS) 5 MG tablet** | | Take 1 tablet (5 mg total) by mouth 2 times every day.  *Qty:* 180 tablet, *Refills:* 3 | |
|  | | | |
| **aspirin 81 mg chewable tablet** | | Take 1 tablet (81 mg total) by mouth every day.  *Qty:* 90 tablet, *Refills:* 3 | |
|  | | | |
| **atorvastatin (LIPITOR) 80 MG tablet** | | Take 1 tablet (80 mg total) by mouth every day.  *Qty:* 90 tablet, *Refills:* 3 | |
|  | | | |
| **carvedilol (COREG) 12.5 mg tablet** | | Take 1 tablet (12.5 mg total) by mouth 2 times every day with meals.  *Qty:* 180 tablet, *Refills:* 3 | |
|  | | | |
| **hydrALAZINE (APRESOLINE) 50 mg tablet** | | Take 1 tablet (50 mg total) by mouth every 8 hours.  *Qty:* 270 tablet, *Refills:* 3 | |
|  | | | |
| **lisinopril (PRINIVIL) 20 mg tablet** | | Take 1 tablet (20 mg total) by mouth every day.  *Qty:* 90 tablet, *Refills:* 3 | |
|  | *Associated Diagnoses:* Essential hypertension | | |
|  | | | |
| **torsemide (DEMADEX) 20 mg tablet** | | Take 1 tablet (20 mg total) by mouth every day.  *Qty:* 90 tablet, *Refills:* 3 | |
|  | | | |
| **capsaicin (ZOSTRIX) 0.025 % cream** | | Apply to painful areas  *Qty:* 120 g, *Refills:* 6 | |
|  | | | |
| **lidocaine (LIDODERM) 5 % patch** | | Apply 2 patch to painful area. Patches may remain in place up to 12 hours.  *Qty:* 90 patch, *Refills:* 6 | |
|  | | | |
| **isosorbide dinitrate (ISORDIL) 20 mg tablet** | | Take 1 tablet (20 mg total) by mouth 3 times every day.  *Qty:* 270 tablet, *Refills:* 3 | |
|  | | | |
| **fluticasone (FLONASE) 50 MCG/ACT nasal spray** | | 1 spray by Each Nare route every day.  *Qty:* 16 g, *Refills:* 1 | |
|  | | | |
| **esomeprazole (NEXIUM) 40 mg capsule** | | Take 1 capsule (40 mg total) by mouth every day.  *Qty:* 90 capsule, *Refills:* 3 | |
|  | | | |
| **gabapentin (NEURONTIN) 300 mg capsule** | | Take 4 capsules (1,200 mg total) by mouth 3 times every day.  *Qty:* 1080 capsule, *Refills:* 3 | |
|  | | | |
|  | | | |
| **STOP taking these medications** | | | |
|  | | | |
|  | **traZODone (DESYREL) 50 mg tablet** | | *Comments:*  *Reason for Stopping:* |
|  |  | | |
|  | | | |

**Discharge Instructions:**

The patient was educated on warning signs regarding the current medical conditions. If any of these issues were to arise or worsen, the patient was instructed to contact the PCP or seek further medical evaluation in the emergency room.

**Test Pending/Items to Follow Up:**

- pending placement

**Follow-up Appointment Date and Time:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Future Appointments** | | | | |
| **Date** | **Time** | **Provider** | **Department** | **Center** |
| 1/6/2020 | 2:00 PM | GHS CARDIAC ELECTROPHYSIOLOGY | CARDIAC | GHS Outpatie |
| 1/14/2020 | 2:00 PM | Bobzien, Brian P., MD | PAIN | GHS Outpatie |
| 2/26/2020 | 10:20 AM | Ramos, Christopher R., MD | VAS SURG | GHS Outpatie |
| 2/26/2020 | 1:30 PM | GHS NEUROLOGY PM&R PHYSICIAN | NEURO PM&R | GHS Outpatie |
| 3/5/2020 | 1:40 PM | O'Neal, Wesley, MD | CARDIAC | GHS Outpatie |

Greater than 30 minutes were spent in coordinating this discharge plan.

Anish Shah, MD

12/9/2019

5:01 PM

**MEDICAL DISCHARGE SUMMARY**

**NAME:** Louis Carswell **MRN:** 14378656 **DOB:** 5/12/1959

**ADMIT Date:** 12/8/2019 8:58 AM **D/C Date:** 12/09/19

**Attending of Record**: Shah, Anish, MD

**Admitting Physician**: Anish Shah, MD

**Discharge Physician:** Anish Shah, MD, Anish Shah, MD

**Outpatient PCP:** Baker, Dylan M., MD

**Principal and Secondary Diagnoses:**

#. Placement

**Diagnostic Tests:**

No significant testing

**Brief Presenting History:**

Louis Carswell is a 60 y.o. male h/o HTN, DM, ETOH abuse, chronic leukopenia/thrombocytopenia, Wernicke-Korsakoff syndrome p/w request for placement, and recent ETOH intoxication (12/6). He is unable to provide a hx due to his limited mental status, but notes that his "hands don't work". He has no other complaints that he is able to state. He is homeless as well. He states his last drink was on Wednesday, and that he has had episodes of withdrawal in the past.

**Hospital Course by Problem List:**

#. Disposition

- pt homeless, has physical limitations, requests housing

- PT/OT/SW/NCM

#. Wernicke-Korsakoff syndrome d/t ETOH abuse, c/b cerebellar ataxia, c/b peripheral neuropathy, c/b vitamin deficiency, c/b ETOH abuse/dependence, c/b marrow suppression d/t ETOH toxicity

- monitoring for sx of withdrawal

- sig vitamin replacement

#. DMT2

- monitor BG

#. HTN

- sig home meds

#. HLD

- sig statin

The remainder of the patient's medical problems were chronic and stable without any further intervention this admission. The patient will continue the current treatments and medications.

**Discharge Condition:**

BP 142/72 | Pulse 80 | Temp 36.8 °C (98.2 °F) (Oral) | Resp 18 | Ht 1.778 m (5' 10") | Wt 77.6 kg (171 lb) | SpO2 100% | BMI 24.54 kg/m²

No acute distress, pleasant elderly gentleman

Easy WOB

Warm ext, NRRR

Insight poor, judgment poor

Abd soft, nontender, no ascites

**Discharge To:**

Transfer to DMC

**Discharge Medication Reconcilitation:**

|  |  |  |
| --- | --- | --- |
| **Current Discharge Medication List** | | |
|  | | |
| **CONTINUE these medications which have NOT CHANGED** | | |
|  | | Details |
| **albuterol HFA (VENTOLIN) 108 (90 Base) MCG/ACT inhaler** | | Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing.  *Qty:* 1 Inhaler, *Refills:* 1 |
|  | *Comments:* Dispense Proair HFA  *Associated Diagnoses:* Smoking greater than 30 pack years; Shortness of breath | |
|  | | |
| **aspirin 81 mg chewable tablet** | | Take 1 tablet (81 mg total) by mouth every day.  *Qty:* 30 tablet, *Refills:* 1 |
|  | *Associated Diagnoses:* Coronary artery disease due to calcified coronary lesion | |
|  | | |
| **atorvastatin (LIPITOR) 20 MG tablet** | | Take 1 tablet (20 mg total) by mouth every day.  *Qty:* 30 tablet, *Refills:* 1 |
|  | | |
| **budesonide-formoterol (SYMBICORT) 160-4.5 MCG/ACT inhaler** | | Inhale 2 puffs into the lungs 2 times every day.  *Qty:* 1 Inhaler, *Refills:* 1 |
|  | *Associated Diagnoses:* Smoking greater than 30 pack years; Shortness of breath; Reactive airway disease, mild intermittent, uncomplicated | |
|  | | |
| **carvedilol (COREG) 6.25 mg tablet** | | Take 1 tablet (6.25 mg total) by mouth every 12 hours.  *Qty:* 60 tablet, *Refills:* 1 |
|  | *Associated Diagnoses:* Essential hypertension with goal blood pressure less than 140/90 | |
|  | | |
| **cholecalciferol (VITAMIN D3) 1000 units TABS tablet** | | Take 1 tablet (1,000 Units total) by mouth every day.  *Qty:* 30 tablet, *Refills:* 0 |
|  | | |
| **cyanocobalamin, Vitamin B12, 1000 MCG tablet** | | Take 1 tablet (1,000 mcg total) by mouth every day.  *Qty:* 30 tablet, *Refills:* 1 |
|  | | |
| **esomeprazole (NEXIUM) 40 mg capsule** | | Take 1 capsule (40 mg total) by mouth every morning before breakfast.  *Qty:* 30 capsule, *Refills:* 1 |
|  | *Associated Diagnoses:* Gastroesophageal reflux disease, esophagitis presence not specified | |
|  | | |
| **lisinopril (PRINIVIL) 10 mg tablet** | | Take 1 tablet (10 mg total) by mouth every day.  *Qty:* 30 tablet, *Refills:* 1 |
|  | | |
| **metFORMIN (GLUCOPHAGE) 1000 mg tablet** | | Take 1 tablet (1,000 mg total) by mouth 2 times every day with meals.  *Qty:* 60 tablet, *Refills:* 1 |
|  | *Associated Diagnoses:* Type 2 diabetes mellitus without complication, without long-term current use of insulin (HCC) | |
|  | | |
| **folic acid (FOLVITE) 1 mg tablet** | | Take 1 tablet (1 mg total) by mouth every day.  *Qty:* 90 tablet, *Refills:* 3 |
|  | | |
|  | | |

**Discharge Instructions:**

The patient was educated on warning signs regarding the current medical conditions. If any of these issues were to arise or worsen, the patient was instructed to contact the PCP or seek further medical evaluation in the emergency room.

**Test Pending/Items to Follow Up:**

- placement

**Follow-up Appointment Date and Time:**

No future appointments.

Greater than 30 minutes were spent in coordinating this discharge plan.

Anish Shah, MD

12/9/2019

6:51 PM

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Bonnie Hatcher**

**Hospital Day: 4**

Bonnie Hatcher is a 64 y.o. female h/o HFpEF, COPD, OSA not on CPAP, hx of CVA R MCA with mild L sided deficits, HTN, preDM, hx of PUD who presents with several days of worsening BLE edema and SOB. Patient appears volume overloaded but SOB also is likely multifactorial with COPD and untreated OSA contributing. Being managed now for volume overloaded.

**SUBJECTIVE**

No acute complaints this AM

NAEO

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | furosemide | 80 mg | IV PUSH | BID diuretics |
| • | acetaZOLAMIDE | 500 mg | Oral | BID diuretics |
| • | amLODIPine | 10 mg | Oral | Daily |
| • | aspirin EC | 81 mg | Oral | Daily |
| • | atorvastatin | 80 mg | Oral | Daily |
| • | cholecalciferol | 1,000 Units | Oral | Daily |
| • | esomeprazole | 20 mg | Oral | Daily |
| • | folic acid | 1 mg | Oral | Daily |
| • | glycopyrrolate-formoterol | 2 puff | Inhalation | BID Resp |
| • | ipratropium-albuterol base | 1 each | Nebulization | BID Resp |
| • | lisinopril | 20 mg | Oral | Daily |
| • | Enoxaprin SC inj for VTE Prophylaxis (HIGH risk for VTE) | 40 mg | Subcutaneous | Q24H |
| • | insulin lispro | 0-8 Units | Subcutaneous | TID w/meals |
|  | And | | | |
| • | insulin lispro | 0-4 Units | Subcutaneous | Nightly |
| • | miconazole |  | Topical | BID |

**OBJECTIVE**

BP 148/67 | Pulse 75 | Temp 36.8 °C (98.3 °F) (Oral) | Resp 23 | Ht 1.6 m (5' 3") | Wt (!) 118.2 kg (260 lb 9.3 oz) | SpO2 99% | BMI 46.16 kg/m²

GEN: laying in bed, NAD

CV: warm ext, +1 pitting edema of LE

PULM: distant breath sounds, equal chest rise

ABD: morbidly obese

PSYCH: insight poor

All labs, studies, and imaging was personally reviewed.

Bicarb 44

K 4.2

Cr 1.0

**ASSESSMENT and PLAN**

#. Acute on chronic hypercapnic respiratory failure

#. OSA/OHS

#. COPD - not in exacerbation

- Does not have cpap/bipap at home. Family willing to buy one. Spoke with pulm re: recs for which machine they should try to buy. They recommended contacting Erin with Apria Healthcare 813-295-3152. Spoke with Erin: she recommends buyng autoCPAP (APAP) on cpap.com with settings btwn 4-20. Will let family know to look at cpap.com.

- Repeat ABG on bipap improved. ABG off bipap acceptable. Continue BIPAP at night

- Needs sleep study as outpatient- called scheduler, will call patient on Monday to schedule

- Continue Bevespi-aerosphere

- Duonebs prn

- needs PFTs as outpatient, called scheduler, will call patient on Monday to schedule

#. Acute exacerbation of chronic HFpEF

#. Hypercarbemia

- s/p lasix 80 mg IV with good UOP

- improving with diuresis, added dose of acetazolamide to help with contraction alkalosis

- Creatine stable

- monitor lytes, tele, strict I/Os

#. Hx of R MCA CVA with residual left sided deficits

- continue asa, statin

#. HTN

- continue amlodipine, lisinopril

#. Hx of PUD

- nexium

#. Pre-DM

- A1c 6.2% in 8/2019, recheck A1c

- ssi +poct

#. Tobacco use

- counseled on cessation

#. Chronic microcytic anemia

- no signs of active bleeding

- check anemia labs

#. Dispo planning

- SW consult re: home CPAP

- PT/OT

- lives with daughter who assists her with some ADLs. Pt home-bound due to limited ambulation. Ambulated with cane PTA.

General

Diet: low salt, fluid restricted

Lines and Catheters: piv

VTE Prophylaxis: lovenox

Code Status: DNR/DNI

Family Contact  Primary Emergency Contact: Johnson, regina

Dispo: pending

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Robert Cobbs**

**Hospital Day: 25**

Robert Cobbs is a 38 y.o. male h/o Fournier's gangrene in 7/2018, homelessness who presents with L leg pain x 1 day as well as melena x3 days, found to have Hb 4.3 and sepsis 2/2 L leg abscesses. EGD showed non-bleeding gastric AVMs and large internal hemorrhoids per C-scope. Pt was also noted to have pancytopenia, B sxs (fever and night sweats) and abd LAD and splenomegaly concerning for malignancy likely lymphoma/ leukemia. Pt is s/p BM bx on 11/27 with results so far non diagnostic. TB/fungal etiology also in ddx given cavitary lung lesion. S/p core bx by IR of abd LN- results pending.

**SUBJECTIVE**

Complains of increased fatigue

NAEO

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | vancomycin | 1,250 mg | Intravenous | Q24H |
| • | ciprofloxacin | 500 mg | Oral | Q12H SCH |
| • | fluconazole | 200 mg | Oral | Daily |
| • | acyclovir | 400 mg | Oral | Q12H SCH |
| • | esomeprazole | 40 mg | Oral | Q12H SCH |

**OBJECTIVE**

BP 125/65 | Pulse 108 | Temp 36.8 °C (98.2 °F) (Oral) | Resp 18 | Ht 1.88 m (6' 2") | Wt 86.2 kg (190 lb) | SpO2 100% | BMI 24.39 kg/m²

GEN: no acute distress, laying in bed

CV: tachycardiac, warm ext

PULM: easy WOB

ABD: soft, nontender, PCN in place

PSYCH: mood/affect congruent, cooperative

All labs, studies, and imaging was personally reviewed.

Hb ~6

**ASSESSMENT and PLAN**

#. Diffuse abdominal lymphadenopathy / splenomegaly

#. Pancytopenia

- Appreciate heme input, infection may be driving his leukopenia and thrombocytopenia, but signs and sxs more concerning for malignancy.

-s/p BM bx on 11/27, f/u

- S/p abd LN core biopsy by IR 12/5- fungal/AFB cultures, surgical pathology and leukemia/lymphoma panel in process

-transfuse platelets if <50.000 in the presence of active bleeding

--CTM h/h and transfuse if hgb < 7. No active bleeding.

- Follow up BMBx 11/27- prelim results so far non diagnostic

- HSV DNA pcr returned as positive. Serology for brucella, bartonella, coxiella negative. urine histoplasma pending, cocci Ab and blasto Ab neg, AFB/fungal cx on LN node pending

- Continue cipro, acyclovir, fluconazole for neutropenia

#. Apical RUL Cavitary lesion

#. Cough, no sob or cp

-CXR shows asymmetrical opacity in left apex. CT chest shows apical cavitary lesion

- 1/2 from 12/5/19 sputum afb stain negative. 2nd AFB stain 12/6 negative. D/c'ed airborne isolation

- Re-consulted ID: agree with above work up and awaiting LN biopsy result

#. Melena

#. Normocytic anemia : due to combination acute blood and possible bone marrow process

- Denied NSAID use or alcohol use

- T&C, consented. S/p 6 units pRBCs thus far during admission. Last transfusion on 12/4

- PPI 40mg BID switched to PO (from IV) 11/20

- EGD significant for AVMs, colonoscopy with large internal hemorrhoids but no other bleeding source

appreciate GI input

-CTM h/h

#. LLE abscesses s/p I&D

#. MRSA Bacteremia

#. Elevated LA - infection vs due to some degree of liver dysfunction vs malignancy.  He is currently hemodynamically stable.

#. Fever - possibly due to malignancy, will continue w/u for new infection. Appreciate ID assistance. Recommendation noted.

-First BCs + for MRSA. Repeat blood cxs since NGTD, urine cx NGTD.

-Cont vanc with pharmacy to dose, will need 4 weeks 11/15 - 12/13. Not a candidate for OPAT given homeless. Appreciate assistance from SW.

-TTE as above, no vegetations seen. TEE negative for endocarditis

-wound care/nursing to dress

-ortho with low concern for septic arthritis of L ankle (dry tap)

-Most recent Blood cxs NGTD. Urine cx 11/26 neg.

- consulted Surgery again given concern for another LLE abscess on ankle, but per surgery- believe it's a hematoma

#. Non-oliguric AKI vs CKD. Could also have some degree of CKD at bl.

- unknown bl crt,  R mod hydro, 1.2X1.0X1.8 obstructing R ureteral stone, s/p PCN tube on 11/29

- renally dose medications

- Cr stable

#. Elevated transaminases

#. Elevated alk phos, elevated GGT supportive of liver process. Consulted GI, appreciate assistance.

-Hepatitis panel neg for acute infection

-Ab us as above, no biliary or haptic vessel obstruction.

-MRCP shows hepatosplenomegaly, heterogeneous enhancement. Paged GI to notify of results- agree with waiting on LN biopsy results as likely due to underlying process

- HSV positive, CMV negative, ANA negative, SMA negative, AMA negative

#. Hypercalcemia

- PTH <1.2

- PTHrp pending

- vitamin D 25 low, vitamin D 1,25 normal

- spep, k/l ratio unremarkable

#. Hypomag:

-Replacing

#. Hypoalbuminemia

-nutrition consult

#. Homelessness

- Appreciate SW assistance.

#. History of severe infections

- HIV negative

- Denies alcohol use

- A1c wnl

- B12 and FA normal

General:

             - Diet/education: Regular

             - DVT Prophylaxis: SCD due to GIB

             - Functional Status/Consults: Ortho, Gen Surg, GI,  Heme, ID, IR

             - T/L/D currently in place: PIV

             - Code Status: Full

             -Dispo: Continues to require inpatient management.

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Remecia Lorraine Johnson**

**Hospital Day: 8**

Remecia Lorraine Johnson is a 39 y.o. female h/o metastatic colon cancer including large brain metastases, hx of biliary obstruction due to mets s/p IR percutaneous drain, HTN who presents after falling and hitting her head, then found to be septic.

**SUBJECTIVE**

Met her just before she went for radiology

NAEO

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | ferrous sulfate | 325 mg | Oral | Daily with breakfast |
| • | QUEtiapine fumarate | 25 mg | Oral | Nightly |
| • | docusate sodium | 100 mg | Oral | BID |
| • | sennosides | 17.2 mg | Oral | Nightly |
| • | polyethylene glycol | 17 g | Oral | Daily |
| • | Enoxaprin SC inj for VTE Prophylaxis (HIGH risk for VTE) | 40 mg | Subcutaneous | Q24H |
| • | levETIRAcetam | 500 mg | Oral | Q12H |
| • | morphine sulfate CR | 15 mg | Oral | Q12H SCH |

**OBJECTIVE**

BP (!) 125/92 | Pulse 96 | Temp 36.8 °C (98.2 °F) (Oral) | Resp 20 | Ht 1.753 m (5' 9") | Wt 50.3 kg (111 lb) | SpO2 98% | BMI 16.39 kg/m²

GEN: NAD, comfortable in bed

CV: warm ext, NRRR

PULM: easy WOB

ABD: soft, drain in place

PSYCH: mood/affect congruent

All labs, studies, and imaging was personally reviewed.

Tbili 1.3

Hb 7

**ASSESSMENT and PLAN**

#. Sepsis unknown origin

Presented with 3/4 SIRS criteria, unclear source. LFTs, Tbili elevated but overall stable. Mild tenderness surrounding biliary drain. Patient w/dysuria x2 days.

- BCx, Ucx- ngtd

- lactate downtrended

- clinically improved on zosyn. Continued low grade fever may be due to malignancy

- CXR with opacities but likely worsened known pulm metastatic disease as patient denies cough,sob

- CT abd/pelvis non specific gallbladder wall edema and progression of mets, otherwise no evidence of infection. IR consulted to evaluate drain as below.

- Emory ID consulted given no clear source of infection: recommend 7 days of zosyn for possible post-obs pna. End date 12/8/19

#. Hx of Biliary obstructions s/p IR percutaneous drain

- Metastatic colon cancer c/b bilary compression s/p external/internal biliary drain placement, s/p exchange IR drain 11/15, 12/5

- mild tenderness to palpation, CT abd/pelvis as above

- biliary drain bag in place, no leak, but output reported ~ 2.6L/24.  S/p IR exchange for upgraded size 12/6. Continue to monitor output/leakage. Improvement of bilirubin levels after exchange. After discussing with IR fellow on call,  RN communication placed to flush the drain q8h with 10 cc normal saline (flush forward only, not aspiration). She can flush q12h after dc.

#. Pleuritic chest pain

- resolved

- EKG/trop wnl, CTPE without evidence of PE

- likely due to extensive metastatic lesions

#. Normocytic anemia

- no obvious signs of bleeding, CTabd did not show any intra-abd hematoma

- asked Onc if chemo on 11/20 can cause anemia- not likely

- s/p 1unit pRBC 12/4/19

- replete iron

#. Metastatic colon cancer, recurrent

#. Brain Mets

Plan: Colon cancer s/p resection in 2016 with no adjuvant tx, now with widely metastatic disease with rapid progression on FOLFOX and FOLFIRI. Patient with Her2+ disease

- Pain control: MS Contin 15mg q12 hr + roxycodone 15mg q6hr prn. Monitor on increase of roxicodone

- Bowel regimen: colace + senna + miralax + prn dolculax. Continue to monitor for BM

- Continue keppra 500mg bid for seizure prophylaxis

- Neurosurgery evaluation this admission, per note consult note; Patient asymptomatic from present skull lesion, will likely continue to grow and eventually cause AMS/weakness. Considering craniectomy vs radiation for symptom control. Currently proceeding with radiation as patient overall not good surgical candidate and with poor prognosis.

- Oncology consulted, appreciate assistance

- Previous MD spoke with covering Onc fellow today- he will notify scheduler to get Onc follow up visit next week .

- RadOnc consulted- simulation 12/5/19- plan to start treatment next week . appt on 12/12/19

#. Goals of care

- Poor prognosis per Onc. Per patient, she is not interested in hearing about prognosis. Understands that cancer is not curative. Mother is interested in hearing about prognosis and ok with patient to discuss this with mother. Per palliative's discussion with mother, mother may not be aware that cancer is not curative. Onc tried to reach patient yesterday 12/6 but unavailable. May talk with Onc as outpatient if not able to reach.

- Palliative care consult

- Currently Full Code per patient. Patient has named her mother surrogate decision maker if unable to make decisions

#. Adjustment disorder

- psych consulted

- seroquel 25mg nightly to help with sleep/mood

#. Hx of HTN

- continue to hold home amlodipine 5mg in the setting of sepsis

- likely home amlodipine can be dc'ed on discharge med rec

General:

VTE Prophylaxis: lovenox (per neurosurgery, ok to be on anticoag even with large brain met)

Diet: Regular

Family contact:  Primary Emergency Contact: Sims,Janice, Home Phone: 929-427-6906

Code Status: Full

Dispo: likely DC tomorrw

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Michael Smith**

**Hospital Day: 2**

Michael Smith is a 63 y.o. male  h/o COPD, HTN, CVA p/w recurrent SOB after recent tx for PNA/COPD at Wellstar. He is being managed now for a COPD exacerbation along c- prior/recent PNA

**SUBJECTIVE**

Feeling better this AM

Improved cough

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | ipratropium-albuterol base | 1 each | Nebulization | EVERY 4 HOURS |
| • | vancomycin | 1,500 mg | Intravenous | Q12H |
|  | And | | | |
| • | CeFEPIme (MAXIPIME) IV | 2 g | Intravenous | Q8H |
| • | amLODIPine | 5 mg | Oral | Daily |
| • | aspirin EC | 81 mg | Oral | Daily |
| • | atorvastatin | 40 mg | Oral | Daily |
| • | budesonide-formoterol | 2 puff | Inhalation | BID |
| • | diclofenac | 4 g | Topical | BID |
| • | multivitamin | 1 tablet | Oral | Daily |
| • | Enoxaprin SC inj for VTE Prophylaxis (HIGH risk for VTE) | 40 mg | Subcutaneous | Q24H |
| • | predniSONE | 50 mg | Oral | Daily with breakfast |

**OBJECTIVE**

BP 113/67 | Pulse 101 | Temp 36.4 °C (97.5 °F) (Oral) | Resp (!) 40 | Ht 1.88 m (6' 2") | Wt 81.6 kg (180 lb) | SpO2 95% | BMI 23.11 kg/m²

GEN: laying in bed comfortably

CV: warm ext, NRRR

PULM: mild wheezing, no rhonchi

ABD: soft nontender

PSYCH: mood/affect congruent

All labs, studies, and imaging was personally reviewed.

Lactate 2.8

**ASSESSMENT and PLAN**

#. Sepsis d/t HAP

- pt decompensated AM of 12/9, c- SOB, tachypnea, fever to 39

- CXR c- increased LLL pneumonia

- BC pending, escalated ABX to VAN/CPE, will monitor

- lactate trending

#. Acute emphysema flare, h/o COPD, unknown PFTs

- sig SABA/SAMA

- prednisone burst

#. HTN

- sig home meds

#. H/o CVA

#. Hematuria

- OP f/u, consideration for cystoscopy if persistent (versus prostate issues)

Code: Full

Lines: PIV

Prophylaxis: SQh

Diet: Regular

Contact: In chart

Disposition: pending resp status

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending

**INTERNAL MEDICINE PROGRESS NOTE**

**Service: Emory Medicine Team Q**

**Name: Tina Ladd**

**Hospital Day: 2**

Tina Ladd is a 54 y.o. female h/o HIV, COPD, HTN, and DHF who p/w nausea/vomiting, early satiety, shortness of breath, orthopnea, and worsening DOE since Wednesday, c/w ADHF.

**SUBJECTIVE**

Complains about her sore throat

Otherwise doing well, improving from SOB perspective

Review of systems negative for constitutional, cardiac, upper or lower respiratory, gastrointestinal, or neurological symptoms except as reflected as above

Scheduled Meds:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | abacavir | 300 mg | Oral | Q12H |
| • | amLODIPine | 5 mg | Oral | Daily |
| • | gabapentin | 600 mg | Oral | Nightly |
| • | cloNIDine | 0.2 mg | Oral | Q8H |
| • | dolutegravir sodium | 50 mg | Oral | Daily |
| • | pravastatin | 40 mg | Oral | Daily |
| • | lamiVUDine | 150 mg | Oral | Daily |
| • | budesonide-formoterol | 2 puff | Inhalation | BID Resp |
| • | aspirin EC | 81 mg | Oral | Daily |
| • | ergocalciferol(vit D2) | 50,000 Units | Oral | Weekly |
| • | DULoxetine DR | 60 mg | Oral | Daily |
| • | Enoxaprin SC inj for VTE Prophylaxis (HIGH risk for VTE) | 40 mg | Subcutaneous | Q24H |

**OBJECTIVE**

BP 135/78 | Pulse 80 | Temp 36.6 °C (97.9 °F) (Oral) | Resp 16 | Ht 1.549 m (5' 1") | Wt 86.2 kg (190 lb) | SpO2 99% | BMI 35.90 kg/m²

GEN: laying in bed, uncomfortable as the airconditioning is broken

CV: warm ext, no lower ext edema, JVP up to mandible

PULM: orthopnea at 40 degrees llaying back down

ABD: soft, obese

PSYCH: mood/affect congruent

All labs, studies, and imaging was personally reviewed.

Cr 3.0

Renal US pending

Urine lytes pending

**ASSESSMENT and PLAN**

#. ADHF h/o DHF, h/o HTN, h/o LVH, c/b hypomagnesemia/hypokalemia, c/b early satiety, d/t recent viral infection

- hx c/w volume overload and sx of left sided elevated filling pressure, likely in setting of uncontrolled HTN

- control BP and diuresis, responding well to furosemide 100 mg IV bid

- replete lytes, monitor UOP, cardiac/fluid restrict diet

#. CRS II / CKD

- Cr increased to 3.0 at peak

- renal us and lytes pending

#. Elevated troponin d/t demand ischemia

- trending, likely demand

#. Resistant HTN

- restart home meds, tolerating well

- based on sx chronicity not c/w flash pulmonary edema/hypertensive emergency

- holding lisinopril d/t diuresis

#. HIV

- sig home meds

#. COPD

- sig prn inhalers

Code: DNR/DNI

Lines: PIV

Prophylaxis: SQH

Diet: Cardiac

Contact: Daughter

Disposition: Home pending diuresis

Anish Shah

Emory Team Q

PIC 71350

Hospital Medicine Attending