Training Chart-This chart is used for educational purposes only

Date: 11/11/15

- Hx tonsillectomy
- Pr cryosurg ablation of prostate

Outpatient prescriptions marked as taking for the encounter (Office Visit) with --,

Medication	Sig
• enoxaprin (ENOXAPRIN) 40 MG/0.4ML injection	by Subcutaneous route 2 times daily.
• metoprolol-XL (TOPROL-XL) 25 MG tablet	take 25 mg by mouth Daily.
• HYDROmorphone HCl (DILAUDID)	1 mg by Does not apply route.
• famotidine (PEPCID) 20 MG tablet	take 20 mg by mouth 2 times daily. for stomach acid
• amiodarone (PACERONE) 200 MG tablet	take 200 mg by mouth Daily. for heart rhythm
• warfarin (COUMADIN) 7.5 MG tablet	take 1 Tab by mouth Daily. for blood thinner

No Known Allergies

Family History

Problem	Relation	Age of Onset
• Diabetes Type II	Brother	
• Cancer *throat*	Brother	
• Diabetes Type II	Brother	
• Heart Attack	Mother	
• Diabetes Type II	Sister	

Social History

Occupational History

- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol Use: *2 drinks per year*	Yes
• Drug Use:	No
• Sexually Active:	Not on file

Review of Systems

Constitutional: Positive for appetite change and fatigue. Negative for fever.
Respiratory: Negative for cough, wheezing and shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Positive for abdominal pain and constipation **(due to his pain medication.)**. Negative for diarrhea, rectal bleeding and blood in stool.
Genitourinary: Negative for hematuria.
Neurological: Positive for dizziness and weakness.

Objective:

BP 120/70 | Ht 5' 10" (1.778 m) | Wt 184 lb (83.462 kg) | BMI 26.40 kg/m2

Physical Exam

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Carotid bruit is not present.
Cardiovascular: Normal rate, normal heart sounds and normal pulses. An irregularly irregular rhythm present.

No edema noted

Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry. There is pallor.

Assessment / Plan:

1. **Bladder rupture (596.6K)**
2. Long term current use of anticoagulant (V58.61AN)
3. Hyperlipidemia
4. DM neuro manif type II, uncontrolled
5. Nephritis
6. Prostate cancer
7. Atrial fibrillation

PROTIME-INR, PR COLLECTION VENOUS BLOOD,VENIPUNCTURE, PROTIME-INR
GAMMA GT, HEPATIC FUNCTION PANEL, LIPID PANEL
BASIC METABOLIC PANEL, CBC AND DIFFERENTIAL, HEMOGLOBIN A1C

PSA

REFERRAL TO [redacted])GY

11/11/15

Reason for Visit

Hospitalization Followup
Irregular Heart Beat
Prostate Cancer

Progress Notes

Subjective:

Chief Complaint: Hospitalization, Irregular Heart Beat and Prostate Cancer
HPI:
HPI Comments: Patient is seen in follow-up hospitalization from . He presented to the emergency department , and was in atrial fibrillation, as well as septic shock with low blood pressure due to sepsis. Patient had had cryotherapy of prostate for prostate cancer and apparently developed several abscesses of the bladder and had a rupture of the bladder. He developed peritonitis from this. He now has a suprapubic catheter and is being followed by Dr. . He is on coumadin and amiodarone for his atrial fibrillation, which he has not had any current symptoms. He was in the hospital for several weeks and then was in a subacute rehab facility. He still is on lovenox injections apparently due to his coumadin being subtherapeutic. He is still weak and still has a low appetite, but seems to be improving.

is a(n) o. male presenting with Hospitalization, Irregular Heart Beat and Prostate Cancer. The history is provided by the patient and a friend.

Hospitalization
Episode onset: last couple of months. Associated symptoms include abdominal pain and constipation (due to his pain medication.). Pertinent negatives include no chest pain, no shortness of breath and no diarrhea.

Irregular Heart Beat: This is a new problem. Onset occurred within the last 6 months (3 months ago). He is currently asymptomatic. Arrhythmia Classification: Atrial fibrillation (A-fib). Primary symptoms include weakness and fatigue. Patient negative for palpitations, syncope, irregular heartbeat, shortness of breath, chest pain and exertional chest pressure. Progression of this problem is unchanged. reports that his symptoms are constant. Previous pharmacological treatments include Amiodarone and warfarin. Identifiable causes for his illness include stress.

Prostate Cancer
Present symptoms negative for hematuria.

Past Medical History
Diagnosis
- DM renal manif type II, uncontrolled
- DM eye manif type II, uncontrolled
- DM neuro manif type II, uncontrolled
- Nephritis NOS in other disease
- Background diabetic retinopathy
- Polyneuropathy in diabetes
- Unspecified vitamin D deficiency
- Nephritis NOS in other disease
- Unspecified disease of nail
- Malignant neoplasm of prostate
- Intervertebral lumbar disc disorder

- Lumbago
- Unspecified disorder of bladder

Past Surgical History
Procedure Date

Admission Date: 11/05/15

ADMISSION DIAGNOSIS
Bladder rupture.

CONSULTANTS
Palliative care.

PROCEDURES
1. Limited CT of the abdomen showing resolution of bilateral pleural effusions with removal of pleural drains.
2. CT abdomen and pelvis showing improvement of air space disease and pleural fluid improvement of flank edema and retroperitoneal fluid collection showing less density and is minimally smaller in size. Foley catheter and percutaneous drains are stable.

CONDITION ON DISCHARGE
Stable.

HOSPITAL COURSE
This is a . . -year-old male with a history of prostate cancer status post cryotherapy x2. He presented initially with increasing abdominal pain, nausea and decreased urine output. He was ultimately found to be in acute respiratory failure with rapid atrial fibrillation and was admitted to the ICU. He was found on CT to have emphysematous changes in his bladder and likely an abscess adjacent to it. It was determined that it was likely that he had a ruptured bladder. Percutaneous nephrostomy tube was initially planned, however, the patient developed hypotension and anemia and was found to have a large retroperitoneal bleed displacing the kidney. He underwent

hemodialysis when he developed acute renal failure. In lieu of nephrostomy tube, he had suprapubic catheter placed, Foley catheter and a drain in the pericystic area to allow bladder decompression. He was subsequently transferred here to our facility for further drain management. His drains continued to drain well. His bilateral chest tubes were maintained. His volume overload was treated with diuretics. Follow-up CT was obtained with results as noted above. His pleural drains were subsequently removed. He completed 14 days of Flagyl. He was seen by physical therapy and nutrition therapy. All of his bladder drainage remained stable. He had some difficulty with insomnia. Palliative care was involved with this. This has been a problem for a long time prior to his hospital stay. We did not find an acceptable regimen for his insomnia despite multiple efforts with Ambien, temazepam, and trazodone. Ultimately, his significant other requested that he not be over-medicated and requested that we stop his sedatives. His Corpak was ultimately removed, and he had reasonable p.o. intake. I spoke with Dr. on the day prior to discharge. I reviewed the progress. We checked urine creatinine on all of his drains. All of them had creatinine values in the 40s and 50s suggesting this was continued drainage of urine in all of his catheters.

A urine culture was obtained. He did have significant white cells in his urine, and his urine grew serratia. It was unsure whether this was colonization or true infection.

His sugars remained stable during his stay here on his insulin regimen. The facility was contacted for further rehab. will be accepting the patient for continued drain care. He will be having followup with on Monday I spoke with interventional radiology. They do not have any further plans for catheter manipulation until seen by

DISCHARGE DIAGNOSES
1. Bladder rupture.
2. Prostate carcinoma.
3. Positive Clostridium difficile status post 14 days metronidazole.
4. Paroxysmal atrial fibrillation not anticoagulated
5. Large retroperitoneal hematoma status post embolization.
6. Volume overload, resolved.
7. Hypertension, well controlled.
8. Bilateral pleural effusions status post drains.
9. Diabetes mellitus type 2, well-controlled.
10. Protein calorie malnutrition.
11. Deconditioning.
12. Shock septic due to above with intensive care unit stay.
13. CKD with acute renal failure secondary to above requiring short episode of hemodialysis

DISCHARGE MEDICATIONS
1. Tylenol as needed.
2. Amiodarone 200 mg daily.
3. Bisacodyl 5 mg daily p.r.n. constipation.
4. Calcium carbonate 500 mg 3 times daily.
5. Cepacol lozenges 1 p.o. q.2 hours p.r.n. sore throat.
6. Colace 100 mg twice daily, hold for loose stools.
7. Enoxaparin 40 mg subcu daily.
8. Pepcid 20 mg daily.
9. Dilaudid 1 mg q.3 hours p.r.n. pain, prescription written #24.
10. Lantus 20 units subcu q.h.s. with low-dose corrective insulin regimen.

11. Lorazepam 0.5 mg a.m., 1 mg p.m.
12. Toprol-XL 25 mg daily.
13. Niacin 500 mg daily.
14. Polyethylene glycol 17 mg every other day.
15. Pravastatin 80 mg q.h.s.

DISCHARGE INSTRUCTIONS
Followup as noted will be with . on Monday Interventional radiology will be following up depending on further recommendations. Glucose checks q.a.c. and q.h.s. Diet will be diabetic liberal heart healthy with Glucerna shakes 3 times daily with meals. Activity will be up with assist. Continue daily efforts with physical therapy, occupational therapy. Wound care for details please see wound care recommendations section of transfer summary.

Call office for any other problems with his bladder drains. He will be seen at the accepting facility for his routine medical issues.

P **Never Reviewed**

	Codes	Priority	Class
Hyperlipidemia	272.4		
DM Renal Manif Type II, Uncontrolled	250.42		
DM Eye Manif Type II, Uncontrolled	250.52		
DM Neuro Manif Type II, Uncontrolled	250.62		
Nephritis NOS in Other Disease	583.81		
Background Diabetic Retinopathy	362.01		
Polyneuropathy in Diabetes	357.2		
Dermatophytosis of nail	110.1		
Hypoglycemia, unspecified	251.2		
Prostate cancer	185		
Essential hypertension, benign	401.1		
Other vitamin B12 deficiency anemia	281.1		
Unspecified vitamin D deficiency	268.9		
Organic insomnia, unspecified	327.00		

Developmental History

None

Screening Results
None
Previous Results
None