DISCHARGE SUMMARY

J&R Multispeciality Hospital

Department of Neurology

Faculty.
Dr. Louis
Senior Surgeon

Dr. Neslon Jemmision
Surgeon

Dr Stephen Stark
Senior Professor

Name: Lase Mackarthy

Age/Sex : 77, Male

Admission date: 8/9/2018

FINAL DIAGNOSIS

1. THROMBOLYSIS
2. HYPERTENSION
3. Oclusal plane deviation of STENT
4. Sprain of rib heavily
5. Coronary artery disease
6. Hypercholesterolemia

HISTORY OF PRESENT ILLNESS

The patient is a 62-year-old obese woman who was referred to the Beth Israel Hospital for cardiac catheterization and the indicated procedures. She suffered an inferior myocardial infarction in 1988 and subsequently underwent angioplasty of the right coronary artery. On 7/20/95, she presented to an outside hospital with a second inferior wall myocardial infarction complicated by congestive failure, pulmonary edema and cardiac arrest. She was successfully resuscitated and underwent angioplasty and stent placement of the proximal right coronary artery. Catheterization at that time also demonstrated severe three- vessel disease. An echocardiogram showed an ejection fraction of 25%. An exercise treadmill thallium performed prior to discharge showed anterior ischemia after 7.5 minutes of exercise. Medical management was maximized; however, she returned to an outside hospital the week prior to admission to unstable angina. A stress test resulted in chest pain and inferior lateral S-T depressions after only two minutes of exercise.

PAST MEDICAL HISTORY

1. Hypertension
2. High cholesterol

PAST SURGICAL HISTORY

1. Total abdominal hysterectomy
2. Cholecystectomy
3. Appendectomy

MEDICATIONS ON ADMISSION

1. Norvasc, 2.5 mg q.d.
2. Aspirin, 325 mg q.d.
3. Isordil, 10 mg t.i.d.
4. Lisinopril, 20 mg q.d.
5. Lopressor, 100 mg b.i.d.
6. Ticlid, 250 mg b.i.d.
7. Lovastatin, 20 mg q.d.
8. Coumadin, which was discontinued earlier in the month

PROCEDURES

1. Cardiac catheterization on 8/10/95
2. Coronary artery bypass x 4
3. Thrombobolysis
4. 2 packed cell transfusion
5. Intubation and mechanical ventilation

LABORATORY

An admission chest x-ray shows some left lower lobe atelectasis but was otherwise clear. An electroc shows interventricular conduction delay but no acute ischemic changes. There is evidence of old inferior wall myocardial infarction. Admission labs are unremarkable.

HOSPITAL COURSE

A repeat echocardiogram showed an ejection fraction of approximately 25% with moderate mitral regurgitation. This was not evident on ventriculogram at catheterization, however. Left ventricular end diastolic pressure at catheterization was 24 with a wedge of 25. After consultation with the patient, the decision was made to proceed with coronary artery bypass, albeit at slightly increased risk.

On 8/14/95, the patient underwent the procedure described above. All targets were of reasonable caliber and quality, and the conduit was of good quality. She was weaned from bypass without difficulty and there was no evidence of perioperative myocardial injury.

This was treated with frequent dressing changes and it subsequently healed up and did not require operative intervention. She also developed cellulitis in her left lower extremity that proved very

refractory to treatment. After no resolution with IV Ancef, she was switched to Vancomycin. This, in conjunction with continuous elevation, resulted in some improvement; however, the cellulitis persisted. No fluctuance or drainage from the wound was present. An Infectious Disease consultation was obtained and they recommended IV Oxacillin. With IV Oxacillin and bedrest to ensure continuous elevation, the cellulitis slowly resolved. By postoperative day #23, the erythema had resolved and she was approved for discharge. At the time of discharge, she was ambulating well on flat ground and maintaining good hemodynamic response to exercise and adequate arterial oxygen saturations on room air. The erythema was all but gone in her left lower extremity, and her sternal incision was well healed without evidence of drainage.

MEDICATIONS ON DISCHARGE

1. Albuterol, 2 puffs q.d.
2. Ascriptin, 325 mg p.o. q.d.
3. Atenolol, 25 mg p.o. q.d.
4. Niferex, 150 mg p.o. q.d.
5. Colace, 100 mg p.o. b.i.d.
6. Keflex, 500 mg q.i.d. for an additional 10 days

DISPOSITION

The patient is being transferred for additional rehabilitation at the Mariner Healthcare Facility in Sassaquin.

FOLLOW-UP

She will be seen in one month for routine postoperative evaluat