Discharge Summaries (continued)

Discharge Summaries by Kelley Weinfurtner, MD at 1/14/2016 9:00 AM (continued) Version 1 of 1

Author: Kelley Weinfurtner, MD
Filed: 1/14/2016 5:26 PM
Editor: Kelley Weinfurtner, MD (Resident)
Service: Hospital Medicine
Date of Service: 1/14/2016 9:00 AM
Author Type: Resident
Status: Attested
Cosigner: Cynthia L Fenton, MD at 1/15/2016 2:19 PM
Attestation signed by Cynthia L Fenton, MD at 1/15/2016 2:19 PM

Attending Attestation - Day of Discharge Management

My date of service is 1/13/16

Final Physical Exam: Lungs: CTA, symmetric excursion and normal I:E CV: RRR S1 S2 no m,r,g no JVD

Brief Hospital Course

Admitted with severe asthma exacerbation with history of 24 intubations, at least 3 in the past year. In the ED he had progressive hypercarbic respiratory failure and was intubated urgently. He received solumedrol and b-agonist inhalers. There was no e/o infection and his BAL,respiratory panel were negative. His course was c/b ICU delirium/agitation requiring antipsychotics for sedation and re-intubation after failed initial extubation. Once extubated the 2nd time (day 4) his respiratory function remained clear with no setbacks. Mental status at discharge returned to baseline. Dr. Fahy, primary Asthma MD was involved in his care. He will have close f/u next week with him and will slowly taper pred from 40 to 20 as tolerated over the next 8 days prior to that visit.

I spent 20 minutes preparing discharge materials, prescriptions, follow up plans, and face-to-face time with the patient/family discussing above.

Cynthia L Fenton, MD
1/15/2016

UCSF MEDICAL CENTER - DISCHARGE SUMMARY

Patient Name: Stephen Gaudet
Patient MRN: 46236505
Date of Birth: 9/12/1954

Facility: Parnassus
Attending Physician: Cynthia Fenton

Date of Admission: 1/5/2016
Date of Discharge:[KW1.1] 1/13/2016[KW1.2]

Admission Diagnosis: Asthma exacerbation
Discharge Diagnosis:[KW1.1] Asthma exacerbation[KW1.3]

Discharge Disposition:[KW1.1] Home[KW1.4]

History (with Chief Complaint)

Stephen Gaudet is a 61 y.o.[KW1.1] man with h/o severe asthma (>25 intubations), HTN, HLD, who was admitted for hypoxemic respiratory failure secondary to asthma exacerbation.

Patient presented with 1 week of worsening shortness of breath and wheezing. Patient thought it was due to pollen exposure and allergies (had itchy and red eyes). He increased his nebulizer and inhaler frequency without significant improvement. He also took prednisone 40 mg day prior to presentation, and another prednisone 40 mg on morning of admission.. He experienced chills, but denied fever, URI symptoms, GI symptoms, CP/palpitations, rashes, headache, lightheadedness. He has had no known sick contacts, no changes in his asthma medication regimen, no recent exotic travel or prolonged immobilization. He received his flu vaccination this season.[KW1.4]

Brief Hospital Course by Problem[KW1.1]

#Hypoxemic respiratory failure 2/2 asthma exacerbation, requiring intubation
In ED, patient was afebrile, HD stable, but in moderate respiratory distress breathing at 28 breaths per minute[KW1.3] with accessory muscle use[KW1.5] He was given solumedrol 125mg IV, terbutaline 0.25mg, continuous albuterol nebs; however,[KW1.3] his respiratory status continued to decline so he was rapidly intubated. He was continued on solumedrol 80mg IV Q8H and frequent duonebs. He was extubated and reintubated on 1/7 due to patient's agitation and overall increased work of breathing. He was then successfully extubated 1/9. Respiratory viral panel negative, all cultures including BAL negative, and CXR clear, so exacerbation thought due to environmental exposure rather than infectious. Dr. Fahy, patient's primary pulmonologist, recommended dynamic chest CT to evaluate for any evidence of tracheomalacia contributing to frequent intubations; however, CT was unremarkable. Patient was weaned off steroids and discharged on steroid taper.
-P[KW1.5]rednisone 40mg daily for 3 days (1/14-1/16)[KW1.1]
-Then p[KW1.3]rednisone 30mg daily for 3 days (1/17-1/19)[KW1.1]
-Then p[KW1.3]rednisone 20mg daily until[KW1.1] f/u appt with Dr. Fahy[KW1.3] (1/20-)[KW1.1].[KW1.3]
-Continue albuterol/ipatropium nebs PRN, tiotropium daily, and fluticasone-salmeterol BID.[KW1.5]

#Steroid-induce[KW1.3]d[KW1.5] psychosis
Patient was on very high-dose steroids as above and on HD#5[KW1.3] while still in the ICU[KW1.5] after extubation, he developed[KW1.3] significant agitation, anxiety, and disorientation, as well as visual hallucinations. Thought due to high dose steroids with component of ICU delirium. Patient improved after he was transferred out of ICU and steroids were tapered.[KW1.5]

#[KW1.3]Normocytic a[KW1.5]nemia[KW1.3]
Patient noted to have Hgb of 11 and iron studies showed iron deficiency anemia (ferritin 32, 5% transferrin sat).
-Would start iron supplementation as outpatient.
-Would recommend colonoscopy to evaluate for source of IDA if no recent one.

#Coronary artery disease
On CT chest, patient noted to have moderate-severe calcified coronary atherosclerotic disease.
-Continue statin
-Recommend starting aspirin 81mg, defer to PCP.[KW1.5]

Physical Exam at Discharge

Visit Vitals

• BP	153/83 (BP Location: Left upper arm, Patient Position: Sitting)
• Pulse	65
• Temp	36.9 °C (98.4 °F) (Oral)
• Resp	20
• Ht	157 cm (5' 1.81")
• Wt	65.7 kg (144 lb 13.5 oz)
• SpO2	95%
• BMI	26.65 kg/m2

Intake/Output Summary (Last 24 hours) at 01/14/16 0900
Last data filed at 01/13/16 0922

	Gross per 24 hour
Intake	360 ml
Output	250 ml
Net	110 ml

Physical Exam[KW1.1]
General: sitting comfortably in chair
Resp: good air movement, no wheezes
CV: RRR, S1, S2, no m/r/g
Abdomen: NABS, NT, ND
Ext: no edema
Skin: port in place in left chest, covered with tegaderm.
Neuro: Alert and oriented x3, including to situation.[KW1.5]

Relevant Labs, Radiology, and Other Studies[KW1.1]
On admission: WBC 9.9, ABG 7.30/51/74
Ferritin 32, Iron 14, transferrin 226, %sat 5, vitamin B12 281[KW1.5]

CXR 1/5/16:
IMPRESSION:
Left venous catheter is positioned with tip at the cavoatrial junction. Heart normal in size. Lungs are clear. The left third rib is poorly seen and may be hypoplastic. This appearance is unchanged in comparison with multiple prior films dating from 2007.

CT PE 1/10/16:
FINDINGS:
Noncalcified 3 mm pulmonary nodule in the right upper lobe (axial image 48 of series 2), stable compared to 2007 and therefore benign. Mild bibasilar atelectasis, but otherwise the lungs are clear.
No evidence of tracheomalacia on dynamic expiratory views (approximately 10% tracheal narrowing with expiration).
Trace bilateral pleural effusions are again noted, unchanged compared to CT from 2007.
Right chest port with tip at the cavoatrial junction. Moderate-severe calcified coronary atherosclerotic disease.

The small pericardial effusion.
No suspicious bone lesions are identified.
Limited visualization of the upper abdomen demonstrates no significant abnormality.
IMPRESSION:
1. No evidence of tracheomalacia.
2. Stable trace bilateral pleural effusions compared to prior from 2007.[KW1.3]

Procedures Performed and Complications[KW1.1]

Intubation x2[KW1.5]

DISCHARGE INSTRUCTIONS

Discharge Diet[KW1.1]

Regular Diet[KW1.5]

Functional Assessment at Discharge/Activity Goals[KW1.1]

No change in condition or functional status from admission.[KW1.5]

Allergies and Medications at Discharge

Allergies: Pine nut and Penicillins[KW1.1]

Your Medications at the End of This Hospitalization

	Disp	Refills	Start	End
albuterol (PROVENTIL) 2.5 mg /3 mL (0.083 %) NEB inhalation solution	3 mL	12	12/7/2015	

Sig - Route: Take 3 mLs (2.5 mg total) by nebulization every 4 (four) hours as needed (severe). - Nebulization

ALBUTEROL INH
Sig - Route: Inhale 2 puffs into the lungs every 4 (four) hours as needed. - Inhalation
Class: Historical Med

benazepril (LOTENSIN) 20 mg tablet
Sig - Route: Take 20 mg by mouth Daily. - Oral
Class: Historical Med

benazepril-hydrochlorthiazide (LOTENSIN HCT) 10-12.5 mg tablet
Sig - Route: Take 1 tablet by mouth Daily. - Oral
Class: Historical Med

cetirizine (ZYRTEC) 10 mg tablet
Sig - Route: Take 10 mg by mouth as needed. - Oral
Class: Historical Med

EPINEPHRINE (EPIPEN IM)
Sig - Route: Inject into the muscle as needed. - Intramuscular
Class: Historical Med

fluticasone (FLONASE) 50 mcg/Actuation nasal spray
Sig - Route: 1 spray by Nasal route Twice a day. - Nasal
Class: Historical Med

fluticasone-salmeterol (ADVAIR DISKUS) 500-50 mcg/dose diskus inhaler
Sig - Route: Inhale 1 puff into the lungs Twice a day. - Inhalation

disability.

Family History

Problem	Relation	Age of Onset
• Cancer	Other	
• Heart disease	Other	
• Hyperlipidemia	Other	
• Hypertension	Other	
• Osteoporosis	Other	
• Vision loss	Other	

Review of systems unobtainable due to intubated.

My personal examination findings include:
GEN - intubated, sedated
CV - rrr, nl s1s2, no murmur appreciable on my exam, no precordial heave
Resp - mechanically ventilated, synchronous with vent, diffuse end expiratory wheezing, no cracles, chest port in place, c/d/i
Abd - soft, NABS, no grimacing w palpation, soft

Assessment and Plan

I agree with the findings and care plan as documented.
My additional comments on the assessment and management:

History of multiple intubations in the past. This presentation consistent with pt's typical asthma exacerbation. Trigger seems to be environmental exposure per d/w pt's partner. No evidence of infectious trigger. On my exam, no murmur present - suspect was flow murmur in setting of high adrenaline state during asthma exacerbation. Appreciate ICU management of vent.

Severity of Illness

Intubated on mechanical ventilation.
Invasive hemodynamic monitoring.
Treating pain/discomfort with IV opiates.
Patient is at high risk for clinical deterioration due to severe asthma exacerbation requiring ICU care and mechanical ventilation.
Organ systems impaired or failing: pulmonary

I devoted my full attention for this service to the direct care of this patient and time devoted to teaching and other procedures is not included.

Total time spent providing direct clinical care (non-overlapping/non-continuous time): 45 minutes

Sarah Christina Schaeffer, MD
1/5/2016

H&P by Sarah Christina Schaeffer, MD at 1/5/2016 8:50 PM (continued) Version 2 of 2

Electronically signed by Sarah Christina Schaeffer, MD at 1/15/2016 9:21 AM

H&P by Cynthia L Fenton, MD at 1/5/2016 8:50 PM Version 1 of 2

Author: Cynthia L Fenton, MD | Service: Hospital Medicine | Author Type: Physician
Filed: 1/6/2016 3:14 PM | Date of Service: 1/5/2016 8:50 PM | Status: Signed
Editor: Cynthia L Fenton, MD (Physician)
Related Notes: Related Note by Caroline Ong, MD (Resident) filed at 1/5/2016 10:55 PM
Addendum by Sarah Christina Schaeffer, MD (Physician) filed at 1/15/2016 9:21 AM

Attending Attestation

My date of service is 1/6/2016. I was present for and performed key portions of an examination of the patient. I am personally involved in the management of the patient.

Family History unobtainable due to: intubated

Review of systems unobtainable due to intubated.

My personal examination findings include:
Lungs: intubated, symmetric excursion, good air movement with only faint wheezes
CV: RRR S1 S2 no m,r,g PMI non-displaced

I reviewed CXR with radiologist and discussed the findings with the radiologist. Possible increased interstitial markings in this AM CXR vs. Hypoventilation.

Assessment and Plan

I agree with the findings and care plan as documented.
My additional comments on the assessment and management: Asthma exacerbation, severe, requiring intubation for impending hypercarbic respiratory failure - markedly improved airway mechanics after IV solumedrol overnight. Sending BAL with bacterial and viral panel, especially given new CXR with possible abnormalities. Rapid flu negative. Will ensure he has been seen in Asthma clinic.

Remainder per note above.

Appreciate ICU assistance.

INtubated, sedated

I devoted 30 minutes direct clinical care for Mr. Gaudet today.

Cynthia L Fenton, MD
1/6/2016

History and Physicals (continued)

H&P by Nirav Rati Bhakta, MD at 1/5/2016 4:59 PM (continued) Version 1 of 1

severe airflow obstruction without CO2 retention, OSA, HTN, with innumerable hospitalizations and at least a dozen intubations in the past for asthma who has had an exacerbation with unknown trigger. He increased his outpt oral prednisone from 10 mg to 40 mg for two days by report but still worsened. He is followed in the UCSF pulmonary clnic, most recently by Drs John Fahy and Michael Peters. Although he has low blood eosinophils, his degree of type-2 inflammation remains uncertain given he is on chronic systemic steroids.

Lungs clear on CXR. Today, I have d/c'ed ketamine gtt that was at 10 as at this dose it is of unclear significance. I am continuing bronchodilators, recommend change steroids to once daily. I will wean propofol with goal to extubate. In the meantime I will continue TV 8 mL/kg, RR 12 (he is breathing up to 15 with no e/o air trapping) and maintaining PaCO in the low 40s. I will continue fentanyl prn pain. Although he takes ativan at home, low-dose, and has needed in the hospital previously per his notes, I will not give it until he is extubated and doing well. He has PIVs and a left chest port.
We will f/u resp viral panel.

Severity of Illness
Close monitoring from significant risk of clinical deterioration.
Need for mechanical ventilation.

Critical Care Diagnosis
Acute respiratory failure

I devoted my full attention for this service to the direct care of this patient and time devoted to teaching and other procedures is not included.

Nirav Rati Bhakta, MD
My date of service is 1/6/2016
Total Time Spent with Patient: 60 minutes

Electronically signed by Nirav Rati Bhakta, MD at 1/6/2016 10:28 PM

H&P by Esteban Figueroa, MD at 1/5/2016 4:59 PM Version 2 of 2

Author: Esteban Figueroa, MD | Service: Critical Care Medicine | Author Type: Resident
Filed: 1/6/2016 8:09 AM | Date of Service: 1/5/2016 4:59 PM | Status: Signed
Editor: Esteban Figueroa, MD (Resident)
Related Notes: Cosigned by Nirav Rati Bhakta, MD (Physician) filed at 1/6/2016 10:28 PM
Original Note by Esteban Figueroa, MD (Resident) filed at 1/6/2016 2:06 AM

CRITICAL CARE H&P NOTE

1/6/2016

Chief Complaint
SOB and Wheezing c/w Asthma Exacerbation

History of Present Illness
Stephen Gaudet is a 61 y.o. male patient with Hx of Asthma (very exacerbation prone, over 20 Intubations), HTN, OSA, Anxiety who presented to ED with 4 days of SOB. Reportedly was SOB on 1/1 was taking Prednisone 10mg at baseline then increased to 40mg for 2 days PTA as well as frequency of his breathing treatments. However SOB progressed became more wheezy and presented to ED.

In ED received 2 g Mag, Solumedrol 125 mg, Terbutaline 0.25 mg, continuous nebs and was rapidly intubated for increased work of breathing and impending hypoxemic respiratory distress. Induction with

History and Physicals (continued)

H&P by Esteban Figueroa, MD at 1/5/2016 4:59 PM (continued) Version 2 of 2

Critical Care Medicine Service

Electronically signed by Nirav Rati Bhakta, MD at 1/6/2016 10:28 PM

H&P by Esteban Figueroa, MD at 1/5/2016 4:59 PM Version 1 of 2

Author: Esteban Figueroa, MD | Service: Critical Care Medicine | Author Type: Resident
Filed: 1/6/2016 2:06 AM | Date of Service: 1/5/2016 4:59 PM | Status: Cosign Needed
Editor: Esteban Figueroa, MD (Resident)
Related Notes: Addendum by Esteban Figueroa, MD (Resident) filed at 1/6/2016 8:09 AM
Cosign Required: Yes

CRITICAL CARE H&P NOTE

1/6/2016

Chief Complaint
SOB and Wheezing c/w Asthma Exacerbation

History of Present Illness
Stephen Gaudet is a 61 y.o. male patient with Hx of Asthma (very exacerbation prone, over 20 Intubations), HTN, OSA, Anxiety who presented to ED with 4 days of SOB. Reportedly was SOB on 1/1 was taking Prednisone 10mg at baseline then increased to 40mg for 2 days PTA as well as frequency of his breathing treatments. However SOB progressed became more wheezy and presented to ED.

In ED received 2 g Mag, Solumedrol 125 mg, Terbutaline 0.25 mg, continuous nebs and was rapidly intubated for increased work of breathing and impending hypoxemic respiratory distress. Induction with Ketamine and Succinylcholine, started on Propofol and Fentanyl gtt for sedation, then transferred to 9ICU for further management.

Past Medical History

Diagnosis	Date
• Effusion of lower leg joint	
• Asthma, chronic *Severe asthma*	
• Allergic rhinitis, cause unspecified	
• Anemia	
• Other chronic nonalcoholic liver disease	
• Hypertension	
• Hyperlipidemia	
• Osteopenia *Last DEXA 2008, T - 1.9 lumbar, T - 1.1 hip*	
• COPD (chronic obstructive pulmonary disease)	

No past surgical history on file.

Past Surgical Hx
• Tonsillectomy at age 21

Social Hx
- Married, Lives in Crockett, CA

History and Physicals (continued)

H&P by Caroline Ong, MD at 1/5/2016 8:50 PM (continued) Version 1 of 1

African American		
eGFR if African Amer	111	1/5/2016
Glucose, fasting	89	5/21/2009
Potassium, Serum / Plasma	3.9	1/5/2016
Sodium, Serum / Plasma	142	1/5/2016

Lab Results

Component	Value	Date
Base excess	Neg 4.0	1/5/2016
Called By:	Chow, Kevin	5/3/2011
Comments (1)	See Text	1/30/2010
Called, Read back by:	RACHEL MAULUCCI	5/3/2011
Date Called:	20110503	5/3/2011
FIO2	50.00	1/5/2016
Bicarbonate	22	1/5/2016
PCO2	44	1/5/2016
pH, Blood	7.31*	1/5/2016
PO2	135*	1/5/2016
Oxygen Saturation	99	1/5/2016
Sample Type	Arterial	1/5/2016
Time Called:	151100	5/3/2011

I spoke with Dr. Figueroa from ICU regarding sedation plan and ventilation settings.

Problem-based Assessment & Plan

61M with h/o severe asthma with frequent exacerbations requiring intubations, OSA, and HTN who presented with SOB subsequently rapidly intubated for increased work of breathing and hypoxemic respiratory distress.

#Hypoxemic respiratory distress: Increased work of breathing, SOB and hypoxemia consistent with asthma exacerbation. CXR without acute changes suggestive of infection, edema, mass, or foreign body. POCT flu negative. Afebrile without leukocytosis, without localizing signs of infection, we will not treat with antibiotics at this time, though may be viral infection.
- F/u rapid flu swab
- Appreciate ICU assistance with sedation and ventilation, currently on ketamine, fentanyl, and propofol for sedation

#Asthma: Current exacerbation likely precipitated by environmental exposure to pollen, given no history of URI symptoms, infectious sxs, or exercise, though unable to rule out viral infection at this time. History of frequent asthma exacerbations requiring intubations with PFTs performed in 7/2015 showed severely decreased FEV1/FVC <50% expected. Has been hospitalized 7 times in the past year with most recent hospitalization in 11/2015 at John Muir. Peak flow 4.53 in July 2015.
- POCT flu negative
- f/u rapid flu

History and Physicals (continued)

H&P by Caroline Ong, MD at 1/5/2016 8:50 PM (continued) Version 1 of 1

- Duonebs q2h then will space out to q4h
- Received solumedrol 125 mg in ED, will continue solumedrol 80 mg q8h then transition to prednisone when able to take PO

#Labile BP: Hypotensive in setting of propofol infusion and bolus for sedation, improved with 3 L NS and downtitration of propofol.
- Started on levophed 3, will wean down to maintain MAP > 65 or SBP >120
- Holding benazepril and HCTZ given hypotension on propofol

#New heart murmur with h/o pulmonary Hypertension: TTE in 2009 showed PASP 49 mmHg with normal systolic function and evidence of diastolic dysfunction or valvular disease. 3/6 RUSB systolic murmur appreciated on exam, which may be due to hyperdynamic state v. new valvular disease. Patient appears to be euvolemic to slightly hypovolemic on exam.
- Recommend repeat TTE as appropriate

#ICU bundle:
- NPO
- Left port (for easy frequent blood draws), PIV x 2 (hand and foot)
- Pantoprazole 40 mg IV qd, was on home PPI
- Enoxaparin 40 mg for DVT ppx
- Foley inserted 1/5/15

Code Status: FULL

Caroline Ong, MD
1/5/2016

Electronically signed by Cynthia L Fenton, MD at 1/6/2016 3:14 PM

Operative Notes

No notes of this type exist for this encounter.

Consults

No notes of this type exist for this encounter.

Laboratory Results

Vitamin B12 [215282887] Resulted: 01/13/16 1234, Result status: Final result

Ordering provider: Kelley Weinfurtner, MD 01/12/16 0000 Resulting lab: UCSF CHINA BASIN CLIN LAB

Specimen Information

Type	Source	Collected On
	Blood	01/12/16 0547

Components

	Value	Ref range	Flag	Comment	Lab
Vitamin B12	281	211 - 911 ng/L		-	CB ClinLab

Complete Blood Count with 5-part Differential [215282903] (Abnormal) Resulted: 01/13/16 0507, Result status: Final result

Ordering provider: Kreshnik Zejnullahu, MD 01/13/16 0000 Resulting lab: UCSF LAB