

Name: Steve Gaudet | DOB: 9/12/1954 | MRN: [REDACTED] PCP: Gina T. Moreno-John, MD

Your Admission - 06/02/20

Notes

Discharge Summary

Veronica Elizabeth Manzo, MD at 6/6/2020 7:45 AM

Attestation signed by Farhan Farooq Lalani, MD at 6/9/2020 7:37 PM

Attending Attestation - Day of Discharge Management

My date of service is 6/6/2020.

Final Physical Exam:

GEN - nad

RESP - improved breath sounds, no audible wheezing

Brief Hospital Course

Mr. Gaudet was admitted with a severe asthma exacerbation. He received Magnesium in the ED and was started promptly on continuous nebs and IV steroids. On the night of admission he was intubated for hypercarbic respiratory failure. He was intubated for two days and continued to receive continuous nebs and IV steroids. After two days he was extubated successfully. He was monitored in house further to ensure that he continued to improve. His oxygen requirement abated and he was eventually discharged in good condition.

During this hospitalization the patient was treated for:

Respiratory failure: Acute with hypercapnia and hypoxemia

Nutritional Assessment

I spent 45 minutes preparing discharge materials, prescriptions, follow up plans, and face-to-face time with the patient/family discussing plan of care.

Farhan Farooq Lalani, MD

UCSF MEDICAL CENTER - DISCHARGESUMMARY

Patient Name: Stephen Gaudet

Patient MRN: [REDACTED]

Date of Birth: 9/12/1954

Facility: Parnassus

Attending Physician: FARHAN FAROOQ LALANI, MD

Date of Admission: 6/2/2020

Date of Discharge: 6/8/2020

Admission Diagnosis: Asthma exacerbation

Discharge Diagnosis: Acute respiratory failure (HCC)

Discharge Disposition: Home

History (with Chief Complaint)

Stephen Gaudet is a 65 y.o. malew/ PMHx of severe asthma with frequent intubations (>50, last 4/2020) c/b grade III posterior glottic stenosis s/p dilation x 4 (last 11/2019, last scope 4/2020 with patent glottis), PTSD, who presented with progressive dyspnea refractory to home uptitration of therapy.

On a usual day, Steve walks 2-3 miles a day though with very frequent breathing treatments, usually using continuous albuterol 6-20 times a day and a baseline of prednisone 10mg daily.

Over the past week, he's had worsening dyspnea and feelings of chest tightness. He is often able to prevent ED visits by increasing his home regimen. Despite almost qhourly albuterol and uptitration of prednisone to 40-60mg daily, he continued to have no improvement and came to the ED.

He has been sheltering in place with his partner Douglas since March, and they at most will go to the store infrequently. They have had no sick contacts or unusual exposures. He thinks his symptoms may have been triggered by changes in temperature (recent humidity) and seasonal allergies. He denies fever, chills, or any other localizing infectious triggers.

In the ED, his initial vitals and labs were:

T36.9, HR80's, BP 150/100, RR24/98% on RA. Initial VBG was 7.38/51 with a bicarb of 40. Per the patient, a PCO2 >40 is typically high for him. He was given ~4 hours of 10mg/hr continuous albuterol, IV mag 2mg, IV solumedrol 62.5mg, and 1L p-lyte with minimal improvement in symptoms. He was then started on BIPAP, with next VBG of 7.33/55. He was then admitted to the ICU for BIPAP for acute hypercarbic respiratory failure.

Brief Hospital Course by Problem

#Acute hypercarbic respiratory failure 2/2 asthma exacerbation

#Severe asthma

COVID/RVP negative; likely in setting of environmental triggers (seasonal allergies and warmer weather recently). S/p IV mag 2, IV solumedrol 62.5mg (~78mg of prednisone), and continuous nebs in ED. Has had reportedly >50 intubations in the past that have been complicated by ICU delirium particularly during and after extubation. Intubated without issue on 6/3 using intubation protocol below. S/p extubation on 6/4 using precedex. Patient's air hunger and anxiety were well controlled with ativan 0.5mg q4hr PRN and fentanyl 50mcg q30 min PRN air hunger.

- S/p IV solumedrol 30mg BID (6/3-6/5) -->**Continue prednisone 60mg daily (6/6-), with wean as an outpatient.**

- **Continue albuterol nebs**

[] F/u with Pulmonologist, Dr. John Fahy scheduled on 6/11

#Acute Stress Disorder

Has experienced recent abrupt deaths of several of his beloved cats, compounded by this current hospitalization. Denies SI/HI. Psych consulted while inpatient-> recommended starting seroquel 25mg QHS, melatonin 0.5mg q 6PM, and seroquel 12.5mg BID PRN anxiety/mild agitation. Patient only wanted to take the seroquel at night.

- **STARTED** seroquel 25mg QHS.

#Hx ICU delirium/severe steroid psychosis

#Hx PTSD due to awareness during intubations

Per patient and partner, worse after extubation, avoid more than IV solumedrol 60mg qday to prevent steroid psychosis. Notably recalls smooth extubation in April 2020 and December 2019 admissions without delirium thereafter. Per prior admission, **if requires intubation: Versed 2mg, Fentanyl 200 mcg, Ketamine 150 mg, Propofol 100mg, Succinylcholine 100mg, +/-phenylephrine for hypotension post intubation; should be intubated with 6 or 6.5 ETT.** This admission: substituted succinylcholine for rocuronium 10. Intubated with 6.5 ETT. Douglas (partner) recommends: 1) Not waiting for his agitation to escalate too much before giving Haldol; recommends intervening quickly 2) 1:1 nursing because patient has tried to pull out his port before, often quite agitated 3) OK to extubate on precedex which has been helpful, though patient prefers not to be sedated on precedex during intubation

Posterior glottic stenosis s/p dilation, last 11/2019

Followed by Dr. Russell with ENT; last dilation + Kenalog injection at end of November 2019 with well-healed larynx on follow up 12/19. In the past, has had very specific intubation requirements but should be easier now since dilations. Examined while in-patient on 4/24/2020 by Dr. Limb which showed "patent, nonedematous airway. Unchanged from scope on 3/5/20. The bilateral vocal cords are mobile - limited abduction bilaterally but good adduction. 10mm aperture. No evidence of recurrent scar." **No issues experienced during 6/3 intubation.**

#Steroid use

At risk for adrenal insufficiency given long-term use of corticosteroids. Historically on prednisone 10mg qday which is below typical threshold for PCP prophylaxis, but given occasional uptitrations in home steroid dosing, may benefit from ppx.

[] Discuss need for PCP ppx given chronic steroid use

#HTN/HLD

- Continue home benazepril 40mg qday (nonformulary) -> lisinopril 40mg
- Continue home atorvastatin 40mg qday

#Recent pyelonephritis (5/3/2020), resolved

Seen on CT, associated with flank pain and thought to be due to possible stone. s/p recent treatment with CTX and 10-day course of keflex.

Physical Exam at Discharge

BP 158/89 (BP Location: Right upper arm, Patient Position: Lying) | Pulse 74 | Temp 37.1 °C (98.8 °F) (Oral) | Resp 20 | Ht 165.1 cm (5' 5") | Wt 60.6 kg (133 lb 9.6 oz) | SpO2 94% | BMI 22.23 kg/m²

Intake/Output Summary (Last 24 hours) at 6/8/2020 1206

Last data filed at 6/8/2020 1100

	Gross per 24 hour
Intake	535 ml
Output	500 ml
Net	35 ml

Physical Exam

GEN: Thin, sitting up in chair

HEENT: NC/AT

CHEST: L port c/d/i

CV: regular rate, rhythm, no m/r/g

PULM: Decreased air movement posteriorly with no crackles/wheezing. **No accessory muscle usage**

ABD: Thin, soft, NTND. No TTP in all four quadrants.

EXT: No LEE.

NEURO: Alert fluent speech, moving all extremities against gravity.

PSYCH: Appropriate mood and affect

Relevant Labs, Radiology, and Other Studies:**Recent Labs**

	06/08/20 0448	06/07/20 1637	06/07/20 0437	06/06/20 0346
WBC	12.6*	--	12.8*	10.3*
HGB	11.3*	--	11.2*	11.7*
HCT	36.4*	--	36.6*	37.5*
PLT	218	--	236	229
NA	144	--	146*	141
K	3.6	--	3.2*	4.0
CL	107	--	107	106
CO2	31*	--	32*	27
BUN	14	--	18	19
CREAT	0.72*	--	0.76	0.75
GLU	92	--	99	178
CA	8.5	--	8.5	8.5
MG	2.0	--	2.0	2.1
PO4	--	3.3	--	--

Radiology Results (last week)

Procedure	Component	Value	Units	Date/Time
XR Chest 1 View (AP Portable) [367120801]				Collected: 06/06/20 1150
Order Status: Completed				Updated: 06/06/20 1155
Narrative:				
XR CHEST 1 VIEW AP 6/6/2020 2:19 AM				
HISTORY: r/o PNA				
COMPARISON: 6/3/2020				
Impression:				
FINDINGS/IMPRESSION:				
Endotracheal tube has been removed				
No other change				
No evidence of pneumonia				
Report dictated by: Karen Gomes Ordovas, MD, signed by: Karen Gomes Ordovas, MD				
Department of Radiology and Biomedical Imaging				
XR Chest 1 View (AP Portable) [366632005]				Collected: 06/03/20 0750
Order Status: Completed				Updated: 06/03/20 0758
Narrative:				
XR CHEST 1 VIEW AP 6/3/2020 2:41 AM				
HISTORY: Eval ET tube placement				
COMPARISON: Chest radiograph 6/2/2020				
Impression:				

Procedure	Component	Value	Units	Date/Time
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FINDINGS/IMPRESSION:

Tip of endotracheal tube is 6 cm above the carina. Unchanged position of left chest wall port.

Low lung volumes. Lungs appear clear. No pleural effusion or pneumothorax.

Unchanged cardiomeastinal silhouette.

Report dictated by: Aki Tanimoto, MD, signed by: Aki Tanimoto, MD
Department of Radiology and Biomedical Imaging

XR Chest 1 View (AP Portable) [366632009]

Order Status: Canceled

XR Chest 1 View AP [362696655]

Collected: 06/02/20
0745

Updated: 06/02/20
0801

Order Status: Completed

Narrative:

XR CHEST 1 VIEW AP 6/2/2020 7:28 AM

HISTORY: asthma exacerbation

COMPARISON: 4/23/2020

Impression:**FINDINGS/IMPRESSION:**

Left chest port with tip within 2 cm of the cavoatrial junction.

Clear lungs. No pleural effusion or pneumothorax.

Unchanged cardiomeastinal silhouette.

Report dictated by: Jamie Holtz, MD, signed by: Graham Wilson Wallace, MD
Department of Radiology and Biomedical Imaging

Performed and Complications:**6/3/2020 Arterial Line**

R radial, 22G, US guided, no complications

6/3/2020 Intubation

--- Cuffed, 6.5 mm Tube

Patient tolerance: **Patient tolerated the procedure well with no immediate complications**

Comments: **Intubated with T4 Glidescope.**

DISCHARGE INSTRUCTIONS**Discharge Diet**

Regular Diet

PHYSICAL THERAPY ASSESSMENTS AND RECOMMENDATIONS AT DISCHARGE

Available equipment or existing home modifications:

Prior functional limitations:

Rehab potential:

Discharge Activity comments:

Functional Assessment at Discharge/Activity Goals

No change in condition or functional status from admission.

Allergies and Medications at Discharge

Allergies: Methylprednisolone; Penicillins; Varicella-zoster ge-as01b (pf); Pine nut; Atorvastatin; Losartan; and Propofol

Your Medications at the End of This Hospitalization

	Disp	Refills	Start	End
albuterol (PROVENTIL) 2.5 mg /3 mL (0.083 %) inhalation solution Sig: 3 MI by nebulization every 2-4 hours as needed Notes to Pharmacy: Please dispense 1 month supply	1050 mL	12	3/17/2020	
albuterol 90 mcg/actuation metered dose inhaler Sig - Route: Inhale 3 puffs into the lungs every 4 (four) hours as needed for Wheezing or Shortness of Breath. Generic - Inhalation Notes to Pharmacy: Generic	6 Inhaler	11	1/9/2020	
atorvastatin (LIPITOR) 40 mg tablet Sig - Route: Take 1 tablet (40 mg total) by mouth Daily. - Oral	90 tablet	3	11/25/2019	
benazepril (LOTENSIN) 40 mg tablet Sig - Route: Take 1 tablet (40 mg total) by mouth Daily. - Oral	90 tablet	3	1/31/2020	
cetirizine (ZYRTEC) 10 mg tablet Sig - Route: Take 10 mg by mouth daily as needed for Allergies. - Oral Class: Historical Med				
EPINEPHrine (EPIPEN) 0.3 mg/0.3 mL injection Sig - Route: Inject 0.3 mLs (0.3 mg total) into the muscle once as needed for Anaphylaxis. Use as instructed - Intramuscular	1 each	6	4/14/2016	
fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray Sig - Route: 1 spray by Nasal route 2 (two) times daily as needed for Allergies - Nasal	3 Bottle	11	4/20/2020	
fluticasone-salmeterol (ADVAIR DISKUS) 500-50 mcg/dose diskus inhaler Sig - Route: Inhale 1 puff into the lungs Twice a day. - Inhalation Class: Historical Med				
HYDROcodone-acetaminophen (NORCO) 5-325 mg tablet Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed (pain and shortness of breath) - Oral Earliest Fill Date: 5/11/2020	120 tablet	0	5/11/2020	
LORazepam (ATIVAN) 1 mg tablet Sig: TAKE 1 TABLET BY MOUTH TWICE A DAY IF NEEDED FOR ANXIETY WITH SHORTNESS OF BREATH Notes to Pharmacy: Not to exceed 5 additional fills before 08/08/2020	60 tablet	0	5/11/2020	
magnesium citrate solution Sig - Route: Take 296 mL by mouth daily as needed (800mg once per day). - Oral Class: Historical Med				
omeprazole (PRILOSEC) 20 mg capsule Sig: TAKE 1 CAPSULE DAILY Cosign for Ordering: Accepted by Gina T. Moreno-John, MD on 5/26/2020 4:59 PM	30 capsule	5	5/26/2020	
polyethylene glycol (MIRALAX) 17 gram packet				

	Disp	Refills	Start	End
Sig - Route: Take 17 g by mouth daily as needed. - Oral				
Class: Historical Med				
predniSONE (DELTASONE) 5 mg tablet	30 tablet	3	6/8/2020	
Sig - Route: Take 1 tablet (5 mg total) by mouth daily Please wean steroids as tolerated to baseline. You can decrease your steroid dose by 10mg each 2-3 days until you are at your home dose. - Oral				
Cosign for Ordering: Required by Farhan Farooq Lalani, MD				
QUetiapine (SEROQUEL) 25 mg tablet	30 tablet	1	6/8/2020	
Sig - Route: Take 1 tablet (25 mg total) by mouth nightly at bedtime - Oral				
Cosign for Ordering: Required by Farhan Farooq Lalani, MD				
SENNOSIDES (SENNALAX ORAL)				
Sig - Route: Take 8.6 mg by mouth daily as needed. Every bedtime prn - Oral				
Class: Historical Med				
vitamin E (E-GEMS) 400 unit capsule				
Sig - Route: Take 1,000 Units by mouth Daily. - Oral				
Class: Historical Med				

Booked UCSF Appointments**Future Appointments**

Date	Time	Provider	Department	Center
6/11/2020	4:30 PM	John V. Fahy, MD	PulmA05	All Practice

Case Management Services Arranged**Case Management Services Arranged: (all recorded)****Discharge Assessment**

Condition at discharge: fair

Final Discharge Disposition: Home or Self Care

Primary Care Physician

Gina T. Moreno-John

Address: 1545 Divisadero St Second floor Box 0320 / San Francisco CA*

Phone: 415-353-2131

Fax: 415-353-2640

Outside Providers, for pending tests please use the following numbers:

For UCSF Laboratory - Please Call: (415) 353-1667

For UCSF Microbiology - Please Call: (415) 353-1268

For UCSF Pathology - Please Call: (415) 353-1613

Signed,

Veronica Elizabeth Manzo, MD

6/6/2020

Discharge Instructions provided to the patient (if any):**Discharge Instructions**

Dear Stephen Gaudet,

You were admitted for an asthma exacerbation. In the hospital, we took a picture of your chest, which did not show clear evidence of infection. You were intubated for about 2 days and treated with steroids. You were seen by our psychiatrists who recommended you start on seroquel at night. This medication may should help with your sleep. On discharge, your steroid dose was 60mg. Please continue to lower your steroid dose as tolerated (~10mg). You have a follow up appointment scheduled on Thursday with Dr. Fahy, your pulmonologist.

Key information for you to know:**MEDICATION CHANGES** (for dosing see complete medication list below):

- Please **START** taking
Seroquel 25mg every night as needed for insomnia
- The following medications have **CHANGES IN DOSE**
Prednisone 50mg daily (6/9-), lower dose by 10mg every 1-2 days as needed to resume to your home dose of prednisone.
- We recommend no other changes to your medications.

FOLLOW-UP INSTRUCTIONS:

- Follow-up appointments with your outpatient providers are listed below.

RETURN INSTRUCTIONS:

- Please contact a healthcare provider or return to the emergency room for: worsening shortness of breath, chest pain, wheezing, new fevers/chills.
- If you have questions, please contact your primary care provider or hospital team (phone numbers above).

It was a pleasure taking care of you.

Sincerely,
Dr. Veronica Manzo - Intern
Dr. Kaylin Nguyen - Resident
Dr. FARHAN FAROOQ LALANI, MD - Attending

Patient Instructions

None

Discharge Instr - Other Orders

Veronica Elizabeth Manzo, MD at 6/8/2020 9:42 AM

Dear Stephen Gaudet,

You were admitted for an asthma exacerbation. In the hospital, we took a picture of your chest, which did not show clear evidence of infection. You were intubated for about 2 days and treated with steroids. You were seen by our psychiatrists who recommended you start on seroquel at night. This medication may should help with your sleep. On discharge, your steroid dose was 60mg. Please continue to lower your steroid dose as tolerated (~10mg). You have a follow up appointment scheduled on Thursday with Dr. Fahy, your pulmonologist.

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Dr. Veronica Manzo - Intern

Dr. Kaylin Nguyen - Resident

Dr. FARHAN FAROOQ LALANI, MD - Attending

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