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

Your Admission - 09/03/20

Notes

Discharge Summary

Leah Nicole Wormack, MD at 9/10/2020 10:35 AM

Attestation signed by Sanjay Reddy, MD at 9/10/2020 3:31 PM

Attending Attestation - Day of Discharge Management

My date of service is 9/10/2020.

Final Physical Exam:
HEENT- NCAT, OP clear
Pulm- CTA with improved air movement B with symmetric expansion
CV- rrr, no m/r/g or JVD appreciated

Brief Hospital Course
65yo man with h/o asthma and multiple intubations with complex airway disease of bronchiolitis obliterans and posterior glottic stenosis, admitted for acute hypoxemic respiratory failure requiring intubation, with glottic stenosis dilation by ENT after extubation and plan to f/u with pulmonary. Pt also with UTI, which he will complete a levaquin course for.

During this hospitalization the patient was treated for:
Respiratory failure: Acute with hypoxemia

I spent 30 minutes preparing discharge materials, prescriptions, follow up plans, and face-to-face time with the patient/family discussing return precautions, importance of close follow-up.

Sanjay Reddy, MD

UCSF MEDICAL CENTER - DISCHARGESUMMARY

Patient Name: Stephen Gaudet
Patient MRN [redacted]
Date of Birth: 9/12/1954

Facility: Parnassus
Attending Physician: SANJAY REDDY, MD
Office Phone: 415-476-4808

Date of Admission: 9/3/2020
Date of Discharge: 9/10/2020

Admission Diagnosis:Dyspnea
Discharge Diagnosis: Posterior glottic stenosis, Asthma exacerbation

Discharge Disposition: Home

History (with Chief Complaint)

Stephen Gaudet is a 65 y.o. male w/ PMH asthma (c/b frequent exacerbations requiring intubation >50), complex airway disease (bronchiolitis obliterans) HTN, posterior glottic stenosis 2/2 repeat intubations admitted for hypercarbic respiratory failure.

At home, pt uses advair BID,prn abuterol, and pred 5 po qd. His baseline respiratory symtpoms worsened 6 days ago,he believes 2/2 smoke/ poor air quality. He started using albuterol nebs 0.5mcg q1hr and took 70 of prednisone. Since then he has continued the frequent albuterol nebs and attempted to taper his steroids (8/28 - 70mg, 8/29 - 60mg, 8/30 - 50mg, 8/31 - present 50mg qd) but his symptoms have not improved. Endorses chest tightness. Denies systemic infection symptoms fever/chills/cough/sputum production/systemic sx. Unable to elicit additional history due to worsening respiratory status requiring BiPAP. Spoke with partner who corroborates history.

Brief Hospital Course by Problem
#Urinary Tract Infection (Complicated)
Pt confused/ AMS despite stopping sedation and weaning precedex. Spoke to partner who noted UTI in previous hospitilizations that caused AMS.
-- 9/7 UA w/ Micro with + Leuk esterase, + Nitrite, >50 WBC
-- 9/7 Urine Cx: > 100,000 Klebsiella Oxytoca
Tx:
-- IV Ceftriaxone (9/7 - 9/10) > De-escalate to Levaquin (9/10 - to end 9/13) for 7 days total

#Severe asthma
#Acute hypercarbic respiratory failure 2/2 asthma exacerbation (resolved)
Patient has severe asthma requiring >50 lifetime intubations that have been complicated by ICU delirium particularly during and after extubation. Wildfires and poor air quality likely triggered most recent exacerbation requiring hospitalization. Patient was afebrile and did not have localizing signs of infection.
Dx:
- CXR WNL
- COVID neg, RVP negative
Tx:
- Intubated 9/3 - 9/6
- 9/3 Solumedrol 30 mg BID > 9/9 transition to Prednisone 60mg QD to be titrated by outpatient pulmonologist

#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, had very specific intubation requirements but expected easier intubations during this hospitalization following previous 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 [were] mobile - limited abduction bilaterally but good adduction. 10mm aperature. No evidence of recurrent scar."
- 9/8 S/p laser incision + dilation + kenalog injection w/ ENT

#AMS (resolved)
Pt w/ h/o AMS after extubation 2/2 steroids + sedation. During hospital course, developed agitation and delirium 2/2 UTI + steroid psychosis
- Ativan 0.5-1 mg prn for agitation

--Zyprexa 5 mg q4 prn for delirium
- At time of discharge, Pt AxOx4

Chronic Problems

#HTN

Was hypertensive during hospital stay in the setting of respiratory distress, but became hypotensive requiring phenylephrine when on propofol. Post-intubation, became hypertensive with SBPs up to the 200's, improved with hydralazine.
- Continued home benazepril 40mg qday (nonformulary) -> lisinopril 40mg when able to take PO
- Hydralazine 5 mg IV q6 PRN SBP>180 while in ICU
- discharged on home benazepril

#HLD

- Continued home atorvastatin 40mg qday

Physical Exam at Discharge

BP 145/78 (BP Location: Right upper arm, Patient Position: Sitting) | Pulse 70 | Temp 37 °C (98.6 °F) (Oral) | Resp 18 | Ht 158 cm (5' 2.21") Comment: measured w/RN at bedside | Wt 57.5 kg (126 lb 12.2 oz) | SpO2 100% | BMI 23.03 kg/m²

Intake/Output Summary (Last 24 hours) at 9/10/2020 1518
Last data filed at 9/10/2020 1300

	Gross per 24 hour
Intake	900 ml
Output	300 ml
Net	**600 ml**

Physical Exam
General: Ambulating in hall, On RA
HEENT: NC/AT
CV: RRR, no m/r/g
Pulm: good air movement across all lung fields, no wheezes, rales, or rhonchi
Abd: nontender, nondistended
Extremities: No lower extremity edema
Neuro: nonfocal, AxO x4

Relevant Labs, Radiology, and Other Studies

Recent Labs

	09/10/20 0422	09/09/20 0313	09/08/20 0406
WBC	**12.7***	**13.9***	**14.5***
HGB	**11.8***	**11.8***	**10.9***
HCT	**38.1***	**38.1***	**34.5***
PLT	257	168	178
RBC	4.63	4.64	**4.22***
MCV	82	82	82
MCH	**25.5***	**25.4***	**25.8***
MCHC	31.0	31.0	31.6

Recent Labs

	09/10/20 0422	09/09/20 0313	09/08/20 0406
NA	**146***	142	144
K	3.8	4.6	4.3
CL	110	108	107
CO2	26	23	25
BUN	**28***	**31***	17

CREAT	0.78	0.92	**0.70***
GLU	107	122	158

No data recorded Most recent:

Recent Labs

	09/10/20 0422	09/09/20 0313	09/08/20 0406
GLU	107	122	158

Recent Labs

	09/10/20 0422	09/09/20 0313	09/08/20 0406
CA	8.8	8.9	8.5

Recent Labs

	09/08/20 0406
PH37	7.42
PCO2	43
PO2	**238***
HCO3	28
SAO2	100
FIO2	Not specified

Procedures Performed and Complications

9/9/20 microdirect laryngoscopy with dilation
9/8/20 posterior glottic stenosis laser excision and balloon dilation + kenalog injection
9/6/20 extubation
9/4/20 intubation
9/3/20 aterial line placement

DISCHARGE INSTRUCTIONS

Discharge Diet

Regular Diet

PHYSICAL THERAPY ASSESSMENTS AND RECOMMENDATIONS AT DISCHARGE

Available equipment or existing home modifications:
Prior functional limitations: IND PTA. Reports walking ~ 3 miles/day. (I) IADLs including driving, cooking, cleaning.
Rehab potential: Patient will be able to tolerate 3 hours of therapy
Discharge Activity comments:

Functional Assessment at Discharge/Activity Goals

No functional activity limits.

Special comment on risk of falls in this patient:

This patient is at risk for functional decline or falls, and may benefit from continued home physical therapy and referral to community based services (such as community based Tai Chi, yoga, or walking services). Other supportive care (such as a podiatry and ophthalmology evaluations) may also be useful.

This patient may also benefit from vitamin D 800IU daily to reduce risk of fracture and serious injury. In some cases, calcium supplementation may also be appropriate.

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: 0.5ml with 3ml Normal Saline by nebulization every 2-4 hours as needed Notes to Pharmacy: Please dispense 1 month supply Prior authorization: Closed	1050 mL	12	7/17/2020	
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	8/26/2020	
atorvastatin (LIPITOR) 40 mg tablet Sig - Route: Take 1 tablet (40 mg total) by mouth daily - Oral	90 tablet	3	7/17/2020	
azithromycin (ZITHROMAX) 500 mg tablet Sig - Route: Take 1 tablet (500 mg total) by mouth 3 (three) times a week on Mondays, Wednesdays, and Fridays - Oral	12 tablet	11	6/12/2020	
benazepriL (LOTENSIN) 40 mg tablet Sig - Route: Take 1 tablet (40 mg total) by mouth Daily. - Oral	90 tablet	3	1/31/2020	
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: One by mouth twice a day if needed for shortness of breath or anxiety Notes to Pharmacy: Not to exceed 5 additional fills before 08/08/2020	60 tablet	1	7/31/2020	
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 Sig - Route: Take 17 g by mouth daily as needed. - Oral Class: Historical Med				
traZODone (DESYREL) 50 mg tablet Sig - Route: Take 25 mg by mouth nightly as needed for Sleep - Oral Class: Historical Med				
zolpidem (AMBIEN) 10 mg tablet	10 tablet	0	7/28/2020	

	Disp	Refills	Start	End
Sig - Route: Take 1 tablet (10 mg total) by mouth nightly as needed for Sleep - Oral				
levoFLOXacin (LEVAQUIN) 500 mg tablet	3 tablet	0	9/10/2020	9/13/2020
Sig - Route: Take 1 tablet (500 mg total) by mouth daily for 3 days - Oral				
Cosign for Ordering: Accepted by Sanjay Reddy, MD on 9/10/2020 2:51 PM				
predniSONE (DELTASONE) 20 mg tablet	30 tablet	0	9/11/2020	
Sig - Route: Take 3 tablets (60 mg total) by mouth daily - Oral				
Cosign for Ordering: Accepted by Sanjay Reddy, MD on 9/10/2020 2:51 PM				
tiotropium (SPIRIVA) 18 mcg capsule for inhalation	90 capsule	11	6/11/2020	
Sig - Route: Inhale 1 capsule (18 mcg total) into the lungs every morning Inhale with two full breaths every morning. - Inhalation				

Discharge With Opioid Medications for:
ACUTE PAIN

- According to our records, this patient was not taking opioid medications before this hospitalization.
- We do not plan to manage refill and the Primary Care Provider should manage refills.
- Please evaluate with each refill of an opioid that your patient meets the criteria for ongoing opioid therapy with the goal to avoid chronic opioid use. Please ensure the patient knows about alternatives for pain management and understands how to taper opioids.

Pending Tests
None

Outside Follow-up
None

Booked UCSF Appointments
Future Appointments

Date	Time	Provider	Department	Center
9/14/2020	11:30 AM	Jenna Lester, MD	DERMZM4	All Practice
9/17/2020	1:00 PM	John V. Fahy, MD	PulmA05	All Practice
9/28/2020	8:30 AM	Brook Anne Calton, MD	PAL CARE	All Practice
10/22/2020	11:00 AM	Matthew S Russell, MD	OHNS GEN OTO	All Practice

Pending UCSF Referrals
None

Case Management Services Arranged
Case Management Services Arranged: (all recorded)

Discharge Assessment
Condition at discharge: good

Advance Care Planning Documentation during this hospitalization:

Code Status: FULL

Patient-Level Advance directive, POLST, or Living Will Documents:
Scan on 8/20/2020 4:50 PM by Victoria Phelps
Scan on 3/8/2019 8:40 AM by Hoa Van: DGIM/Advance Health Care Directive
Scan on 2/27/2007

Scan on 9/22/2006
Scan on 12/20/2005

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 UCSFMicrobiology - Please Call: (415) 353-1268
For UCSF Pathology - Please Call: (415) 353-1613

Signed,
Leah Wormack, MD MS

Discharge Instructions provided to the patient (if any):

Discharge Instructions

Dear Stephen Gaudet,

You were admitted for an Asthma Exacerbation and Posterior glottic stenosis. In the hospital, you were intubated 9/3/20 to 9/6/20. We also treated you with nebulizer treatments, steroids, and ativan and fentanyl for air hunger. Your respiratory status improved well and we were able to get you on 60 mg of Prednisone. You should continue that dose until you see your pulmonologist, and he can give you instructions about how and when to wean it down.

While in the hospital you developed a urinary tract infection which made you confused. We treated you with antibiotics here and you will continue an antibiotic called Levaquin, until 9/13/20.

Key information for you to know:

MEDICATION CHANGES (for dosing see complete medication list below)**:**
- Please **START** taking : prednisone 60mg, levofloxacin 500 mg daily for 3 more days (antibiotic to treat UTI)

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, fever, confusion, pain with urination or increased urinary frequency/urgency.
- 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. Wormack - Intern
Dr. Ghooray - Resident
Dr. SANJAY REDDY, MD - Attending

Patient and Family Advisory Council

Would you like to have the opportunity to improve the care experience of patients who are in the hospital? The UCSF Division of Hospital Medicine is actively recruiting members for a Patient and Family Advisory Council (PFAC). The PFAC is comprised of a group of patients and/or loved ones who meet monthly to discuss hospital initiatives and improvements. Please email DHM.PFAC@ucsf.edu for further information, or visit our website at https://tinyurl.com/DHMPFAC.

Discharge Instr - Other Orders

Kala Ghooray, MD at 9/10/2020 11:37 AM

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