Note From Your Admission on 07/22/24

Consults by Marian Poley at 7/22/2024 1:25 PM

Attestation signed by Matthieu Legrand at 7/22/2024 5:36 PM

Attending Attestation

My date of service is 07/22/24.

I was either virtually or physically present for key portions of the encounter and am personally involved in the management of the patient. I reviewed, verified, and revised the note as necessary.

Assessment and Plan
Stephen Gaudet is a 69 y.o. male patient with severe asthma, previously multiple exacerbations and intubation, now presenting for new exacerbation requiring continuous nebs and BiPAP. Will admit to the ICU.

MDM Complexity Data
No additional complexity of data reviewed
No additional complexity of data

MDM Complexity of Problems present and monitored
Progression of chronic illness: Asthma

MDM Complexity Risk
Treat with IV controlled substances

Severity of Illness
Close monitoring from significant risk of clinical deterioration.
Use of NIPPV.

Critical Care Diagnosis
Respiratory Care: Respiratory failure: Acute with hypercapnia and hypoxemia (present on admission)

Critical Care Time: I have discussed the events of the last 24 hours and the plan for the day with the team providing critical care and, as outlined above, consultant services. I have 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. My total critical care time spent is 30 minutes.

Matthieu Martin Legrand, MD

Adult Critical Care Medicine Triage/Consult Note

Primary service at time of request: ED
Evaluation requested by *(resource RN, primary team APP/resident, hospitalist, PACU RN, etc.)*: ED resident Dr Ornelas
Reason for evaluation: severe asthma with acute status asthmaticus

Relevant history:
Stephen Gaudet who is a retired respiratory therapist from UCSF with severe asthma (on tezpire monotherapy, outpatient recent course of high dose prednisone) who presents for acute dyspnea concerning for status asthmaticus. He has a complicated pulmonary history and follows in our severe asthma clinic with Dr Fahy as well as Dr Tang in allergy.

He is well known to the ICU, has been intubated previous 50+ (last in March 2023 with ETT 6.0, prior to this 2021 with ETT 6.5) with posterior glottic stenosis s/p multiple dilations (followed by Dr Butrymowicz) with most recent visit concerning for significant worsening of glottic stenosis. Additionally has significant PTSD from previous intubations, has a care plan for any potential attempts.

Exam:
Temp: [37.1 °C (98.7 °F)] 37.1 °C (98.7 °F)
Pulse: [79-86] 79
*Resp: [23-38] 23
BP: (182-255)/(99-180) 182/111
FiO2 (%): [50 %] 50 %
SpO2: [87 %-99 %] 97 %

O2 Device: None (Room air) (07/22 1211)
FiO2 (%): 50 % (07/22 1310)

Notable physical exam findings:
Acute respiratory distress with increased work of breathing, pulsox waveform poor
Speaks in short phrases with significant dyspnea
Poor air movement in all regions of the lungs, no expiratory wheezing. Placed on BiPAP 10/5 50% with VT ~ 450-500 with significant tachypnea to mid 30s
More full abdomen, nontender to light and deep palpation
Warm and well perfused

Data:
Recent Labs

Lab	07/22/24 1229	07/15/24 1624
WBC	**10.4***	**11.4***
NEUTA	**7.14***	**7.18***
HGB	15.4	14.8
HCT	48.0	45.6
MCV	92	91
PLT	257	241
NA	--	145
K	--	3.6
CL	--	109
CO2	--	24
BUN	--	10
CREAT	--	0.93
GLU	--	79
CA	--	9.3
MG	--	1.9
AST	--	24
ALT	--	21
ALKP	--	92

TBILI	--	0.6
ALB	--	3.7
PT	13.0	--
INR	1.0	--

• XR Chest 1 View (AP Portable)

Result Date: 7/22/2024
FINDINGS/IMPRESSION: Left chest wall port tubing with tip the cavoatrial junction. Please note that the port reservoir is not visualized on chest radiograph and may be radiolucent, unchanged from prior. Zio patch projecting over the left hemithorax. Clear lungs. No pleural effusion or pneumothorax. Normal cardiac and mediastinal contours. Report dictated by: Maya Vella, MD, signed by: Maya Vella, MD Department of Radiology and Biomedical Imaging

I have personally reviewed and interpreted the following studies: Telemetry showing tachycardia. CXR showing clear lung fields, indwelling left sided port.

I discussed the care of this patient with the bedside RN, the respiratory therapist, and the primary team.

Assessment:
Stephen Gaudet is a 69yoM with severe asthma, hx of many previous intubations (50+, most recently 2023) complicated by glottic stenosis who presents today for acute dyspnea likely secondary to acute status asthmaticus recalcitrant to outpatient high dose steroids.

He requires ICU admission for BiPAP titration and his main goal is to avoid intubation. I have discussed his need for NIPPV with the accepting team and him, and have let him know that we will avoid intubation if possible.

I have contacted his primary pulmonologist and his allergist to discuss his care further.

Recommendations and Interventions:
- Start BiPAP 10/5 50%
- Recommend IV antibiotics with ceftriaxone/azithromycin
- Agree with continuous albuterol
- PRN Fentanyl 50mcg per patient plan

Disposition:
ICU

Severity of Illness
Close monitoring from significant risk of clinical deterioration.
Use of NIPPV.

The patient is currently being treated for the following:
Respiratory Care: Respiratory failure: Acute with hypercapnia and hypoxemia (present on admission)
Acid-base disturbances: Respiratory acidosis (present on admission)

Marian Flora Colberg Poley, MD
Critical Care Medicine Service
Please reach out at any time via Voalte (**Crit Care Triage 1st Call Parn**) if the patient develops worsening clinical status.

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