

Clinical Note – Patient #1

Admission Date : 2018-05-26

Discharge Date : 2018-05-31

Date of Birth : 1935-11-10

Sex : F

Service : MEDICINE

Allergies : Codeine / Iodine

Attending : Derrick L. Mayo , M.D.

Chief Complaint : large pericardial effusion , transfer from OSH

Major Surgical or Invasive Procedure : Thoracentesis 2018-05-27

History of Present Illness : 82 F with h/o COPD , CAD , pafib and SSS s/p pacer on 05-08 for symptomatic pauses is transferred for large pericardial effusion ? needing drainage and CHF .

She was admitted to Cambridge Hospital 2018-05-24 with ARF (Cr 3.5 up from 0.9) and SOB .

According to her guardian she was discharged to her NH for a few days after her pacer was placed 05-08 , which was complicated by a PTX requiring CT placement which had been d/c 'd in the hospital after resolution of her PTX .

She had some nausea / vomiting and generally was taking poor pos at her NH .

There had been some concern her nausea was due to her amiodarone which had been discontinued about 1 week ago .

She was then sent to Franklin Medical Center 05-24 with lethargy and n/v .

At Erich Lindemann Mental Health Center she was discovered to have ARF , a large pericardial effusion , and bilateral pleural effusions .

She was treated with IVF for her ARF .

She underwent a TTE at Erich Lindemann Mental Health Center today (05-26) showing mod-lg circumferential pericardial effusion without evidence of RV diastolic collapse and no MV inflow evidence of tamponade , pacer wire located in RV apex .

There was still concern for her effusion contributing to her SOB at the OSH so she was transferred for drainage and treatment of CHF .

Today she only complains of some SOB , which she says remains largely unchanged over the past few days .

She denies any CP / cough / fever / abd pain / diarrhea / black or bloody stools / headache .

Past Medical History :

htn

afib , SSS

COPD

CAD

pacer DDDR (Vitatron CL860) placed 05-08 for SSS with symptomatic bradycardia , c/b R PTX requiring chest tube

GERD

CVA

hypothyroidism

legally blind

Social History :

NH resident , guardian Robert Murrell

Family History :

NC

Physical Exam :

Exam : T 96.2 HR 70 BP 118/46 R 24 sat 90% on 60%FM

pulsus paradoxus = 6-8 mm

gen : mild resp distress speaking in full sentences but using accessory muscles

HEENT : mmm , JVP at 14 cm , no bruits , supple

CV : RRR , 02-19 sys m at RUSB

pulm : no BS 01-15 way up bilat , no consolidation

abd : s/nt/slightly distended , dec BS , no CVA tenderness

ext : 1+ LE edema

Pertinent Results :

ECG : a paced at 70 bpm / nml axis , LBBB , no ST or TW changes

CXR at Erich Lindemann Mental Health Center 05-26 : bilateral pleural eff and pericardial eff

CT chest at Erich Lindemann Mental Health Center 05-25 : large pericardial effusion , bilat pleural eff with underlying consolidation which could represent PNA vs. atelectasis

TTE at Erich Lindemann Mental Health Center 05-26 : mod-lg circumferential pericardial eff , no evidence of RV diastolic collapse , no MV inflow evidence of tamponade , pacer lead located in RV apex

head CT at Erich Lindemann Mental Health Center 05-24 : atrophy , dense calcification of the tentorium , most likely of metabolic etiology

IMAGING AT Providence Behavioral Health Hospital :

ECHO 2018-05-28

IMPRESSION : Moderate to large pericardial effusion (minimal fluid anteriorly (1cm), ? bloody).

No definite tamponade physiology .

Pacer seen in RV apex , but cannot exclude perforation .

CXR 2018-05-30

FINDINGS : The lung volumes are Moderate bilateral pleural effusions are unchanged .

Mild pulmonary edema is unchanged .

Lung volumes are low .

Bibasilar atelectasis is unchanged .

IMPRESSION : Unchanged moderate bilateral pleural effusions and mild CHF .

RENAL US 2018-05-28

FINDINGS : The right kidney measures 11 cm in length , the left kidney measures 9.7 cm in length .

No hydronephrosis is seen .

No urinary calculi are seen .

The bladder appears unremarkable and contains a Foley catheter .

IMPRESSION : No evidence of hydronephrosis .

Brief Hospital Course :

A/P :

82 y/o f w h/o afib , SSS s/p pacer 05-08 c/b PTX requiring CT , CAD , who was readmitted 05-24 with ARF and lethargy , found to have a large pericardial effusion and bilateral pleural effusions , with echo showing no evidence of tamponade , who is transferred for possible pericardial effusion drainage and treatment of CHF , as well as drainage of bilateral pleural effusions .

She had a BNP of > 5000 on admission .

Since admission , she ruled out for MI by enzymes , and had a right sided thoracentesis which yielded transudative fluid .

WBC s since admission were as high as 14,000 but normalized .

She also had 2 echocardiograms which revealed persistent pericardial effusions .

She has been gently diuresed but has worsening ARF .

Her O2 requirement has increased despite diuresis .

She denies any CP / cough / fever , abdominal pain / diarrhea , black or bloody stools or headache .

Her urine output decreased to nearly zero .

In the setting of her ongoing pericardial effusion , she was transferred for closer observation to the CCU

The CCU fellow and team declined to do pericardial drainage , as the pt was hemodynamically stable , without change in appearance of effusion by echo performed at bedside by cards fellow .

As she was felt by the CCU to be a poor candidate for right heart cath , was hemodynamically stable with blood pressure 110 s- 120 s systolic and pulse 70 s- 80 s , she was called out of the CCU and back to the cardiac floor without intervention .

The procedure team was called to consider doing a left thoracentesis , but she was declined because it was felt that her effusions were transudative , secondary to CHF , and it was recommended to treat CHF

The pt continued to have low urine output .

She was given a lasix drip IV upon call-out of the ICU , and additional boluses of IV lasix , 200 mg then 300 mg IV were given with a good response , however , she remained net positive fluid balance .

Renal consultants did not feel there was an emergent need for dialysis .

A nitro drip was started in an effort to decrease her preload and afterload .

On call out from the CCU , the pt was satting 93% on 4-5L NC , and through the following night , her oxygen requirement increased to NRB , wherein she was satting upper 80 s- low 90 s.

ABG that evening was 7.29/51/56 on 4L NC and early the next morning , was 7.25/62/64 on NRB .

A CXR was performed the evening of 5/16 , showing moderate sized bilateral pleural effusions , stable cardiomegaly and a possible RLL infiltrate .

Vancomycin and Zosyn were started .

She was afebrile .

The morning of 5/17 , her pulsus paradoxicus was 12 .

Because of her ABG , and declining clinical status , the CCU was notified for possible transfer .

The CMED CSRU Intern called the Murphy , Robert Leigh , to give her the update with regards to the pt 's deteriorating clinical status .

It was felt that given her age , multiple co-morbidities , that her prognosis was poor even prior to CCU admission , possible pericardial drainage or repeat thoracenteses .

Goals of care were clarified with her Murphy , Robert Sanchez .

Explained to Lewin that pt will likely need to be intubated , as she cannot lie flat , and most likely cannot undergo pericardial drainage , thoracentesis , or right heart cath with BiPAP (which would have been the next measure after NRB , and prior to intubation) .

Explained that despite these invasive measures , she still has a very poor prognosis .

Odell stated she had been thinking about this all night of 2018-05-30 , and agreed that this is not what the pt would have wanted .

Odell does not believe the pt would want to be intubated , with central line , right heart cath , in the CCU .

She requested the patient be made Comfort Measures Only .

She was DNR/DNI on admission .

This was documented in the computer , confirmed with Cardiology attending and fellow , and conveyed to the CCU staff , who were informed she may need to go for transfer (which was subsequently cancelled) .

The pt will be made comfortable , with goals of care shifted towards suppressing her air hunger and pain .

#. SOB : Most consistent with CHF by exam , although unknown what the severity of her COPD is currently .

TTE revealed large pericardial effusion .

Pt is now s/p drainage of right pleural effusion , diagnostic and therapeutic , with studies consistent with transudate , etiology most likely 02-15 CHF .

We continued her albuterol / atrovent nebs , diuresis with IV lasix drip and boluses .

Her 05-27 CXR post procedure w/o PNx , effusion much improved , yet her 05-28 CXR worse than 05-27 with some reaccumulation of right pleural effusion .

Then , on 05-29 , she demonstrated bilateral pleural effusions (reaccumulated) , right lower lobe infiltrate (started on vanco / zosyn)-> put on face mask , given lasix x 1 bolus 100 mg , responded somewhat and o2 sat stable in low 90 s.

She was given 200 mg IV lasix X 1 with an additional 100 cc of urine output the evening of 5/16 .

Her lasix gtt continued during this time .

Her oxygen sats did not improve .

She was then made CMO .

See above .

#. Pericardial effusion : unclear etiology , OSH had raised question of RV perforation from pacer , however she had a normal echo appearance of lead , no tamponade by exam .

This has still be known to occur during the placement of pacemaker .

It was felt posthumously that her large pericardial effusion was most likely secondary to a complication of pacer placement , although this was not seen on imaging .

In the last 12 hours of her life , her pulsus was 12 , and she was felt to likely to have aspect of tamponade physiology , since her preload was reduced .

#. CHF : normal EF on TTE so possibly with diastolic dysfunction , ruled out for MI

- See course of diuresis above .

- We continued ASA / imdur / CCB / hold diovan until pt was made CMO .

#. Pleural effusions : Likely due to CHF although had some leukocytosis at admission to OSH .

Mary studies c/w transudate .

- After she was made CMO , the pt was started on Morphine gtt to maximize comfort and minimize air hunger .

#. Afib/SSS : She was A-paced , pacer placed 05-08 in DDDR mode , complicated by PTX requiring chest tube which resolved and tube was removed during admit for pacer , no evidence of PTX on most recent CXR .

Her pacer wires in correct position .

We continued amiodarone until pt was made CMO .

Anticoagulation has not been given this admission .

She was a poor anticoagulation candidate .

We started her on dilt for additional a fib control (revert back to a fib on 05-29), which was stopped when the pt was made CMO .

#. Oliguric ARF : likely prerenal due to n/v poor po intake and poor forward flow , However , need to continue diuresis .

Her urine lytes consistent with ATN , FENA 4% .

Renal u/s negative for hydronephrosis .

Renal consultants did not feel that there was an indication for urgent hemodialysis .

She continued to put out low amounts of urine throughout the admission , despite aggressive diuresis with IV lasix gtt and boluses .

See above .

#. ID : initially had leukocytosis at admission , with chest CT showing possible underlying consolidations vs. atelectasis , levoflox started 05-24 and subsequently stopped (no consolidations on CXR and afebrile) .

U/A on 05-27 c/w UTI .

Pt now on IV Ceftriaxone (was on levoflox since 05-24 however UA now floridly positive (more so than UA at OSH) so felt possibly levo-resistant .

Pt started on CTX 05-27 .

She was empirically started on vanco/zosyn for empiric hosp acquired pna coverage

- possible opacity on CXR - along w/ leukocytosis .

#. Anemia : Unclear source .

She was guaiac negative .

- no transfusions , CMO/DNR/DNI

#. FEN : check lytes , most recently normal .

cardiac/renal diet

#. Access : PIV

#. Code : DNR/DNI/CMO verified with Robert Marks 2018-05-29

#. Communication : Guardian Robert Fitzgerald (520) 328 5499 .

Medications on Admission :

aranesp 100 mcg (X1 05-26)

diltiazem CD 240 mg

paxil 20 mg daily

detrol LA 4 mg daily

EC ASA 81 mg daily

pepcid 20 mg daily

amiodarone 200 mg daily

levofloxacin 250 mg IV daily (started 05-24)

levothyroxine 50 mcg daily

diovan 160 mg daily

imdur 60 mg daily

albuterol-ipratropium INH 2 sprays tid prn

Discharge Disposition :

Expired

Discharge Diagnosis :

1. Pulmonary Edema and Hypoxic Respiratory Failure
2. Large pericardial effusion

3. Moderate bilateral pleural effusions
4. Congestive Heart Failure
5. Paroxysmal Atrial Fibrillation
6. Sick sinus syndrome status post pacer placement
7. Coronary Artery Disease

Discharge Condition :

Expired

Discharge Instructions :

Not applicable

Followup Instructions :

Not applicable

Jessica Ashley MD 19-617

Completed by : James Weishaar MD 01-503 2018-05-31 @ 1428

Signed electronically by : DR. Barry Smith on : FRI 2018-06-01 8:26 AM