NOTE 1:

ID: Pt is 26yo female with a history of transverse myelitis and bipolar I, admitted with chronic bilateral hip and shoulder osteonecrosis of unclear etiology.

24 events: No acute events overnight

Subjective: Pt reported that compared to yesterday, she feels like her pain has gotten worse. She attributes this to the pause in lidocaine, and states that she needs more pain medications to manage her pain in her R hip, which is worse than her L. She describes the pain as achy, sharp and burning that radiates down to her R shin. She mentions that applying a heat pack to the groin helps with the pain. She also maintains that her L shoulder is sore, and her R thumb is sore upon adduction. Despite the pain, she reports that she was able to walk to the door and back yesterday. In addition to her concerns about pain, patient felt that the ketamine has helped her anxiety levels and mentioned that her symptoms have ameliorated.

Objective:

Meds:
Tylenol 1000mg
Celecoxib 200mg
Vit D3 tables 5000 units
Enoxaparin 40mg
Escitalopram oxalate 20mg
Lurasidone 80mg
Midodrine 2.5mg
Polyethylene glycol 17g
Pregblain 300mg
Quetiapine 100mg
Senna 2 tablets
Tapentadol 100mg

Lines:
Peripheral IV on R cubital fossa

In/Out:
In: 942mL (PO)
Out: 775mL (urine)
Net: 167mL

Vitals: BP 103/57, P: 79, RR: 16, T: 36.4, SpO2: 98%, BMI: 32

Physical Exam:

General: Overweight, moderately distressed especially with movement of her legs, who appears her stated age and is found lying in bed.
HEENT: EOMI, sclera anicteric
Pulm: No visible respiratory effort or distress. Lungs are clear to auscultation bilaterally. No wheezes, rhonchi, crackles.
Cardiac: Regular rate and rhythm. No murmurs, gallops, or rubs.
Neuro: Alert and oriented to time, person, and place; CN II-XII are grossly intact. Notable point tenderness in lower R back upon palpation. Muscle bulk and tone are normal throughout all major muscle groups. Strength is 4/5 in her L upper extremities, specifically biceps and triceps, and 3/5 in her bilateral knees, though this could be attributed to pain vs neurological symptoms. Otherwise, strength is 5/5 in her bilateral deltoids, R upper extremities and ankle flexion/extension. Biceps, brachioradialis, triceps, patellar, and Achilles reflexes are all 2+ bilaterally and symmetric. Bilateral shoulders had full range of motion. Patient had a slight tremor in bilateral hands during examination, but this tremor disappeared when we were examining other parts of the body. She is able to hold her phone without a tremor. The rest of the exam was deferred due to pain.
Skin: no gross rashes

Labs: 2/5/22
No new results for WBC, BMP in last 24 hrs
Lidocaine: 2.6

Assessment/Plan:
In summary, pt is 26yo female with a history of transverse myelitis and bipolar I, admitted with chronic bilateral hip and shoulder osteonecrosis of unclear etiology. She described worsening pain today compared to yesterday but attributed that to stopping lidocaine. Upon exam, she has point tenderness in her lower R back, 4/5 strength in her L upper extremities and 3/5 strength in her bilateral knees. Labs reveal lidocaine levels of 2.6.

1. Osteonecrosis of the hips
    a. Patient was admitted to acute pain service in January for ketamine infusion in her lower back. She had a workup through pain clinic and neuroimmunology, though the results are inconclusive; the clinic suggested consultation to pain psych. She then presented to ED with severe bilateral hip pain that limited her ability to walk.
    b. Pain management
        i. Continue pain management medications:
            1. Tylenol, Pregblain, Tapentadol
        ii. Treat constipation due to opiate use
            1. Polyethylene, Senna
        iii. Follow up with pain management
    c. Mobility
        i. Enoxaparin for PE prophylaxis due to limited mobility
        ii. Continue PT and work on increasing mobility

    d. Follow-up with ortho and pain management
2. Transverse myelitis
    a. While symptoms do not seem consistent with the diagnosis, she attributes her pain to this. MRI was negative for transverse myelitis.
    b. May need more imaging/tests to rule out
3. Hypotension
    a. May be due to pain
    b. Continue midodrine, which has improved her symptoms in the past
4. Generalized anxiety disorder
    a. Continue Escitalopram, Lurasidone, Quetiapine
    b. Referral to psych if needed.
5. Vitamin D deficiency
    a. Continue vitamin D supplements
6. Discharge plan
    a. Ensure patient knows follow up appointments
    b. Need to ensure pain is under control before discharge

Note 2:

ID: Pt is 68yo female with a history of sarcoidosis, heart failure, and currently well-managed HTN and HLD, admitted for malignant small bowel obstruction, s/p central line placement on 2/8.

24 events: No acute events overnight. Still on liquid diet only; Family meeting still waiting to occur

Subjective: Pt feel optimistic about her diagnosis and is "looking forward" . She reports not having any bowel movements or urination. She is mobile and mentioned that she has been able to walk to the door and back. She reports feeling warm, but denies any significant pain

Objective:

Meds:
IV fat emulsion/TPN: liquid diet
atorvastatin, carvedilol, lisinopril: HLD, HTN
ceftriaxone: finishing course due to sepsis
olanzapine/paroxetine: antipsychotics

Lines:
NG tube in her left nares
Central Line on her right
peripheral IV in her left hand

In/Out: in- 1250mL; out- 250mL (urine + gastric)

Vitals: BP 121/79, P: 92, RR: 18, T: 36.6, BMI: 25

Physical Exam: The physical exam was declined by patient's request, but upon observation:
General: Frail, undernourished patient, who appears older than her stated age, seated on her bedside commode
HEENT: NG tube placement with brown fluid output
Pulm: No visible respiratory effort or distress. Clean, dry, and intact central line placement
Neuro: Alert and oriented to time, person, and place; CN II-XII are grossly intact
Psych: Slightly agitated. Upon questioning, she has tangential thought processes and finds it difficult to respond appropriately to questions.

Labs: 2/10 5:20a
Hg: 8.5, Hct: 27.2, RBC 3, MCHC: 31.3
Na 130, Cl 97: stable since hospital visit

EKG: sinus rhythm; left atrial enlargement; left ventricular hypertrophy

Assessment/Plan:
In summary, pt is 68yo female with a history of sarcoidosis, heart failure, and currently well-managed HTN and HLD, presenting with malignant small bowel obstruction, s/p central line placement on 2/8. She is feeling optimistic but is slightly agitated with tangential thought processes. She declined the physical exam, but upon visual inspection, she presents as a frail patient who appears older than her stated age.

1. malignant small bowel obstruction due to unconfirmed malignancy
    a. Due to incomplete outpatient colonoscopy, CT showed suspected cecal malignancy with abdominopelvic metastases to lymph nodes, diffuse peritoneal carcinomatosis, and moderate left hydronephrosis. She then presented with nausea/vomiting and abdominal pain. Consult to gen surg revealed this to be non-operable
    a. cont liquid diet
    b. cont to monitor for bowel movements and pain
    c. schedule outpatient oncology consult
    d. f/u with pathology to confirm origin of cancer- 2/9 results not back yet
    e. consider palliative chronic decompression venting G-tube with GI consult
2. spontaneous bacterial peritonitis
    a. Onset of delirium on 2/5, patient had ascites with leukocytosis; there was improvement in sx after a day of cefepime. High ANC on paracentesis on 2/6 was concerning for spontaneous bacterial peritonitis
    b. finish the course of ceftriaxone
    c. continue to monitor WBC levels
3. mild anemia
    a. continue to monitor lab values

4. hyponatremia
    a. Hyponatremia has stayed stable since admission
    b. continue to monitor lab values
5. anxiety
    a. continue meds: olanzapine/paroxetine
    b. consult psych if necessary
6. HTN/HLD
    a. continue atorvastatin, carvedilol, lisinopril and monitor levels
7. discharge
    a. gather more history on family members to discuss goals of cancer
    b. son in jail, but has other family members on the east coast
    c. discuss f/u options and living situations
    d. referral to case management

Note 3:

ID: Patient is a 61yo F with a PMH of ESRD currently on home hemodialysis and bradycardia with MicraPPM on 1/4 presenting to the hospital with constipation and pain, and admitted on 02/12.

S: Patient mentioned that her pain is much better than yesterday, and feels optimistic that everything is getting better. She rates her pain 3/10, and describes it as pain across her abdomen. This is significantly decreased since her admission, where she describes the pain as 9/10. She also mentioned that the bed sores from her stay at the skilled nursing facility were getting better.

She also mentioned that she had 3 bowel movements today that were soft and brown, which were different from the constipation when she was admitted. She reported slowly increasing appetite, though still decreased appetite compared to before.

She was very excited that she met her goals with PT today.

Review of systems reveals easy bruising across her stomach and arm, though she attributes that to the injections that she is receiving. She also states that she does not feel dizzy and does not have a headache despite her hypotension. She also has not urinated for years since dialysis

O:
Meds:
Vit C,Vit D
bupropion, gabapetin, citalopram (depression)
cinacalet (ca reducer, dec PTH)
heparin injection
lidocaine (pain)
midorine (hypotension)

polyethylene glycol, senna (constipation)
svelamer carbonate (lowers phosphate; for patients on dialysis)
Line: dialysis double lumen tunneled access on R chest; peripheral IV L hand

I/o: 1600mL PO in; 1500ml out dialysis (2/14)

Vitals: BP 77/50; P:64; RR: 16; SpO2: 97; T: 36.7
General: well-appearing obese, lying in bed.
Pulm: clear to auscultation bilaterally; worked to take deep breaths. unable to auscultate her back due to difficult mobility
Cardaic: regular rate/rhythm; bradycardia
Ab: scars from prior surgeries ("taking out kidney", "removing belly button"); soft, non-tender upon palpation; could not palpate spleen/liver due to body habitus; could not ausculate bowel sounds (hyporeactive bowel?)
Neuro: oriented to time, person, place. CN II-XII grossly intact
Extremeties: 1+ edema; L great toe amputation; R dorsalis pedis pulse strong; bilateral radial pulses strong

Labs: 02/14 4p
ALT: 10, AST: 21, bilirubin: 0.5
Hct: 32.6 (L)
WBC: 5.9
RBC: 2.96 (L)
platelet: 115 (L)
Na: 127 (L)
K: 6 (H)
Cl: 94 (H)
CO2: 22
Cr: 8.11 (H)
BUN: 40 (H)
BUN/Cr: 5 (L)
Glucose: 41 (L)

Problems:

1. rectal pain, colitis
    a. continue to monitor pain medications
2. chronic hypotension
    a. continue to monitor vitals
    b. ensure medications do not additionally cause hypotension
3. ESRD
    a. Continue to monitor Cr/BUN
    b. Nephrology f/u
4. 1st big toe amputation

a. Ensure that wound is clean

Note 4:

Source of Information: Patient, who appears reliable.

CC:
DS is a 60-year-old male with a history of familial pulmonary fibrosis and short telomere syndrome (status post lung transplant and add date), presenting with shortness of breath, wheezing, and coughing.

HPI:
DS came to the hospital for a scheduled bronchoscopy and bronchioalveolar lavage but complained of shortness of breath and wheezing. A few weeks prior, DS was taking ipratropium bromide, but noticed worsening shortness of breath and wheezing with the medication. A few days before his bronchoscopy, he self-stopped the medication, and felt better. On the day of his appointment, he was able to walk to his appointment, and felt only slight constriction in his breathing. He has a productive cough associated with the wheezing that produced only clear sputum. He noticed that his symptoms felt better when he was lying down on his right side. He did not notice any fevers or chills, no chest pain or edema, and no pain with breathing. DS is most worried about a reoccurrence of a pneumothorax, which previously occurred in early September.

PMH:
The patient was diagnosed with pulmonary fibrosis in 2018 through a lung biopsy but was asymptomatic until 2020. He was positive for the TERT mutation and was also diagnosed with short telomere syndrome. He eventually had a bilateral lung transplant in 5/2021 and is currently post-transplant. He had a stent placed post-transplant and had regular, scheduled bronchioalveolar lavages.

Meds:
- Albuterol inhaler
- Post-transplant medications
    - Immunosuppressants
    - Prednisone
    - Bactrim (trimethoprim-sulfamethoxazole)
    - Nystatin (mycostatin)
    - Posaconazole
    - Lopressor (metoprolol)
    - Warfarin
    - Valganciclovir
- Lipitor (atorvastatin)

Allergies:
- Levofloxacin (resulted in tendonitis)
- Ipratropium bromide (potentially causing shortness of breath)

FH:
Family history significant for short telomere syndrome and pulmonary fibrosis
- His father passed away from pulmonary fibrosis
- His older brother also was diagnosed with pulmonary fibrosis, and is one year out from a lung transplant.

Other
- Other two siblings are healthy
- His mother had schizophrenia and myocardial infarction in her late 40's
- Maternal grandfather had diabetes and cardiac issues

SH:
SC is in the computer chip equipment business, and travels to Asia and Europe frequently for work. He holds a PhD in physics and is currently helps with marketing at his company. He is an avid biker and enjoys snow skiing and hiking. He currently lives with his wife in Palo Alto. He does not drink any alcohol post-transplant, but prior, has enjoyed drinking socially. He reports drinking wine during dinner, at a rate of 1 bottle per week with his wife. He is a never smoker and has only tried recreational and illicit drugs in college.

ROS:
He has noticed some changes in his vision, but attributes it to the prednisone and other medications he is on post-transplant. He also mentioned easy bruising, but again attributes it to the blood thinners post-transplant. Review of systems was otherwise negative.

Exam:
Vitals: Temp: 36.7˚C, HR: 88, BP:123/90, RR: 18, SpO2: 98
General: Well-appearing, no acute distress, appears young for stated age
HEENT: did not obtain
Lungs: breathing unlabored and no use of accessory muscles, but uses tripod position and pursed lips with forced breathing during examination. Slight barrel chest. Equal expansion of lungs. Decreased breath sounds in the right superior lung.
Heart: Normal S1/S2. Regular rate and rhythm. No murmurs, rubs, or gallops. Nondisplaced PMI, normal JVP. Well healed Sternotomy scar
Abd: Non distended. . Palpation, percussion, and auscultation not performed.
Extremities: No peripheral edema.

Culture from bronchoscopy:
- Negative fungal culture
- Negative Legionella, Pneumocystis
- 1+ normal oropharyngeal flora

- Negative respiratory virus PCR panel (Influenza A, Influenza B, RSC, Parainfluenza 1, Parainfluenza 2, Parainfluenza 3, Parainfluenza 4, Metapneumovirus, Rhinovirus, Adenovirus)

Chest Xray:
1. Increased moderate to large right pneumothorax.
2. Increased bibasilar airspace opacities, likely postbronchoscopic in nature.

Assessment and Plan: In summary, DS is a 60-year-old male with a history of familial pulmonary fibrosis and short telomere syndrome status post lung transplant, presenting with shortness of breath, wheezing, and coughing, not relieved by BAL. Add vitals here… even if normal, say so. On exam, he had typical chronic obstructive lung disease presentation with barrel chest and tripod breathing. He had decreased breath sounds in his superior right lungs, but no labored breathing or use of accessory muscles nor ronchi or rales. Labs are notable for slight leukopenia, but are otherwise normal. Bacterial, viral and fungal culture from bronchoscopy are all negative. Chest X-ray shows increased pleural space in his right lung and increased bibasilar airspace opacities. Given these findings, the most likely diagnosis is pneumothorax.

Note 5:

Source of Information: Patient, who appears reliable.

CC:
ZK is a 32 year-old male with an unremarkable past medical history, presenting with 6 days of progressively-worsening abdominal pain with associated shortness of breath, vomiting, and occasional chills, but no coughing.

HPI:
6 days ago, at 10pm, ZK felt sudden 8/10 abdominal pain. He went to bed, but woke up 5-6 times that night to vomit, with associated cramps and stomach pain. These vomiting sessions did not have associated nausea. The next morning, ZK had minimal appetite and desire to drink water. He slept a lot that day and felt a little better. But throughout the next couple of days, he continued to have severe waxing and waning abdominal pain throughout the day. On day 3 of this pain, he felt chills, but did not take his temperature. He described the pain as “waves of pain” that traveled across his abdomen, with more pain in the upper right quadrant. He noticed a distended and firm abdomen and felt extremely bloated. He mentioned that when he sat upright, the pain felt better than when he was lying flat. Throughout the entire period, he was unable to have any bowel movements, with his last bowel movement 6 days ago. Throughout, he noticed shortness of breath, and mentioned a weight loss of 10 pounds. In addition, he noticed oliguria with darker (amber-colored) urine. ZK hypothesizes that these bouts could be attributed to food poisoning or the flu.

PMH:
ZK has an unremarkable past medical history. He had a shoulder repair surgery in the past.

Meds:
ZK is not taking any prescription or over-the-counter medications or supplements.

Allergies:
No reported medical allergies. Only seasonal allergies.

FH:
Unremarkable family history. Father has some back pain, mother had a “foot thing” and some jaw problems. He has a sister who has eczema. No family history of coronary disease, diabetes, HTN.

SH:
ZK is a product partner at a software engineer company. He is from Palo Alto, but currently lives in San Francisco. He is an avid cook and has a healthy diet. He enjoys hiking and goes about once per week. He occasionally drinks socially, but not frequently. He is a never-smoker and does not use any recreational or illicit substances.

ROS:
Other than described above in the HPI, his ROS is unremarkable.

Exam:
Vitals: BP 115/68, P 84, T 38C, RR 16, SpO2 97%, BMI 22.4
General: Mildly-ill appearing with facial pallor.
HEENT: Anicteric sclera with pale conjunctiva. Dry and tacky mucus membranes.
Lungs: No use of accessory muscles to breath. Clear to auscultation
Heart: did not obtain.
Abd: Tense, moderately distended abdomen. Diffusely tender to soft palpation, with more pain in the upper right quadrant. On percussion, abdomen is diffusely hyper-tympanic. No rebound tenderness. Possible hepatomegaly. No costovertebral angle tenderness
Extremities: did not obtain
Skin: did not obtain

Labs:
CMP

Ref Range & Units	10/3/21 1813	
Sodium, Ser/Plas	135 - 145 mmol/L	128Low
Potassium, Ser/Plas	3.5 - 5.5 mmol/L	3.5
Chloride, Ser/Plas	98 - 107 mmol/L	88Low
CO2, Ser/Plas	22 - 29 mmol/L	25
Anion Gap	5 - 15 mmol/L	15
Glucose, Ser/Plas	70 - 140 mg/dL	123
Creatinine, Ser/Plas	0.67 - 1.17 mg/dL	0.74
eGFR	>60 mL/min/1.73 m2	122
eGFR for African American	>60 mL/min/1.73 m2	141
BUN, Ser/Plas	6 - 20 mg/dL	14
Calcium, Ser/Plas	8.4 - 10.5 mg/dL	8.5
Protein, Total, Ser/Plas	6.0 - 8.3 g/dL	6.8
Albumin, Ser/Plas	3.5 - 5.2 g/dL	3.3Low
Total Bilirubin, Ser/Plas	<1.2 mg/dL	0.6
Alk P'TASE, Total, Ser/Plas	40 - 130 U/L	145High
AST (SGOT), Ser/Plas	10 - 50 U/L	57High
ALT (SGPT), Ser/Plas	10 - 50 U/L	51High

Globulin	2.0 - 5.0 g/dL	3.5

CBC with Differential

Ref Range & Units	10/3/21 1538	
White Blood Cell Count	4.0 - 11.0 K/uL	**20.7 High**
Red Blood Cell Count	4.40 - 6.00 M/uL	**4.36 Low**
Hemoglobin	13.5 - 18.0 g/dL	**12.8 Low**
Hematocrit	40.0 - 52.0 %	**38.1 Low**
MCV	80 - 100 fL	87
MCH	27.0 - 33.0 pg	29.4
MCHC	31.0 - 36.0 g/dL	33.6
RDW	<16.4 %	13.1
Platelet Count	150 - 400 K/uL	218

C-Reactive Protein	<0.5 mg/dL	**23.0High**

Hepatitis acute panel: Negative

Abdomen Pelvis CT:
1. Sequela of perforated appendicitis with multiple fluid collections throughout the abdomen as described above. Decreased size of two of the aspirated collections with percutaneous drains in situ with residual components remaining, as detailed above.

2. Similar size of large undrained perirectal fluid collection measuring up to 8.9 cm. The density of this collection appears increased compared to the prior CT which suggests hemorrhage within this collection. Occult contiguity with the adjacent rectum with mixing with the administered rectal contrast is considered unlikely. If there is continued clinical concern for perforation, fluoroscopy exam with rectal contrast may provide further clarification.

3. Diffusely dilated primarily large and distal small bowel in the setting of known acute perforated appendicitis, likely representing ileus.

Assessment and Plan: In summary, ZK is a 32 year-old male with an unremarkable past medical history, presenting with 6 days of progressively-worsening abdominal pain with associated shortness of breath, vomiting, and occasional chills, and no coughing. On exam, he is mildly-ill appearing with tense and moderately distended abdomen that was diffusely hyper-tympanic upon percussion. There is possible hepatomegaly. There was no rebound tenderness, nor costovertebral angle tenderness. Lab results show elevated liver function tests, leukocytosis, and anemia. Imaging reveals a perforated appendicitis with multiple fluid collections throughout the abdomen, with potential hemorrhage.

Problem List
1. Perforated appendicitis
    a. Anemia
    b. Decreased appetite

Note 6:

Source of Information: Although the patient had difficult remembering the events surroundings her suicide attempt, she is otherwise a reliable source.

CC:
BY is a 29-year-old female with a history of bipolar I disorder, multiple psychiatric and rehab stays, and polysubstance abuse, presenting with anoxic brain injury post suicide attempt.

HPI:
BY was transferred to Stanford on 10/03/2021 after respiratory arrest and anoxic brain injury and was placed on mechanical ventilation status post suicide attempt. In June of this year, BY decided to be admitted to a rehabilitation center to address her alcohol abuse. There, she discontinued her anti-psychotic medications, because they made her feel "bored". She proudly recalled that she was sober for 70 days after her rehab stay, but still maintained auditory hallucinations. 10 days before admission, BY felt productive and extreme euphoria, describing this experience as similar to previous manic symptoms. BY then relapsed on alcohol and stayed up for 3 nights straight. During this period, her mood changed from euphoria to down. Her auditory hallucinations were also critical of her, leading to increased paranoia and suicidal ideations. The night of her suicide attempt, she "was drinking", and at 4am, ingested "handfuls" of Clonipin, Adderall (taken from her boyfriend's prescription), and 8 pills of "acid". She then attempted to strangle herself with a metal chain. Morning of the hanging, her dad found her, and brought her to the emergency room. During the history, BY reflected that she tried to commit suicide because she felt that she would be able to have more control and feel better again.

PMH:
BY was diagnosed with Bipolar I Disorder in 2019. She has variations in her mood, where she would have days of high energy, euphoria, and difficulty sleeping. This would then shift rapidly, without trigger, to periods of low mood, where she would sleep for days. She explained that she had always heard voices ever since she was a kid. The voices started out "friendly", but during puberty, they transitioned into critical and negative "sports commentary". She suggested that her auditory hallucinations are unassociated with her mood episodes.

She also had constant trouble with substance abuse and has been in and out of psychiatric facilities and rehab centers since 18 years old.

Meds:
Patient has been on multiple psychiatric medications, but is unable to tolerate the side effects well.
- Depakene
- Caplyta
- Olanzapin
- Benadryl
- Latuda
- Clonipin

Allergies:
- Dystonic reaction to psychiatric medications

FH:
- Father: depression

- Older sister: anxiety
- Younger sister: ADHD
- Uncle (mom's side): alcoholic, with potential undiagnosed mental health disease.

SH:
RY struggles with substance abuse and alcoholism. She has used marijuana, ecstasy, cocaine, molly, among others. She mentioned that the substances help "quiet the voices". RY has a master's in clinical psychology and was practicing as a grief counselor and is hopeful about returning to this work. She currently lives with her mom and dad. Her support system includes her parents and her boyfriend, who does not have issues with alcoholism.

ROS:
ROS was not obtained.

Exam:
Vitals: not obtained
General: Well-appearing, with guarded body language; looks her stated age
Psych: Was initially guarded, but opened up with engagement. Insightful, forward thinking. Denies voices, hallucinations. Well-groomed and well-depth appearance. Some mild cognitive delay in response time. Quiet speech and slightly raspy tone.
Motor: Symmetric muscle bulk throughout, 5/5 strength throughout, including … (did not do the wrist one). Normal Romberg exam. Reflexes were not obtained. Finger-nose-finger test was normal with light tremor. Heel-shin test revealed slight slippage of heel to shin. Normal gait and stride-length.
Cranial Nerve: Visual field was full to confrontation. Extraocular movements intact. Sensation intact to light touch to face and upper extremities. Lower extremities were not tested. Face was symmetric with regular expressions. Palate and tongue were midline.

HEENT: did not obtain
Lungs: did not obtain
Heart: did not obtain
Abd: did not obtain
Extremities: did not obtain
Skin: did not obtain

Labs:
Basic Metabolic Panel

	Ref Range & Units	10/3/21 1151
Sodium, Ser/Plas	135 - 145 mmol/L	139
Potassium, Ser/Plas	3.5 - 5.5 mmol/L	3.7
Chloride, Ser/Plas	98 - 107 mmol/L	104
CO2, Ser/Plas	22 - 29 mmol/L	22
Anion Gap	5 - 15 mmol/L	13
Glucose, Ser/Plas	70 - 140 mg/dL	92
Creatinine, Ser/Plas	0.51 - 0.95 mg/dL	0.63
eGFR	>60 mL/min/1.73 m2	122
eGFR for African American	>60 mL/min/1.73 m2	140
BUN, Ser/Plas	6 - 20 mg/dL	12

Calcium, Ser/Plas	8.4 - 10.5 mg/dL	9.0

LFT

	Ref Range & Units	10/3/21 1151
Albumin, Ser/Plas	3.5 - 5.2 g/dL	4.1
Total Bilirubin, Ser/Plas	<1.2 mg/dL	0.5
Conjugated Bili	<0.40 mg/dL	<0.20
Alk P'TASE, Total, Ser/Plas	35 - 105 U/L	44
ALT (SGPT), Ser/Plas	10 - 35 U/L	**9Low**
AST (SGOT), Ser/Plas	10 - 35 U/L	18
Unconjugated Bilirubin		
Protein, Total, Ser/Plas	6.0 - 8.3 g/dL	6.1

CBC with Differential

	Ref Range & Units	10/3/21 1151
WBC	4.0 - 11.0 K/uL	**11.6High**
RBC	3.80 - 5.20 MIL/uL	4.17
Hemoglobin	11.7 - 15.7 g/dL	13.2
Hematocrit	35.0 - 47.0 %	40.1
MCV	82.0 - 98.0 fL	96.2
MCH	27.0 - 34.0 pg	31.7
MCHC	32.0 - 36.0 g/dL	32.9
RDW	11.5 - 14.5 %	13.2
Platelet count	150 - 400 K/uL	216
Neutrophil %	%	81.5
Lymphocyte %	%	9.4
Monocyte %	%	8.5
Eosinophil %	%	0.2
Basophil %	%	0.1
Imm. Granulocyte, %	0.0 - 0.7 %	0.3
Neutrophil, Absolute	1.70 - 6.70 K/uL	**9.46High**
Lymphocyte, Absolute	1.00 - 3.00 K/uL	1.09
Monocyte, Absolute	0.30 - 0.95 K/uL	**0.99High**
Eosinophil, Absolute	0.05 - 0.55 K/uL	**0.02Low**
Basophil, Absolute	0.00 - 0.25 K/uL	0.01
Imm. Granulocyte, Abs	0.00 - 0.06 K/uL	0.04
nRBC, Abs	K/uL	0.00
nRBC, %	%	0.0

CT Head: No acute bleed or large ischemic infarct

Assessment and Plan:
In summary, BY is a 29-year-old female with a history of bipolar I disorder, multiple psychiatric and rehab stays, and polysubstance abuse, presenting with anoxic brain injury post suicide attempt. Before her suicide attempt, BY self-discontinued her antipsychotic medications. She felt extreme euphoria prior to the event, ultimately leading to a downward spiral of drinking. The night of her attempt, she was

drinking, ingested “handfuls” of Clonipin, Adderall, and 8 pills of “acid”. She then attempted to strangle herself with a metal chain. On exam, she was well-appearing with insightfulness and forward-thinking. She denies voices and hallucinations. She has slight cognitive delay in response time, quiet speech, and slight circumferential though process. Her motor exam reveals symmetric bulk and 5/5 strength, with normal Romberg test. Finger-nose-finger test revealed a light tremor, and heel-shin test revealed slight slippage of heel. Her cranial nerve exam was normal- visual field was full to confrontation, extraocular muscles intact, sensitive to light touch, symmetrical facial expressions and midline palate and tongue. Labs are notable for mild leukocytosis with elevated neutrophils. Head CT revealed no evidence of acute bleed or ischemic infarct. These are all suggestive of rapid-cycling bipolar I disorder, exacerbated by substance abuse, leading to her suicide attempt.

Problem List

2. Suicide strangulation attempt
    a. Continuous EEG to monitor
    b. Brain imaging to monitor
3. Bipolar disorder
    a. Continue to manage her psych medications and ensure compliance
4. Substance abuse
    a. Discuss access to substances in her environment
    b. Liver function tests

Note 7:

Patient is a 26yo. obese female, with a history of right hip replacement, left femur fracture post motor-vehicle accident, and left knee meniscus torsion, polysubstance abuse and mental health issues, presenting with left hip pain post ground level fall.

HPI:

JA had a cortisone shot in her left knee 3 months ago, which helped her knee pain, but led to inability to place any weight in her left hip. After going to the ED, she was told she had a "bone spur", and she transitioned into using a walker and wheelchair. 2 weeks before this fall, she was reaching for someone on top of her dresser, and felt a sharp pain in her left hip, which eventually receded. During the weeks leading up to her fall, she mentioned she had night sweats and chills, but was never feverish. She denied any upper respiratory symptoms.

The morning of her fall, JA was getting dressed when she tripped and stumbled over an open drawer. She heard something in her left hip "snap" and was able to call for help. She noted that the pain in her left hip did not begin until 5 minutes post-fall. She was able to call for help, and when the paramedics arrived, they moved her with difficulty. She described the pain as 10/10 sharp pain that radiated down her left to her ankles. Before this fall, she denied any shortness of breath, chest pain, or dizziness. After her fall, she mentioned that she felt dizzy and SOB, though she attributed that to the pain.

PMH:

JA was in a motor vehicle accident at 16 years old, leading to a left femur fracture and right hip dysplasia. She received a right hip transplant at 26 years old and has felt no issues with her right hip ever since.

She has been diagnosed with PTSD, bipolar disorder, and depression at 19 years old from sexual abuse during her childhood. During her depressive episodes, she feels a squeezing sensation in her chest and vomiting.

Meds:
She is currently taking Suboxone, gabapentin and mertazapen for her mental health issues. She is also taking benophazine, and prednisolone for her abdomen pain.

Allergies:
She is allergic to aspartame

Family Hx:
JA has a family history of substance abuse.
- mom: alcoholic
- maternal grandmother: cocaine addict
- maternal grandpa: heroin addict; alcoholic
- maternal aunt: meth addict; alcoholic
- maternal uncle: heroin addict; alcoholic

She also has a family history of diabetes (maternal grandma/grandpa).

Social Hx:
JA has been homeless in the tenderloin region of SF before enrolling in rehab centers. She worked in yardwork and housekeeping. Her support system includes her grandparents and her best friend, who is also working to battle her addiction problems. JA has a doctor in Monterey that she trusts who is working with her mental health.

She also has a history of polysubstance abuse, coming in and out of rehab centers since 18 years old. She has used alcohol, heroin, meth, and cocaine. She mentioned that her opioid addiction arose from pain management post motor vehicle accident. Because her provider denied her further opiates to prevent addiction, she bought oxycodone off the streets, which ultimately led to heroin, meth, and cocaine use. She has been in 5 rehab centers since 18 years old, but has only been able to stay sober for one year.

ROS:
Negative unless stated in the HPI

Physical Exam:

Pulm: No labored breathing or use of accessory muscles. Lungs were clear to auscultation, with no rhonchi or wheezing. She has normal symmetry upon expansion.
Motor: Symmetric muscle bulk throughout, 5/5 strength throughout her upper extremities. Her right lower extremities had 5/5 strength. Her abduction and adduction of the left hips were a 4/5 strength. Her extension of her left knee was a 4/5 strength. Flexion of left knee was 5/5 strength. Romberg exam was not tested. Patient is unable to place any weight on her left leg.
Neuro: She had decreased sensations to light touch in her left lower extremities. She mentioned that the left side felt "duller" compared to the right.
Reflexes: Bilateral patellar reflexes are 5/5 strength. Achilles reflexes were tested but difficult to obtain. Upper extremity reflexes were not tested.
MSK: Range of motion for upper extremities were all normal. Unable to obtain range of motion for lower extremities due to imbalance and pain. Flexion and extension of toes were normal.

Assessment:
In summary, patient is a 26yo. obese female, with a history of chronic hip pain and replacement with comorbid mental health diagnoses, presenting after a fall at rehab center. Patient states she tripped and fell over an open drawer on the ground as she was dressing. She denies syncope, but noted an inability to weight-bear. On exam, she had decreased range of motion in her left hip, decreased light touch sensation, and decreased strength in her left knee.

Problem List:

- Fall
    - Unstable MSK issues
    - Differential: syncope (though unlikely without associated symptoms)
- Hip pain
    - MRI
    - surgery
- Substance abuse
    - Continue Suboxone
    - Discuss discharge/rehab
- PTSD/depression/anxiety
    - Continue psych medications
- Homelessness
    - Provide support for housing

Note 8:

CC:
Patient is a 64yo M, with PMH of HTN, T2DM and recently diagnosed prostate cancer presenting with pain and foul-smelling leakage of an attempted surgical site s/p robotic assisted prosteoctomy attempt.

HPI:

During the surgery on 10/19, the surgeons noted dense adhesions and was unable to compete the surgery. Patient was discharged on 10/20 and was doing fine at home. During this period, patient was in pain, and felt fatigued, but attributed these to the surgery. On Sat 10/24, he started eating solid foods, but as he was eating, he felt a "gushing" sensation from the surgical incision site, and noticed a "geyser-like", foul-smelling discharge from the site. He was prescribed opioids, and completed the course, but still felt immense pain. His wife ended up giving him some of her old opioid meds. His wife also noted that during this period, he had little appetite, and felt fevers and chills. He did not have any bowel movements since his discharge from the hospital, and noticed a burning sensation upon urination (but attributed to catheter usage during surgery). During this period, he also noticed an unproductive cough and shortness of breath. Patient was worried about contamination of the wound and was worried that he may have to go into surgery again.

PMH:
Patient was recently diagnosed with stage 2 prostatic cancer (per wife), and chose the elective prostectomy. He also had an open ileocectomy with a mesh placed and hernia repair in the past. He also has T2DM, HTN, and is being medically managed for those. He mentioned that he had recurrent UTI- once every 3 weeks.

Meds:
Opioids post-surgery, acid reflux medication, Tamsulosin, Lisinopril, Metformin, and a gliptin med.

Allergies:
Penicillin and amoxicillin- leads to rashes

FH:
Father was smoker who passed of lung disease
Mother is alive and well with HTN and diabetes
3 sisters and brother all have diabetes
3 kids are all healthy

SH:
Patient is a retired correction officer who lives with his wife. His wife cooks, and generally eats meat, potatoes, stew, and pasta. He enjoys playing the guitar and working out frequently, and hopes to get back to these activities after this hospital visit. He is a never smoker and does not use recreational drugs. He has the occasional beer on Monday’s and weekends. He is currently sexually active with his wife, and has not noted any concerns with his sexual health.

ROS:
No rashes or lumps.
No headaches, dizziness, vision changes, hearing changes, sinus discomfort or sore throat
No palpitations, chest pain or edema
No vomiting, nausea, diarrhea, or vomiting

No polyuria, oliguria, nocturia or dysuria
No MSK pain
No change in moods or tingling sensations
No easy brusining
No heat/cold intolerance, no excessive thirst/hunger

Exam:
Vitals: -
General: Well-appearing and appears of stated age.
HEENT: -
Lungs: chest tube scar on R side. Patient had difficulty taking deep breaths. Diminished breath sounds at the bilateral bases. Lungs were clear to auscultation, no rales or crackles. He had difficulty sitting up, so remaining pulmonary exam was omitted.
Heart: -
Abd: surgical site with gauze was well-maintained. 2 drainage sites on the L with brown-green drainage. Hypoactive bowel sounds. No hepatosplenomegaly. His abdomen was non-tender but hard to palpate.
Extremities: normal brachial, popliteal, posterior tibial pulse and dorsalis pedis pulse.
Skin: -

Assessment and Plan: In summary, patient is a 64yo M, with PMH of HTN, T2DM and recently diagnosed prostate cancer presenting with pain and foul-smelling leakage of an attempted surgical site s/p robotic assisted prosteoctomy attempt. Since his discharge, he felt fevers and chills, and did not have any bowel movements. On exam, he has diminished breath sounds in the bilateral lung bases. He had 2 active drainage sites with brown-green fluid on his left side. He also had a non-tender, hard to palpate abdomen. Labs revealed anemia (decreased Hgb and Hmt). These are all suggestive of a potential infection of the surgical site.

Problem List

1. Infection of surgical site
    a. Would include culture of the site and antibiotics
    b. Differential could include: enterocutaneous fistula
        i. Would require CT imaging and exploratory surgical intervention
2. Prostate carcinoma
    a. Continue follow-up with oncology, explore repeat prosteoctomy if this aligns with patient's goals of care
3. UTI
4. HTN
5. Diabetes
6. Diet: potatoes and meats

Patient 1 - family medicine clinic, variety of concerns

SUBJECTIVE
HPI: Jane Smith is a 55 year old female who presents to the clinic for weight management. Patient was previously on wellbutrin but self dc'd due to dizziness; remote concern for bulimia but per pt never formally dx'd. Prescribed jardiance by PCP Dr. Lin two months ago with no change in weight.

Pt had ground level fall last week; ROM still limited due to ankle pain.
Pt finds it difficult to cook healthy foods but has tried to eliminate carbs. Some difficulty finding housing and ran out of diabetes meds last year when had to sleep on friend's couch, but no problems since then.
Pt concerned about continued ankle pain and "bloated" feeling present even when she drinks water.

ROS:
Constitutional: Negative for unexpected weight change.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain and leg swelling.
Gastrointestinal: Positive for bloating. Negative for abdominal pain, diarrhea, nausea and vomiting.
All other pertinent ROS in HPI.

PMHx:
Active Problem List:
DIABETES TYPE 2
FIBROMYALGIA
HYPERLIPIDEMIA
DEPRESSIVE DISORDER, OTHER SPECIFIED
HYPERTENSION, ESSENTIAL

Social Hx:
Smoking status: Never
    Passive exposure: Past
Smokeless tobacco: Never
Vaping use: Never used
Alcohol use: No
    Alcohol/week: 0.0 oz
Drug use: Recreational cannabis 1-2x/month

PSHx:
HX APPENDECTOMY - 2011, Dr. Michael Burns
HX CHOLECYSTECTOMY - outside institution, early 2000s

HX CESAREAN SECTION x 2

Medications:
Medications Marked as Taking for the 10/23/23 encounter (Office Visit) with Gomez, Celeste (M.D.)
METFORMIN (GLUCOPHAGE XR) 500mg Oral 24hr SR Tab Take 1 tablet by mouth daily with a meal
EMPAGLIFLOZIN (JARDIANCE)
ASPIRIN (ECOTRIN LOW STRENGTH) 81 mg Oral TBEC Take 1 tablet by mouth daily
ESCITALOPRAM (LEXAPRO) 20 mg Take 1 tablet by mouth daily
LOSARTAN

OBJECTIVE
BP 130/71 | Pulse 79 | Temp 98.1 °F (36.7 °C) (Temporal) | Ht 5' 3" (1.6 m) | Wt 171 lb 1.2 oz (77.6 kg) | SpO2 97% | BMI 30.30 kg/m²
Current weight 171 lb 1.2 oz
Last previously recorded weight 165 lb 0.1 oz on 8/16/23
Weight change is +6 lb 1.1 oz

Physical Exam
Constitutional:
  General: She is not in acute distress.
Cardiovascular:
  Rate and Rhythm: Normal rate and regular rhythm.
  Pulses: Normal pulses.
  Heart sounds: Normal heart sounds. No murmur heard.
Pulmonary:
  Effort: Pulmonary effort is normal. No respiratory distress.
  Breath sounds: Normal breath sounds.
Skin:
  General: Skin is warm and dry.
Neurological:
  Mental Status: She is alert.

ASSESSMENT/PLAN
Jane Smith is a 55 year old female who presents with:

OBESITY, BMI 30-30.9, ADULT (primary encounter diagnosis)
WEIGHT MGMT COUNSELING
Note: Continue with lifestyle changes.
Goal: Work on eating a diet high in fiber, low in fat
No significant weight loss on Jardiance or Metformin.
Start Semaglutide and titrate as prescribed.
Follow up weight check in 3 months.

Plan: NURSING COMMUNICATION ORDER
REFERRAL DIETARY COUNSELING
REFERRAL SOCIAL SERVICES

PAIN IN ANKLE AND JOINTS OF FOOT
Note: mild on physical exam
Plan: pt given home exercises
REFERRAL PHYSICAL THERAPY

FUNCTIONAL DYSPEPSIA
Note: no red flag symptoms
Plan: pt given information on FODMAPS diet
OTC gasx as needed

DIABETES TYPE 2
Note: stable, continue with meds

HYPERLIPIDEMIA
Note: Continue with lifestyle changes
Plan: fasting labs today

DEPRESSIVE DISORDER, OTHER SPECIFIED
Note: stable, seeing therapist, continue with meds

Return to clinic prn

Note: Patient verbalizes understanding and agreement with plan(s) as outlined above. All questions were answered. Patient was advised to seek further medical attention through a follow up visit / urgent care / or the emergency department depending on severity of the situation if symptoms worsen or fail to improve

Electronically signed by:
Celeste Gomez, MD
Family Medicine
10/23/23 11:05 AM

—--

Patient 1 - message

hi Dr. Gomez, I was wondering if we could follow up on my blood sugar numbers since my regular doctor is out….I don’t really like the new med that she put me on and it gives me lots of gas.

—

Patient 2 - dermatology clinic, focused exam

Chief complaint:
Shyan Owens is a 67 yr old male who presents with:
CONSULTATION: Reason: nevus on face and back has been growing/changing, please evaluate

HPI:
New pt here for:

1. Growth on mid chest that has been growing and changing color, now top fell off. A bit of bleeding. Otherwise asymptomatic.

Past Derm Hx

- No skin cancer

Past Fam Hx

- No skin cancer

Past Medical Hx
Patient Active Problem List:
HYPERLIPIDEMIA
ESSENTIAL HTN
ATHEROSCLEROSIS NATIVE CORONARY ARTERY
HX OF CABG
ATRIAL FIBRILLATION
ANTICOAGULANTS, LONG TERM, CURRENT USE
CHRONIC KIDNEY DISEASE, STAGE 3
MI, OLD
ATHEROSCLEROSIS OF AORTA
OSTEOARTHRITIS OF LEFT KNEE
PRESENCE OF CARDIAC PACEMAKER
SENILE PURPURA
ABDOMINAL AORTIC ANEURYSM

ROS

- No shortness of breath, no chest pain

Pertinent Physical Exam findings:
face, neck, b/l hands, b/l arms, chest, back, b/l legs, b/l feet (Total body skin exam)
Face/back: too numerous to count tan 'stuck on' papules

- right upper arm: dark 3mm macule

Assessment/Plan
SEBORRHEIC KERATOSIS
Note: back, chest, face
- benign/reassurance
- mid chest: - Liquid nitrogen was applied for two 10-30 second freeze-to-thaw cycles. Scar and blister risk reviewed and verbal consent obtained. Wound care with plain petrolatum was reviewed. Instructed to return if lesion does not resolve.

XEROSIS CUTIS
Note: recommended liberal cream or mineral oil every day forever. Avoid hot showers. Use dove soap

MELANOCYTIC NEVUS
- arms
- benign/reassurance
For right upper arm: educated on ABCDEs of melanoma. Pt knows to return if any worrisome or evolving lesions.

RTC prn

Trenton Black MD
Department of Dermatology

—

Patient 2 - message

Hi this is Jake, following up on the plan for my dad. The spot you froze for him continues to be raw and a little painful but hasn't completely fallen off; how long can we expect this to continue?

—------

Patient 3 - ICU inpatient HPI

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HISTORY AND PHYSICAL - STANDARD HOSPITAL ADMIT
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ADMIT TO ICU: *ICU Team 3*

Attending: Dr. Patel
Fellow: Dr. Villalobos
Resident: Dr. Lin

For Patricia M Jordan (42 year old female) MRN: 00008270375

ROUTE OF ADMISSION:
From: Emergency Department

CHIEF COMPLAINT:

- Aphasia - last known well time 0445 am
- Weakness of right arm

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HISTORY OF PRESENT ILLNESS:
Patricia M Jordan is a 42 year old female with history of afib on eliquis, CHF, HLD, HTN, and T2DM, who presents with right sided weakness and aphasia, now admitted for stroke and shock.

Patient intubated and sedated. History obtained from girlfriend and ex-wife. Patient had last known well at 0445 am per girlfriend. Girlfriend went to work and returned home at 3pm. At that time, patient was not answering questions and looked “spaced out,” but had intermittent return to near baseline where was AAO approximately x 2 per girlfriend and teenage daughter but with slurred speech. No recent trauma or sick contacts. No tremor or seizure-like movements. No prior history of stroke or MI.

ED Course:
Patient initially presented to ED in afib with RVR with HR to 160s along with right sided weakness and aphasia. Patient was initially awake and able to communicate by giving a thumbs up. Code stroke called at 1550. Patient initially hypertensive then hypotensive to 62/40. ED about to give diltiazem, but patient became less alert and treated for unstable rapid afib with cardioversion. Converted to sinus rhythm thereafter.

Went to CT at 1602. Patient returned to ED room and ED physician called to bedside for acute agitation. IV ativan 2 mg given and HFNC started. Because of AMS and increased work of breathing, patient intubated. CXR revealing diffuse pulmonary edema. 1x IV lasix 40 mg given and foley placed.

REVIEW OF SYSTEMS:
Unable to assess.

PAST MEDICAL/SURGICAL HISTORY / PROBLEM LIST:
Past medical history: HTN, Afib, HLD, T2DM, CHF
No known surgical history.

No previous hospitalizations.

SOCIAL Hx/HABITS:
Per family, occasional marijuana use and alcohol use. Used to be heavy drinker but stopped ~10 years ago. No known tobacco or other substance use.

FAMILY HISTORY: Unknown.

DRUG AND FOOD ALLERGIES:
No Known Allergies

CURRENT MEDICATIONS:
Outpatient Medications Marked as Taking for the 9/15/23 encounter (Hospital Encounter)

- Apixiban (ELIQUIS) 5 mg Oral Tab Take 1 tablet by mouth 2 times a day
- ASA 81 mg PO daily
- Atorvastatin 20 mg PO QHS
- Metoprolol 50 mg PO daily
- Diltiazem 180 DAILY PO
- Spironolactone 25 PO DAILY
- Furosemide 40 mg BID PO
- Omeprazole 20 mg PO DAILY

Adherence unclear; daughter remarks that pt did not like to take pills.

PHYSICAL EXAMINATION:
VITAL SIGNS:
BP 108/69 T 98.3 Pulse 81 Respiration 24 SpO2 100%

Gen: intubated and sedated.
HEENT: normocephalic and atraumatic.
Neck: difficult to assess JVD due to body habitus
Heart: regular rate and rhythm, S1 + S2 normal, no murmur/rubs/gallops
Lung: rales bilaterally.
Abdomen: soft, non-tender, obese, no masses palpated or visualized
Rectal: not indicated
Extremities/MSK: cooler to touch in distal lower extremities, 2-3+ edema in the bilateral lower extremities.
Neuro: unable to assess.

LABORATORY STUDIES:
WBC 9.0 / HGB 14.2 / HCT 45.1 / PLT 300
Lytes 135/4/105/21
BUN/Cr 22/1.36
Glucose random 260
Trop 40 -> 46 -> 131

INR 1.1
BNP 401
Lactate 3.3 (H)
UA unremarkable
Cx pending

RADIOLOGICAL STUDIES:
CXR 6/17: bilateral diffuse pleural effusions, cardiomegaly

CT Cerebral Perfusion 6/17:
Motion artifacts confound results.

TMax > 6 seconds = 200 mL
CBF < 30% = 1 mL
Mismatch volume = 199 mL
Mismatch ratio = infinite

Scattered patchy areas of Tmax prolongation in the bilateral cerebral hemispheres including areas within the left MCA territory corresponding to sites of loss of gray-white differentiation on earlier CT head examination. No areas of cerebral blood flow below 30% able to be detected in either the right or left hemisphere though comparison noncontrast CT head shows changes of left-sided infarcts. Given motion artifacts, MRI may be needed for better assessment.

CTA Brain and Neck 6/17:
Suboptimal CT angiogram given body habitus and bolus but no discrete high-grade arterial stenoses or focal occlusions appreciated.

Cardiomegaly.

Prominent to enlarged mediastinal lymph nodes.

Severe dental disease.

CT Head 6/17
Infarct predominantly affecting the left frontal lobe. There is also evidence of infarct in the left parietal lobe as well as the left insular cortex.

Probable left MCA sign.

ELECTROCARDIOGRAM:
EKG (6/17): New T wave inversions in V2-V6.

—----------

ASSESSMENT AND PLAN
This is a 42 year old female with the following:

#Shock
Unclear etiology. Suspect cardiogenic shock in the setting of pulmonary edema, cooler distal extremities, and acute, persistent hypotension following beta blocker. Patient received IV labetalol at 1627 for DBP above 120 mmHg, however, this was followed by persistent hypotension and patient needed to start norepinephrine at 1700 to maintain BP. May also consider cardioversion related cardiomyopathy (previously reported rare Takotsubo cardiomyopathy).

Considered septic shock, however, no source of infection identified. No recent sick contacts and no prior known infectious symptoms prior to presentation. Given critical illness, however, will treat empirically for now and follow cultures. May discontinue if infectious work-up negative. Considered obstructive shock, but no pericardial effusion on TTE. May consider PE though less likely since she is on eliquis (though compliance unclear).

- admit to ICU
- IV lasix 80 mg TID
- levophed, MAP goal 60
- dobutamine added at 2 mcg/kg/min
- f/u final read of TTE
- empiric antibiotics: vancomycin and zosyn
- f/u procal and cultures (blood x 2, urine, respiratory)
- discontinue antibiotics if infectious work-up negative.
- may consider CT to evaluate for PE
- appreciate cardiology and ICU recommendations

#Acute hypoxemic hypercapnic respiratory failure
#Pulmonary edema
Suspect flash pulmonary edema in the setting of HFrEF and afib RVR. Suspect acute CHF exacerbation decompensated by beta blocker. CXR with bilateral pleural effusions and bilateral lower extremities with edema.
- IV diuresis as above
- intubated until patient hemodynamically stable with improvement in respiratory status

#HFrEF (EF ~25-30% on 6/17/23)
Bedside US revealing reduced EF. Formal TTE done in ED showing EF of ~25-30%. Unknown prior EF as patient is a non-member. Etiology of cardiomyopathy unclear. Ischemia possible, but family states no prior cath. Will likely need ischemia work-up when more stable. Other potential causes include tachycardia induced cardiomyopathy.
- lasix as above
- hold beta blockers
- place NG tube

- continue aspirin
- continue statin
- hold fluids
- strict I/O
- daily weights

#Stroke
Left MCA ischemic stroke suspected secondary to cardioembolism in the setting of known afib. Unclear if patient taking eliquis regularly at home. Not a candidate for IV thrombolytic or endovascular intervention.
- appreciate neuro recommendations:
    - f/u MRI
    - holding AC given size of stroke
    - continue aspirin
    - continue statin
    - f/u final read of echo

#Afib
Now in sinus rhythm.
- telemetry
- holding AC given size of stroke
- consider amiodarone if needed

#NSTEMI, Type 2
#HLD
TROP I, HIGH SENS 131 (AA) 06/17/2023
T wave inversions on EKG. No prior chest pain per girlfriend.
- trend to peak q6H
- f/u final read of echo
- aspirin as above
- statin as above
- holding BB
- lipid panel added to tomorrow AM labs

#AKI vs. CKD
Unclear baseline. May be AKI vs. CKD. May consider T2DM and/or HTN causing CKD. May consider shock causing AKI, though labs were drawn prior to patient becoming hypotensive.
- repeat urine studies ordered
- f/u renal US
- foley
- strict I/O
- monitor creatinine and electrolytes

#T2DM

Per ex-wife and girlfriend, not on medications at home.
- RISS
- A1c added to tomorrow AM labs

FEN/PROPHYLAXIS INTERVENTIONS:
Fluids: NA
Nutrition: NPO
DVT ppx: SCD
GI ppx: protonix

CODE STATUS:Full Code

PATIENT/FAMILY EDUCATION:
I have educated the patient and/or available/appropriate family/surrogate regarding their diagnoses, disease process, prognoses, and plan of care.

ADMIT TO: ICU

Staffed with Dr. Villalobos.

Electronically signed by:
Cassiopeia Lin, MD
Internal Medicine, PGY-1
6/17/2023 8:17 PM
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