

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

12843



5 - SUMMARIES

**000001**

LOS 7710  
4/14/98  
WRB (390)  
Medical records from  
Hospital.

Date of Admission: 4-6-98  
Date of Discharge: 4-8-98 (patient transferred)

DISCHARGE DIAGNOSIS:

1. FULL ARREST WITH COLLAPSE DURING [REDACTED] WITH SEIZURE ACTIVITY.
2. HYPOKALEMIA (2.7 ON ADMISSION).
3. HISTORY OF DIET/ENERGY PILL TAKING WITH HERB EPHEDRINE AND CAFFEINE.
4. [REDACTED]
5. SEVERE ACUTE RESPIRATORY DISTRESS SYNDROME ON ADMISSION.
6. RIGHT PNEUMOTHORAX.
7. ELEVATED CPK AT 37K, (CREATININE 1.1).
8. CEREBRAL HYPOXIA, SEVERE, WITH CHEYNE-STOKE'S BREATHING. NEGATIVE CT.
9. RIGHT LOWER EXTREMITY POSSIBLE ARTERIAL OCCLUSION SECONDARY TO FAILED RIGHT ARTERIAL LINE PLACEMENT.
10. LEFT PNEUMOTHORAX 4-7-98, RESOLVING WITHOUT CHEST TUBE PLACEMENT.

HISTORY OF PRESENT ILLNESS: A currently 15 year old female, apparently during a [REDACTED] just after [REDACTED] was witnessed to see falling to her knees, face forward on the ground and then shaking of all four extremities by her fellow [REDACTED]. The [REDACTED] apparently was there immediately, noticed her to be pulseless and began CPR. Paramedics were called and were there in approximately ten minutes, found her to be asystolic after four defibrillations, one epinephrine, had a cardiac rhythm back. Patient was transferred to [REDACTED] Emergency Room.

In the Emergency Room she was found to have initial chest film clear with ET tube in place. Subsequent film taken approximately one hour to 30 minutes later revealed either pulmonary edema or ARDS onset, symmetrical and bilaterally. The patient was also noticed to have posturing of upper and lower extremities with first onset of seizures. The patient was initially thought to have had blunt chest trauma by initial reports but subsequent reports from the witnesses stated that she basically just collapsed to the ground and began seizures.

Entry potassium was also found to be 2.7.

[REDACTED]  
continued.....  
[REDACTED]

DISCHARGE SUMMARY

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Medical records from [REDACTED]  
Hospital.

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Pertinent history is that the patient apparently had been trying to lose weight, not eating well, possibly anorexic, no direct history of vomiting. She and the team, apparently, had been taking an energy pill called Ripped Fuel made by Twin Lab, a metabolic enhancer which contains the herb Mal Huang extract which is apparently Ephedrine Alkaloid as well as caffeine. She had taken approximately 2-4 of these for "energy". This is felt to be the cause of her arrest. Otherwise, parents state they are unaware of any drug problems. [REDACTED]

[REDACTED] No prior history of familial prolonged QT or other type of cardiac congenital problems noted.

PHYSICAL EXAMINATION: An intubated 15 year old female with initial posturing. Temp 98, P 130, BP stable at approximately 100/60. HEENT, pupils reactive, equally, 4-2 mm. Ears and throat clear. Neck supple. No JVD or adenopathy noted. Heart, sinus tach at this time without murmurs or rubs. Lungs, bilateral rhonchi, no retractions. Cheyne-Stoke's type breathing pattern noted. Abdomen soft, no masses. Non-tender. Genitalia, normal female. Extremities, no joint deformities. Neurologic, some flexure posturing, seizure activity was previously noted. Patient is completely unresponsive. No response to deep pain. Does have spontaneous but abnormal breathing pattern. Initial entry PH was 6.84, potassium 2.7, creatinine 1. CBC normal. EKG shows sinus tachycardia with intermittent PVC's. CT of the head negative.

HOSPITAL COURSE: Patient was taken to the Intensive Care Unit, had recurrence of seizures and Ativan was used and patient placed on Dilantin 500-600 mg initial loading dose. The patient's neurological status did not improve over the next two days. The patient required larger and larger amounts of oxygen, up to 100 percent, subsequently requiring additional PEEP as well, up to 10 of PEEP with 100 percent O<sub>2</sub>, PO<sub>2</sub> has dropped into the 39 range. The patient subsequently, on repeat x-ray, showed that she had developed a pneumothorax. Chest tube was placed with minimal improvement in PO<sub>2</sub>. PEEP was increased to 15 with subsequent improvement of the PO<sub>2</sub> into the 49 and subsequent 59 range. This time arterial line placement was attempted and failed. PO<sub>2</sub> and sats were improving, subsequently was maintained at 15 of PEEP. No further pneumothorax was noted. Patient did show marked improvement of pulmonary status and by the following day chest x-ray was starting to clear. The day prior to transfer the patient was noted to have some mottling of the right upper extremity. It was felt that a clot was passed into the right leg. Dr. [REDACTED] attempted surgical removal and a small clot was removed. However, some mottling persisted on that right leg. It is felt that arterial evaluation of the leg is appropriate at this time and since this cannot occur at this facility, it is suggested that the transfer to a facility with a Pediatric Intensive Care Unit and also has a neurologist on staff who can evaluate the patient's overall neurologic status, which seems to be the most impaired factor. Direct connection has been made with Dr. [REDACTED] physician at [REDACTED] Transfer will be effective via their pediatric transport team which is enroute.

[REDACTED]  
continued.....  
[REDACTED]

DISCHARGE SUMMARY

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Medical records from [REDACTED]

DISCHARGE SUMMARY

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Incidental note was that the prior evening, when patient went to surgery for clot removal of the right leg, patient required increasing amounts of oxygen and PEEP, ventilator was used. X-ray that evening revealed a right recurrent pneumothorax and left pneumothorax, on review this morning with the radiologist. This morning a repeat x-ray shows re-inflation of the right lung and nearly complete spontaneous resolution of the left pneumothorax at this time.

The patient's status this morning reveal that blood gas is markedly improved, currently on 60 percent with an AC rate of 12, PEEP now at 5. Patient is showing a PO<sub>2</sub> of 300/7.37/PCO<sub>2</sub> 31/base excess -6.7.

Incidentally, CPK rose to a max of 37K at this point. Her urine has been alkalinized by adding Bicarb to the IV. Hydration has been increased somewhat from her initial two days, maintenance was maintained for the sake of cerebral edema and her pulmonary ARDS status.

I have discussed this with the transfer physician, Dr. [REDACTED] as well as the parents and they understand the reason and need for transfer at this time and agree with the plan. Transfer will be inacted by a transport team as mentioned above. Records to be sent along.

[REDACTED]  
Trans: 4-8-98

Dict: 4-8-98

cc: [REDACTED]

[REDACTED] M.D.  
[REDACTED]  
[REDACTED]

[REDACTED]  
DISCHARGE SUMMARY

000004

LOS 7710  
4/14/98  
WRB (390)  
Medical records from

DATE: April 6, 1998

HISTORY OF PRESENT ILLNESS: Currently 15 year old female, apparently while during a [REDACTED] after [REDACTED] was seen to collapse, falling face forward on the ground. Some shaking was noted of all extremities by a teammate. [REDACTED] apparently ran over, noted her to be apneic and without pulse. He began CPR. The paramedics were called and arrived approximately within five minutes. Found her to be asystolic and subsequent delivered four defibrillations, plus an Epinephrine dose in the field with return of heart rate and weak pressure. She was transported to the ER here. She was found to have pressure and sinus tach here. Initial report was that she received blunt chest trauma, however, this was false, she basically collapsed on the field.

The patient was reintubated in the ER due to deflated balloon. In the ER was found to have some posturing of upper extremities and some stiffness of the lower extremities. Pupils initially were approximately 4-5 mm., currently have come down equally to 2 mm. and are somewhat reactive. She does have some spontaneous breathing as she is taken to CT scan of the head.

Initial chest x-ray was clear, subsequent approximately 50 minutes later showed bilateral patchy infiltrates, suggesting adult respiratory distress syndrome. Stomach contents were empties. Some question of pill fragments were noted. Entry potassium was 2.7. The patient apparently has been dieting and taking some pills which contain herbal Ephedrine and caffeine, which she apparently took some today. She has also been trying to lose weight and dieting. No history of anorexia from friends. [REDACTED]

[REDACTED] other than her "energy pills". The number she has taken is unknown, however, stomach reveals probably at least 2-4 tablets were taken.

Mom states she is unaware of any drug problems. Has been a good student in school without other problems noted.

PAST MEDICAL HISTORY:

Negative.

ALLERGIES: None known.

SURGERIES: None.

MEDICATIONS: As above.

FAMILY HISTORY: History of hypertension. No history of any type of arrhythmias or prolonged QT type familial problems.

SOCIAL HISTORY: As above.

PEDIATRIC CONSULTATION

CONTINUED

000005

PEDIATRIC CONSULTATION  
PAGE TWO

LOS 7710  
4/14/98  
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Medical records from [REDACTED]  
[REDACTED]

PHYSICAL EXAMINATION:

GENERAL: Intubated 15 year old female with posturing bilaterally.

VITAL SIGNS: T: 98. P: 130, sinus. BP: 130/70.

HEENT: Pupils now reactive 4-2 mm. bilaterally. Ears and throat clear.

NECK: Supple. No JVD.

HEART: Sinus tach at 130. No murmurs heard.

LUNGS: Biltateral rhonchi, few. No retractions.

ABDOMEN: Soft, non-tender. No masses appreciated.

EXTREMITIES: No joint deformities.

NEUROLOGIC: As mentioned, some flex posturing of arms and increased tone in the legs. Toes are downgoing, however. The patient is unresponsive at this time, but does have spontaneous respirations.

Initial ABG P02 192, 7.19, 20. Base excess -19. Entry labs sodium 142, potassium 2.7, bicarb 12, creatinine 1, glucose 276. LDH 301, SGPT 02 slightly elevated at 90 and 85. CBC within normal limits. Chest x-ray as mentioned above. EKG shows sinus tach and frequent PVC's, bigeminy pattern. CT of the head pending.

IMPRESSION:

Full arrest, collapsed during [REDACTED] with seizure activity noted.

Hypokalemia on admission, 2.7.

Probable diet pill excess with Ephedrine/caffeine.

History of drug use.

PLAN:

Admit to the ICU.

Ventilator support with hyperventilation at this time and PEEP.

IV D5 half with Potassium at 80 an hour.

Supplemental KCL IV over 3 hours.

Repeat Potassium.

Drug screen and urine pregnancy test.

Aspirin and Tylenol levels.

CCU protocol for any further arrhythmias.

[REDACTED]  
[REDACTED]  
CONTINUED

[REDACTED]  
PEDIATRIC CONSULTATION

000006

PEDIATRIC CONSULTATION  
PAGE THREE

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Medical records from [REDACTED]  
[REDACTED]

Discussed with family, [REDACTED] and friends concerning prognosis, which is grave at this time due to her neurological sign. The patient is at present time, unstable for transport to PICU. Will re-evaluate in 12-24 hours, reassess.

[REDACTED] M.D.

[REDACTED]  
cc: [REDACTED] [REDACTED] [REDACTED] [REDACTED]  
[REDACTED]

trans: 4/7/98 --  
dict: 4/7/98

LOS 7710  
4/14/98  
WRB (390)  
Medical records from

DATE: April 7, 1998

PATIENT PROFILE: Previously healthy 15 year old girl collapsed on the [REDACTED] and was brought in in full arrest.

PROBLEM LIST:

1. CARDIAC ARREST, PROBABLY RELATED TO FLUID AND ELECTROLYTE ABNORMALITY AND/OR BULEMIA AND/OR UNDERLYING STRUCTURAL HEART DISEASE.
2. SLIGHT GLOBULAR PROMINENT CARDIOMEGALY, UNCLEAR ETIOLOGY, POSSIBLE NUTRITIONAL.
3. DIFFUSE ALVEOLAR INFILTRATES, PROABLY GASTRIC ASPIRATION, POSSIBLE ADULT RESIRATORY DISTRESS SYNDROME RELATED TO HYPOTENSION.

HISTORY: The patient is a previously healthy 15 year old girl. She is a ninth grader at [REDACTED] and, according to her family, is a good student and has had no significant medical problems. She is physically active. She is involved in [REDACTED] She runs. She is a reasonably good athlete. They have not noticed any signs of bulemia. They have not noticed any significant change in her weight, nausea, vomiting. She eats dinner with the family and seems to linger at the table and talk and not go immediately to the bathroom. They have not heard or seen any evidence of bulemia. She has, however, had a very poor diet. She was eating erratically, skipping breakfast, having chips and cokes and other things.

She was at a [REDACTED] yesterday, while running she collapsed. Within a minute or so a bystander CPR was initially. Within about five minutes the paramedics arrived. When she arrived at the hospital she was defibrillated and intubated. She had a central line passed. Several attempts for femoral artery catheter were made. She initially had an apparently normal chest x-ray except for what I think is a somewhat globular prominent heart shadow. Within an hour or so she rapidly developed diffuse infiltrates. She developed a pneumothorax and a chest tube was placed. The lung re-expanded, but her oxygen requirements were significant. She was requiring 100% oxygen. PEEP was then increased progressively from 5-10 to 15 and her blood pressure fell slightly.

This morning she has small reactive pupils and doesn't respond to pain. Her blood oxygen has improved. Her P02 is up to 140 on 100%.

Her admitting labs were pertinent for low potassium of 2.7, low total protein of 5.3 and low cholesterol at 99. Mild liver function abnormalities.

[REDACTED]  
[REDACTED]  
CONTINUED

[REDACTED]  
PULMONARY CONSULTATION

000008

PAST MEDICAL HISTORY:

OPERATIONS: None.

HOSPITALIZATIONS: None.

MEDICATIONS: Over the counter vitamins with Ephedrine.

FAMILY HISTORY: Negative for early vascular disease, diabetes, strokes. There is no one in the family who has had syncope, sudden death or other cardiac abnormalities.

REVIEW OF SYSTEMS:

GENERAL: No malaise, night sweats, weakness or fevers. No substantial change in weight.  
HEENT: No headache. EYES: No blurred vision, double vision, eye pain, infection, or discharge. No recent change in vision. No ringing or burning in the ears. No trouble hearing. CARDIAC: See above. RESPIRATORY: No asthma, wheezing, cough, hemoptysis, or bronchitis. Patient notes no limitations in activities by breathing. GI: See above. GENITOURINARY: No trouble urinating. No trouble getting started or stopped. No burning or irritation. ENDOCRINOLOGIC: No history of diabetes, hyperglycemia, thyroid intake or goiter. NEUROLOGIC: No history of head trauma, lateralizing numbness, weakness, trouble with speech or coordination. No dizzy spells or blackout spells. No overt symptoms of depression. No crying spells. Memory is reasonably good. MUSCULOSKELETAL: No arthritis or arthralgias. No problems with any major joint.

PHYSICAL EXAMINATION:

MENTAL STATUS: As above.

NECK: Supple without neck vein distention. Carotids are easily palpable. Thyroid is normal size and smooth in contour.

CHEST: Clear to auscultation and percussion. No wheezes or rales.

LYMPH NODES: No supraclavicular, cervical, axillary, inguinal, or femoral lymphadenopathy.

CARDIAC: Heart rate of 140. No significant murmurs, gallops or rubs, although with her rapid heart rate, it is hard to hear.

ABDOMEN: Examination reveals an 8 cm. liver by percussion. No spleen is palpated. Bowel sounds are normally active. Abdominal aorta is palpated and is of normal caliber. There are no significant bruits.

NEUROLOGIC: See above.

LABORATORY AND X-RAY DATA: Chest x-ray, blood tests and blood gases as above.

PULMONARY CONSULTATION  
PAGE THREE

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Medical records from [REDACTED]  
Hospital.

ASSESSMENT: The patient has post cardiac arrest, adult respiratory distress syndrome most likely. Given the rapidity and diffuseness of the infiltrates, their central location related to gastric aspiration, will treat her with ANCEF and would add CLINDAMYCIN. I would manage the ventilator, trying to minimize peak flows, minimize peak pressures to help with her *Baro* trauma. Right now she is alkalotic, so I would turn down her tidal volume, decrease her FI02. Would like to get the FI02 down around 40-50% fairly soon, keep her PEEP off. Her neurologic status is unclear at this time, however, I am somewhat optimistic. Her CPR was initiated quickly and paramedics arrived promptly.

She also has a problem with perfusion to her right foot. Several attempts at femoral artery line were made and she has a diminished right femoral pulse and decreased pedal pulses and slightly cold right foot. I am hopeful that this will improve with time.

[REDACTED]

[REDACTED]

cc: [REDACTED]

trans: 4/8/98  
dict: 4/8/98

[REDACTED]

[REDACTED]

LOS 7710  
4/14/98  
WRB (390)  
Medical records from

DATE: April 7, 1998  
0010 hours

S: At the present time the patient developed a right pneumothorax. Chest tube is placed. Her oxygenation is very poor with a PO2 of 35. This persisted despite placement of the chest tube.

Chest x-ray photos have worsened suggesting severe ARDS with vascular bleed. May be partially triggered by the Ephedrine she took as well as her full arrest.

At the present time her PEEP has been increased to 15 with some improvement in her PO2 to 49. PH 7.29/PCO2 30, base excess -11. Blood pressure has remained relatively stable, approximately 90/50. Patient has had urine output.

Neurologically, seizure activity has occurred. The patient was treated with Ativan and Dilantin.

O: Vitals as mentioned. Neck supple. Heart, regular rate, sinus tach at 130, no murmurs heard. Lungs stiff sounding, diffuse rales and rhonchi. Abdomen soft and non-tender. Extremities are unchanged. Neurologic, flaccid post-Ativan, no further seizure activity.

P: 1. Continue PEEP. 2. Repeat ABG. 3. Continue full support. 4. Watch closely for left pneumothorax. 5. Recheck electrolytes and ABG in 4 hours, sooner if PO2 drops.

I have discussed this case with Pulmonary physician, Dr. [REDACTED] who has no additional wisdom to add except to increase PEEP.

I have also called [REDACTED] Intensive Care Unit and discussed with the PICU direction, Dr. [REDACTED]. The case was presented and discussed, he agrees patient is unstable for transfer. He also suggests to increase pressure, if necessary, to PEEP of 20 to obtain minimally adequate oxygenation. Dr. [REDACTED] is consulted if a second pneumothorax occurs in the left lung.

If the patient does stabilize, will consider transfer in 24-48 hours to [REDACTED] Hospital PICU pending neurological status. Discussions have all gone on with the family at least four times over the last two hours and they have been presented the grave prognosis as well.

Trans: 4-7-98  
Dict: 4-7-98  
cc: [REDACTED]

CRITICAL CARE NOTE

000011

MR#: [REDACTED]  
AC#: [REDACTED]  
RM#: [REDACTED]  
DC: 00/00/00  
PT: [REDACTED]  
SEX: F

NAME: [REDACTED]

DOB: [REDACTED]

### CONSULTATION REPORT

TYPE OF CONSULTATION: Vascular Surgical Consultation.

DATE OF CONSULTATION:

REFERRING PHYSICIAN: [REDACTED] M.D.

HISTORY OF PRESENT ILLNESS: This patient is a 15-year-old female who is arriving at 1315 hours from [REDACTED] with a history of an anoxic brain injury status post resuscitation for suspected arrhythmia. She had been resuscitated and in the midst of that resuscitation underwent right arterial catheterization as described by Dr. [REDACTED] over the phone to me in a phone conversation. Subsequently, she had a right cold lower extremity which became pulseless and then subsequently required the catheter to be removed and a surgical exploration of the groin. Again, by surgeon's description, he performed a thrombectomy of the superficial femoral and profunda femoris arteries, finding a minimal amount of clot in the superficial femoral artery. Clinically, he stated that the leg was certainly improved postoperatively. No anticoagulation had been started at that time because of the patient's neurologic status.

Subsequently, over the last eight to twelve hours, the patient has experienced recurrent coolness and loss of pulsations in the right lower extremity and, as stated to me over the phone, was noted to have a warm thigh and a femoral pulse but lack of distal pulses.

### PHYSICAL EXAMINATION

On clinical presentation now, the patient is intubated and unresponsive essentially to gross neurologic examination where there is no motor function in any of the extremities on any direct commands. Of clinical significance, she has no femoral pulse to my examination, no palpable pulses in the entire right lower extremity. The right calf is tense on palpation, and she has essentially no dorsal passive range of motion function to the right lower extremity. As compared to her left lower extremity, she has a femoral pulse, palpable popliteal and tibial arterial pulses with a soft calf and thigh compartment as well.

Again, she unable to respond to any directed commands in order to directly test for any motor or sensory function. Her upper extremities demonstrate radial and ulnar pulses which are intact as well.

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WRB (390)  
Medical records from [REDACTED]

000012

MR#:  
NAME  
M.D.

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ASSESSMENT: Limb ischemia of the right lower extremity with thrombosis of the femoral and proximal probable iliac artery. Severe limb ischemia.

PLAN: I had a discussion with the father and discussed the options at this point. Certainly, the patient has extensive ischemic changes to the calf with lack of any kind of passive range of motion motor function, suggesting prolonged ischemia of this lower extremity and certainly poor prognosis in terms of limb salvage. I discussed this with the father at length, and this is certainly a situation where the neurologic status versus the lower extremity status is of concern.

Our plan at this time is to proceed with emergent angiography to delineate any possible proximal artery dissection and, therefore, a stent could be possibly be placed proximally in order to limit the amount of dissection that would be required at the time of operation. I am doing this realizing that time is of the essence, but I think this would certainly make her clinical course much easier in terms of decreasing the amount of surgery required up in the iliac region.

Therefore, emergent angiography will be performed at this time. This has been discussed with Dr. [REDACTED] and then the patient will be taken immediately to the operating room for a thrombectomy of the right lower extremity and for a compartment fasciotomy.

The prognosis on this patient's lower extremity for salvage is poor. This is related, certainly, to her lack of any motor function by passive range of motion. Her thigh is certainly not tense on clinical examination as compared to her calf and, therefore, I think ultimately she would require an above-knee amputation. I will use every effort at this time intraoperatively to evaluate this patient in terms of intraoperative urokinase infusion in attempts to salvage the limb with realization of her current neurologic status.

Again, this has been discussed with the family, the father, by phone in detail. He has given me verbal consent to proceed with both angiography and surgical intervention without his written consent at this time.

[REDACTED] M.D.

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/:  
JOB:  
ID:  
DD: 04/08/98  
DT: 04/08/98

LOS 7710  
4/15/98  
WRB (390)  
Medical records from [REDACTED]

000013

ADMISSION AND DISCHARGE SUMMARY

INPATIENT ADMISSION

BILLING NO.

HISTORY NO.

PATIENT INFO

PATIENT NAME AND ADDRESS: [REDACTED] MAIDEN NAME: [REDACTED] NEW ADMISSION? [REDACTED] IF PREVIOUS MONTH, YEAR: [REDACTED] ADMIT BY: [REDACTED]

OCCUPATION-EMPLOYER-ADDRESS: [REDACTED] MINOR FT SSN: [REDACTED]

TELEPHONE: [REDACTED] COUNTY: [REDACTED]

FIN. CLASS: [REDACTED] AGE: 04/06/98 19:29 15Y SEX: F RACE: [REDACTED] MARITAL STATUS: S DATE OF BIRTH: [REDACTED] ROOM NO.-BED NO.: [REDACTED] RELIGION/CLERGY/CHURCH: [REDACTED]

COUNTY CODE: [REDACTED] TYPE: INPATIENT ATTENDING PHYSICIAN: [REDACTED] PHYSICIAN CODE: [REDACTED] OCCURRENCE CODE-ACCIDENT RELATED: [REDACTED]

PERSON TO NOTIFY IN CASE OF EMERGENCY: [REDACTED] (AUNT) ACCIDENT DATE/HOUR: [REDACTED] HOSPITALIZED IN LAST 60 DAYS: [REDACTED] IF YES, WHERE?: [REDACTED]

RESPONSIBLE PARTY

NAME AND ADDRESS: [REDACTED] RELATION TO PATIENT: [REDACTED] OCCUPATION-EMPLOYER-TELEPHONE NO.: [REDACTED]

HOME PHONE: [REDACTED] SECURITY NO.: [REDACTED]

INSURANCE

PAYOR NAME: [REDACTED] PLAN CODE: [REDACTED] POLICYHOLDER: [REDACTED] REL. POLICY/CERTIFICATE NO.: [REDACTED] CODE: [REDACTED] GROUP NO: [REDACTED]

OTHER NEAR RELATIVE OR FRIEND

NAME: [REDACTED] (AUNT) RELATIONSHIP: [REDACTED] ADDRESS: [REDACTED] PHONE: [REDACTED]

CODE: [REDACTED] ADMITTING DIAGNOSIS: CARDIAC ARREST Admit Date: 04/06/98 DATE ADMITTED: [REDACTED] TIME: [REDACTED] DATE DISCHARGED: 4-8-98 TIME: [REDACTED] I.O.S.: [REDACTED]

FINAL DIAGNOSIS 1° DX	CODE NUMBER
Cardiac arrest, unknown etiology	[REDACTED]
Cerebral hypoxia	
2° DX Adult respiratory distress syndrome pattern	
3 Possible aspiration pneumonia	
4 Pneumothorax	
5 Ischemia right leg, possibly related to attempted	
6 external line placement	
7 Rhabdomyolysis	
8 Hypokalemia	
COMPLICATIONS OR INFECTIONS	[REDACTED]

TREATMENT	CODE NUMBER
Declothing and repair right superficial femoral artery	[REDACTED]
Central line placement	
Intubation with ventilator support	
Insertion chest tube	
CT scan, brain	

CONSULTANT

TRANSFERRED  A.M.A.  CORONER YES  NO

EXPIRED  AUTOPSY YES  NO