

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

ARMS#

12843



6 - MD NOTES

000001

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

DATE: April 6, 1998 [REDACTED]
2220 hours

HISTORY OF PRESENT ILLNESS: The patient currently in the Unit. CT scan, initial wet reading, negative for bleed. The patient's pressure is stable at approximately 90/40, temp is low at 94.5. Warming blankets being applied. Heart rate is stable, no further arrhythmias.

The patient is noted to have Cheyne-Stoke's breathing pattern.

Additional information reveals the initial entry blood gas was just presented which was PH of 6.8, CO2 14, base excess -28 which suggests that the patient was probably down longer than five minutes with inadequate perfusion which may explain which may give him more grave prognosis in terms of neurological recovery.

O: PERL, approximately 2-3 mm, equal. Neck, supple. Heart, sinus tach 130. Lungs, a few rhonchi heard bilaterally. Abdomen is soft, non-tender. Extremities, unchanged. Neurologic unchanged.

A: 1. Status post full arrest on [REDACTED] with asystole probably greater than five minutes. Entry PH 6.8. 2. Continuing poor neurologic status. Would change to breathing pattern and posturing. 3. Peripheral clamp down, probably secondary to Ephedrine. 4. Probable inadvertent o.d. on Ephedrine/Caffeine. 5. Hypokalemia correcting with two IV's with KCL. 6. History of drug use.

P: 1. Still awaiting official reading on CT. 2. Continue ventilator support, sat low probably secondary to ARDS. 3. Prognosis poor at this point. 4. If blood pressure falls below systolic of 90, will use Dopamine for support, however, wish to avoid in the face of cardiac irritability. 5. Hyperventilate on ventilator. 6. Repeat ABG, electrolytes now.

[REDACTED]
Trans: 4-7-98
Dict: 4-6-98

[REDACTED] M.D.

cc: [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
CRITICAL CARE NOTE

000002



LOS 7710
4/14/98
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PROGRESS RECORD

DATE	NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTION TO PATIENT
4/6/98	<p><u>Red Ten note:</u> 15 y/o ♀ → collapsed on field → s/z noted → cardiac arrest/arrhythmia → CPR by [redacted] there ≈ 5 min EMS there → defib x 4 cepix 1 → e ST to ER. Here posturing e = pupils and spot aspirin to CT scan head... CXR clear → ARDS (no blunt chest trauma) Entry K = (2.7) → has been dieting and taking "Emeran pills" (ephedrine) per friends [redacted] " " [redacted]</p>
②	<p>PH ⊖ all ⊖ Surg ⊖ FH: H/W (⊖ anything prob.) <u>PE:</u> Intubated 15 y/o ♀ e posturing HR = 130 130/70 PERL ⊖ 4-2m (pilot) Suffl. HR ⊖ 130. bilateral crackles/low wheezes BB ⊕ / VS. GUA ⊖</p>

000003

(over)

[REDACTED]

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

Dr. [REDACTED]

PROGRESS RECORD

DATE

NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS,
CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTION
TO PATIENT

Mon
2030
4.6-98

(R) SC CVP placed
for acute monitoring
in cardiac arrest -
cxr = ? ARDS / line in
good position. no pleural
space abn. or pneumo.

[REDACTED]

Mon
2330
4.6-98

(R) Chest tube placed #24 F
5th ICS for pneumothorax
prob. 2nd need for PEEP as
post CVP cxr showed
no evidence pneumo.
Condition critical & poor prognosis
given "shock lung" appearance of
cxr. Discussed to Dr. [REDACTED]
he has been in touch to PICU in
re: aspects of pulm. care.

000004

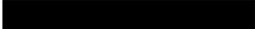


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4/14/98

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PROGRESS RECORD

DATE	NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTION TO PATIENT
4/7/98	

4/7/98 9 A.M.



ICU

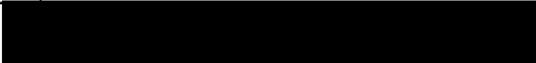
Today patient has had no further seizing. She did have another run of V tach in the early morning, non-sustained. Otherwise has become much more stable. ABG showed improvement. Sats improved throughout the night. Seems to have turned the corner in terms of her adult respiratory distress syndrome. Electrolytes are pending.

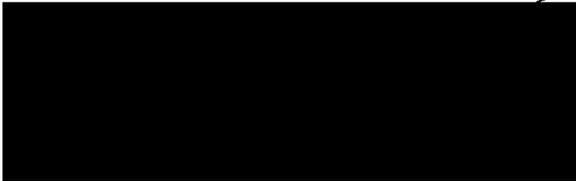
Pulmonary wise her gas-with marked improvement. PEEP at 10, AC 20. P02 is now 149. PH 7.43, PC02 23. Still wishing to maintain a low PC02 in attempt to keep her somewhat alkalotic. Her respiratory rate is still Cheyne-Stoking.

She has developed a fever up to 101-102 this morning, may be central nervous system temperature, difficult to say. Otherwise neurologically essentially unchanged. No purposeful movements. Still has occasional increased tone and flexure movements of the upper extremities. EXAM: Pupil are equal and approximately 2 mm. Ears and throat clear. Neck supple. Some crepitation. Heart regular rate at sinus tach, 130. Lungs decreased rhonchi and rales. Abdomen is soft, non-tender. No masses appreciated. Extremities with some coolness noted right extremity. Small femoral hematoma noted from attempt at ART line last evening. Pulses decreased. No color changes noted in the extremity. Neurologic with no focality. Increased tone bilaterally. Toes still downgoing. Skin no lesions or petechiae noted. Chest x-ray shows some clearing of the adult respiratory distress syndrome pattern, but still bilateral infiltrates are noted. ET tube in position. Chest tube in place with good reinflation. IMPRESSION: Status post full arrest on with asystole times approximately ten minutes. Entry hypokalemia, 2.7. History of pill taking, i.e. herbal Ephedrine, unknown number of tablets. Adult respiratory distress syndrome, improved. V tach. stable at this time. P: Continue to

wean ventilator and decrease pressures as tolerated. Close neuro follow up. Continue to hyperventilate for CNS sake. Cooling blanket if needed for temperatures. Clindamycin added for broader spectrum coverage for possible aspiration. Continue Dilantin and Ativan for seizure control. Repeat ABG and electrolytes this afternoon.

000005





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<p>Tues 4.7.98 1605</p> <p>DP</p> <p>DP</p> <p>PT</p>	<p>Surg -</p> <p>Has developed ischemic (R) foot to ankle</p> <p>- Cool/pale/pulseless -> Discussed -</p> <p>Dr. [redacted] this day earlier (Vascular).</p> <p>He is not available to come to consult/operate today and patient needs urgent (R) femoral artery exploration = thrombectomy/embolectomy (R) SFA / pos. exploration (R) popliteal artery = Fogarty cath. - passage -</p> <p>Discussed w/ [redacted] father + mother, advising of RBA's -> consent given -</p>
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<p>Tues 4.7.98 1745</p> <p>mottled cool pale</p>	<p>[redacted]</p> <p>DP</p> <p>pre = (R) SFA occlusion / intimal tear</p> <p>post = intimal, non-obstructing tear (R) SFA</p> <p>procd = (R) SFA exploration/repair/Fogarty catheter</p> <p>: exploration (R) SFA / POP / PT arteries</p> <p>Surg = Spunkl Anesth = O₂ / Resp. support</p> <p>Condit. = p Tol. well. ICU critical</p>
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DATE	NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTION TO PATIENT
4/17 1900	Pt Back from Surgery - ABU resp response - pupils react, 2-3 mm + reactive. Tap P - Joints - BS 90-100 = low urine output.
	NV for chest & good BS abd ⊖ ⊕ foot st. better p surgery. Doing well p 2 to 1 loss of pces.
	A) Resp status tension = ARDS + aspirak hi famp. - partly central from pneumonia ischemic ⊕ foot.
Thank you!	B) Cont vent - Sedate more - to synchronize work

4/8/98

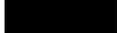
The patient is, unfortunately, basically about the same. Her respiratory status is about the same. She still has significant leak. Her oxygen requirements are going down somewhat. She still has significant central hyperventilation. Neurologically, unfortunately, she is also unchanged. She has mid position pupils and really doesn't respond to pain. She had no dolls eyes. O: Neck veins flat. Chest is really fairly clear. Abdomen is soft. Chest x-ray is pending. Blood gases show high oxygen on 100%. Will decrease her PEEP, decrease her FI02. In view of her significant skeletal muscle necrosis, will add bicarb to the IV to try and diurese to prevent renal failure. Decrease respiratory status. Continue Gentamicin, Clindamycin.

000007



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DATE	NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTION TO PATIENT
<p>Wed 4-8-98 0930</p>	<p>Surg - Continued problems w ischemia (R)LE is beginning contracture of Gastrocnemius and mottling below level of (R)knee. pulseless - Pt. needs urgent arteriography & poss. re-exploration (R)SEA / possible papaverine / streptokinase drip via catheter below level of arteriotomy if the extremity is to be salvaged. The other issue is overall prognosis of pt. which looks poor. Discussed w Dr. [redacted] (vascular) who concurs w plan. No angi. Capacity here @ [redacted] and plan transfer to PICU @ [redacted] [redacted] Dr. [redacted] has discussed w directors there / family advised -</p>

1. YOUR SURGICAL HISTORY - Please list all previous surgical procedures starting with the most recent.

PAST OPERATIONS YEAR ANESTHESIA COMPLICATION
 (a.g. General, Spinal, etc.)

None

2. YOUR MEDICAL HISTORY

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Heart Disease		Lung disease, T.B.		Glaucoma
<input type="checkbox"/>	Angina, Chest pain	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Severe or frequent headache
<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	Epilepsy, stroke
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Hepatitis, Jaundice or	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	Drug/alcohol addiction
<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	Hiatus hernia/Ulcer	<input type="checkbox"/>	Other illnesses
<input type="checkbox"/>	Heart "attack"	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Blood transfusions
				<input checked="" type="checkbox"/>	Gestation at birth - 38 wks (child)

3.

YES	NO	Quit?	When?
<input type="checkbox"/>	<input checked="" type="checkbox"/>		
	Do you, or have you, ever smoked? If so, how much?	or removable dentures?	hearing aid?
<input type="checkbox"/>	Do you have caps Loose or chipped tooth		
<input type="checkbox"/>	Do you wear contact lenses eyelashes false eye		
<input type="checkbox"/>	Do you have difficulty opening your mouth or moving your neck?		
<input type="checkbox"/>	Do you have a cold?		
<input type="checkbox"/>	Do you drink alcoholic drinks each day? If so, how many?		
<input type="checkbox"/>	If female, is there any possibility that you are pregnant at this time? - period 3-4 wks ago		
<input type="checkbox"/>	Have you or anyone in your family had any unusual reactions, problems or complications with anesthesia? (Jaundiced, muscle weakness, breathing problems or unexplained fevers.)		
<input type="checkbox"/>	Do you or have you used any street drugs in the last week?		

4. PLEASE LIST ANY MEDICATIONS YOU ARE TAKING OR HAVE TAKEN IN THE PAST SIX MONTHS.

0 med

5. PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR TAPE

No Allergies

6. WHEN DID YOU LAST HAVE ANYTHING TO EAT? DRINK?

7. HEIGHT 5'4 WEIGHT 120 lbs

Patient/Responsible Party Signature Relationship Date

ANESTHESIOLOGIST'S EVALUATION: Mouth exam to oral cavity - no lesions seen
 - Chest exam to 4th ribs - clear - no wheezing or crackles
 FEED (g) 180 minutes SPO2 790 - Tabbyson eq. ECG - normal - BP
 ok Lab initial hypokalemia - Metabolic (2 part) - good - (P/gram)
 exp. plasma glucose Hypoxemia: ok Lungs wet - not
 Physical Examination: Heart Tachycardia Other

ASA Physical Status: 1 2 3 4 E Plan: General Regional

Anesthetic

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[REDACTED]

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1/14/98

[REDACTED]

4-8-98 S: Patient essentially neurologically unchanged, still has some Cheyne-Stoke's but not as pronounced as yesterday. Corneals are negative, plus/minus Doll's. Does have spontaneous respirations although the pattern is abnormal. No neurological response otherwise. No response to deep pain in either extremity. No obvious posturing although she is on quite a bit of Ativan. She does have increased tone noted in both extremities with abnormal reflexes. Yesterday she was taken to O.R. for an arterial clot, right leg. There is some cooling of the extremity and apparently a small clot was removed. Patient returned, required increased O2. Due to elevated and rising CPK, bicarb was added to IV to alkalinize urine. Creatinine is I.I this morning. LDH 2373, CPK is pending. Bicarb is 16. Patient was apparently tried on SIMV last night by Dr. [REDACTED] and returned to AC at 12, currently PEEP of 5, FIO2 being turned down, approximately 60. Morning ABG on 80 percent, I0 of PEEP, AC of 12, tidal volume 650, PO2 of 302/7.37/3l, base excess -7. Patient is weaning again at this time. O: Pupils minimally reactive, 2-3 mm. Ears, clear. Neck, supple. Some crepittance. Right CVP removed. Heart, sinus tach at 120. Lungs, somewhat cleared, rhonchi noted, no wheezes, less stiff sounding. Abdomen soft, bowel sounds present. Extremities, as mentioned, some slight mottling right foot, cool right lower extremity, similar to yesterday. Remainder unchanged. Neurologic is as above. A: 1. Full arrest/collapse during [REDACTED] with seizure activity noted. 2. Hypokalemia plus diet pill excess with Ephedrine, caffeine, probably causal agent for #1. 3. Drug use history. 4. ARDS with possible aspiration. 5. High spiking temperatures, probably CNS related. 6. Right lower extremity arterial occlusion, probably secondary to failed right femoral line placement, post declotting. 7. Cerebral hypoxia with significant residual and Cheyne-Stoke's breathing pattern/comatose. 8. Rhabdomyolysis secondary to above. P: 1. Continue full support at this time. 2. Close watch of right lower extremity. 3. Continue antibiotics to cover for aspiration. 4. Ventilatory support. 5. MB fraction to be checked. 6. Consider NG tube feedings due to her current catabolic state and if unable, consider TPN at this point in time.

Family discussion has occurred presenting poor prognosis due to her neurological state.

[REDACTED]

[REDACTED]

DATE

17111 Admit H+PE

15:10 I transferred from [redacted] sp cardiac arrest, AAOB, ischemic (B) leg. Pt collapsed while [redacted] on 4/16/88. She had apparently been taking "Rapid Relief" an over-the-counter ephedrine containing compound. Bystander CPR started 5 seconds. Paramedics arrived ~ 10 min later, on arrival, pt asystolic / V-fib defibrillated x 3, Epi x1, (+) PEA, intubated, CPR continued + transferred to [redacted] arrived ~ 20 min - 30 min. Paramedics arrived, pt to PEA, Epi x1 mg given, (+) pulse + BP ~ 4-5 min later. Intubated AB 6. 0.6.84/14/1984 - 28.5. Total down time ~ 40-45 min to return of pulse + BP. Intubated H+2. Began sneezing, lid flutter + dilation. Pt to Aldran. No signs neurological recovery. Head CT on 4-17-88. Developed AAOB. Developed Ischemic (R leg 2° acute line placement + thrombolytic + aspirin 4/17 + developed pulseless asystole leg. Late PM/this AM of CPR 37K. Transferred for neuro eval + Argin/Vased. signs of @ beg. PMx: 8 hosp, results Meds: "Rapid Relief" All NIBP# FHE: if cardiac, a sudden death

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PROGRESS RECORD

000012

DATE

Diast

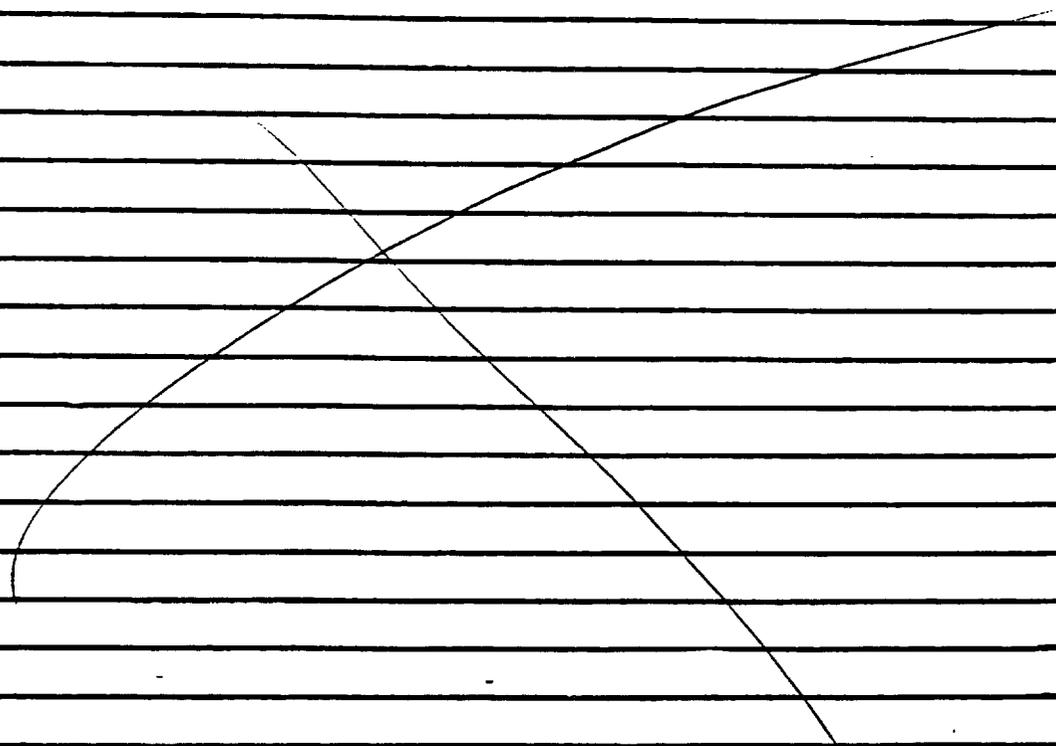
(1) Surg: Aortic valve repair
- valve surgery to correct

(5) FEIN/renal/ur: ↑CPK ⇒ rhabdomyolysis
- at risk for ARF
- follow creat, uric, not closely
- keep euolemic

(4) Heart
- V congs

(D) T.D
- amorph
- V T. congs. disp.

(8) Protein
- 510 correct



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PROGRESS RECORD



000013

DATE

4/8/98 Vascular Surgical consultation.
Treated.

1330 15 yold female transferred - cold, pulse
R lower extremities stiff calf muscle
compartment and no dorsal flexion
on passive ROM. -
no pedal pulse.

Emergency angiography necessary to
I.D. possible iliac dissection and
iliac entry point. - will require
4 compartment fasciotomy, thrombectomy
and is @ very high risk to have
above hence amputation. Discussed further
over the phone.



4/8/98 Radiology

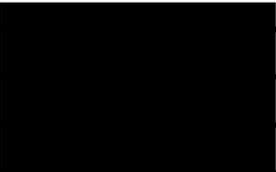
1510

S/P R iliac arteriogram via L groin puncture

cath: 5 PR sheath; 5 PR RIM catheter left
in place - tip in R common iliac art.

Contrast: 25 cc Omni.

Findings: Ocluded R ext. iliac artery ~ 2 cm
 beyond int. iliac. art.



PROGRESS RECORD

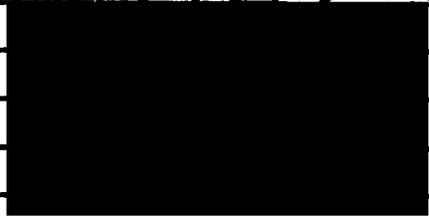
LOS 7710
4/15/98
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000014

DATE

4/8/98
1-500

Ultrasound findings - narrowing of distal
arterial lumen. Thrombotic and
partial occlusion performed. Intra-arterial
E patient BPA/acid small distal vessels
patent in spite of no doppler signal -
Very poor prognosis to save limb - will
likely require AKA/BKA/ general non-vascular
probe removal. - Revascularization
Neurology.



4/8/98

OP NOTE

Dr. [Redacted]

one on RA thrombosed (R) fem art
post op dx same

findings ① thrombosed (R) fem art
② (R) PTX
③ (R) LC compartment sd.

procedure - femoral art. thrombectomy
- saphenous vein patch angioplasty of
damaged ant wall of CFV
- placement #28F (R) ant chest tube
- 4 compartment lower leg fasciotomy

EDL 150 cc

drains - 2 chest tubes on (R) now
- ① fem art sheath still in

PROGRESS RECORD

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000015

DATE

PT: Anticipated No peripheral work
T 37.3 HR 140 BP 130/140/70 RR 30 SpO2 93-94%
wt 63kg

HEENT: of normal, (R) Umen non-reactive
E-T in place (L) 3mm

lungs: (+) crackles (R) base + (L) base
C/T + (R)

CVS: S1D
Aortic: of normal, not distended

Ext: cold (R) leg
Neuro: (+) corneal, (+) gag reflex (Cheyne-Stokes)
of normal asymmetry

(+) discomfort with joint & painful stimuli
(+) withdrawal (R arm + L hand)
painful stimuli of response however ext

labs: EKG: normal LAD 7.37/31/700-67
STX ant leads
COP 37% creat 1.1-1.5 Hct 30
H+ 3.9

A/A
B Needs: poor prognosis. Arterial hypoxemia
ischemic brain damage
- repeat CT

- neuro consult
- int delirium

2) Resp ANDS; (R) PTX (+ air leak)
- ext line V A/B/C
- keep PO2 \geq 80 if possible, w/ PCO2 4

(B) CVS
- VADP

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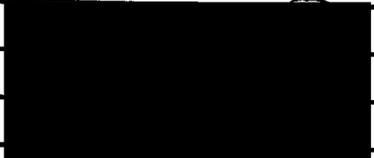
000016

DATE

4/8/98

1800

Popliteal artery signal by Doppler -
clinically foot no better suspect.
Thrombosis of capillaries (small vessels)
Depain - absent! no tibial



4/8/98

Post-Op (late entry)

2200

S: Intubated, sedated

O: 39 - 100s-120s/40s-50s 60s-80s, SR SIMV 20 PC 26 PS 20 FIO2 70% Sat 100%

UOP ~ 180cc + 500cc/hr.

Gen: intubated, sedated, withdraws LUE to pain

Lungs: coarse BS bilat but = 1 CT doesn't tidal, other CT tidsals @ leak.

CX RER,

Abd: soft, NT

Extremis: RLE warm x @ foot - cool & mottled.

+ 2 femoral pulso - dopplable popliteal.

~~Foot~~ Rt foot cool to touch,

~~plate~~ mottled purple-pink. LLE warm + 2 D

A/P: Stable s ~~staple~~ D op.

Neuro status good.

Pulm stable s evidence of new PTX. @ small leak now.

Extremis unchanged. May still need amputation in the future



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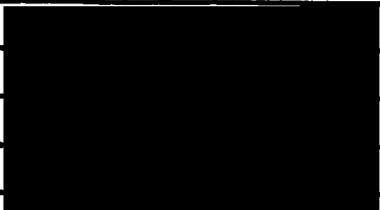


000017

DATE

4/9/98 Vascular

0830 as expected the calf and foot are non-salvageable; now has palpable popliteal pulse. will require three flaps or above level amputation today; if prolonged intubation ext. of family discussed / and other.



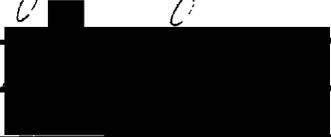
4/9/98 Neurology

0745

15 mg of Cocaine used 4/5. Corneal reflex much less responsive this am. Has severe ischemic damage to R foreleg which will require amputation in next 24h.

U-S. on vent. max support. Corneal. no response to deep pain over heel. minimal movement of arm to deep pain - reflexive. Pupils 6mm - fixed absent corneal, no gag or cough. Reflexes - no response to mass. Plaster on @ wrist, elbow. resp - brain death.

Plan - consider cerebral blood flow study for confirmation of clinical diagnosis



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000018

DATE

4/9/98 Brain flow study

Absence of flow and uptake in brain c/w brain death



4/9/98
low

Pt herniated during Night
Pupils fixed + dilated - non-reactive
of corneas
Cp gas
of respiratory effort
of speech motor
no response to deep pain
cold calories per [redacted] neg

Central brain flow: neg

4:15 Brain death declared (150)
- [redacted] to talk to parents
- supportive care



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000019