

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

ARMS#

12859



5 - SUMMARIES

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Continued...

MEDICAL BOARD SUMMARY

Date of Admission -
Staff - Dr. [REDACTED]
Fellow - Dr. [REDACTED]
Resident - Dr. [REDACTED]
Ward - [REDACTED]
Date of Dictation - 19 Apr 98 0745

[REDACTED] is a 33 year-old active duty O-3 black male without a significant past medical history who was admitted to the [REDACTED] for acute exertional rhabdomyolysis. His hospital course has been complicated by respiratory failure requiring intubation, acute renal failure secondary to myoglobinuria, acute hepatic failure presumed secondary to shock liver, severe coagulopathy secondary to disseminated intravascular coagulopathy, severe electrolyte abnormalities, and hypotension requiring inotropic agents. Over the course of his hospitalization he has required multiple blood products, electrolyte replacements, hemodialysis for volume overload and acidosis. Within 24 hrs of admission he was successfully extubated and hemodialysis was initiated removing 5 liters of volume. Within 36 hrs of extubation the patient's oxygen/ventilation requirements escalated requiring emergent reintubation. Over the ensuing 12 hours the pt's oxygen status improved to deteriorate and his blood pressure decreased. The clinical picture was consistent with multi-organ systemic failure. He required inotropic agents (Dopamine) and mental status has declined to a the point that the patient is no longer competent to make decisions for himself.

This is an emergent medical board because death is imminent in the next 72 hours.

Problem List/Diagnosis

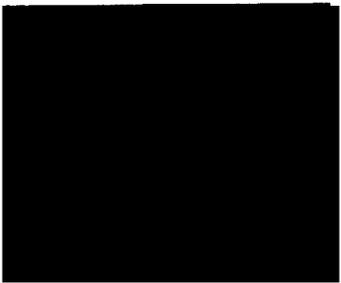
1. Acute exertional rhabdomyolysis - Secondary to profound dehydration associated with participating in PT test. CPKs have peaked > 500,000 and are currently decreasing. No signs of compartment syndrome, Ortho consulted. Complications secondary to this diagnosis are discussed below.
1. Acute renal failure
-Etiology secondary to acute exertional rhabdomyolysis. Requiring emergent hemodialysis for volume overload, acidosis, and severe electrolytes abnormalities. Patient continuing to require hemodialysis daily for these abnormalities. Electrolyte abnormalities include hypocalcemia, hyperphosphatemia, and hypobicarbonemia. Metabolic acidosis secondary to underlying etiology. CPKs have peaked @ > 500,000. Currently cannot determine if renal failure is temporary or permanent.
2. Acute liver failure
-Manifested by coagulopathy, hypoalbuminemia, hyperbilirubinemia, and hypoglycemia. Etiology secondary either shock liver associated with hypotension or secondary to rhabdomyolysis. Currently difficult to assess if encephalopathic because of sedation required for intubation. The pt has a normal neuro exam, is arousable and can follow commands, but is not competent enough to make decisions for himself. Hypoglycemia being closely monitored and corrected. Transplant service consulted.
3. Disseminated intravascular coagulation (DIC)
-PT, PIts, and fibrinogen normal on admission within 24 hours PT increased to > 60, plts decreased to 40, and fibrinogen decreased to < 100. Hematology/Oncology service consulted to assist with management. Evaluation consistent with DIC, recommendations were to reverse underlying process and correct coags/plts as necessary with blood products.
4. Systemic inflammatory response syndrome (SIRS)
-Pt developed fevers and hypotension 12 hours prior to this dictation. Hypotension not corrected with IV fluids and SGC parameters consistent with sepsis. Lactate elevated to 12 and pH decreased to 7.201. Imipenem started empirically. Requiring Dopamine to maintain blood pressure at stable level. Will continue to treat underlying process and continue supportive measures.
5. Acute respiratory failure
-Pt had to be reintubated because of oxygen/ventilation requirements associated with possible pulmonary edema/early ARDS, and severe respiratory alkalosis. Currently ventilator dependent for these needs and can not determine when pt could be extubated.

After discussion with Pulmonary Critical Care, CCU, and Nephrology staff the need for this medical board has been assessed as emergent because given the poor prognosis in this patient death is imminent in the next 72 hrs.

[REDACTED]

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