

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

ARMS#

13266



5 - SUMMARIES

000001

EMERGENCY DEPARTMENT REPORT

NAME: [REDACTED]
E.D. PHYSICIAN: [REDACTED]
FAMILY DOCTOR: [REDACTED]

PT. NUMBER: [REDACTED]
DATE: 11/07/98
AGE: 19
UNIT : [REDACTED]

HISTORY OF PRESENT ILLNESS: This 19-year-old male patient presents to the emergency department per EMS. Apparently some college buddies found him at home unresponsive with limited respiratory effort. Upon EMS arrival, the patient was intubated and brought into the emergency department. He had very low blood pressure and was essentially nonresponsive.

PAST MEDICAL HISTORY: School nurse relates that on his health form there has been no history of any sort of chronic health problems. It is related by his friends that he has had a recent 50 lb weight loss using some sort of a nonprescription diet pill.

SOCIAL HISTORY: It is related that he has not been a drug abuser or alcohol user in he past.

FAMILY HISTORY: Mother does relate that there is some history of diabetes.

ALLERGIES: Unavailable.

PHYSICAL EXAMINATION: Upon the patient's presentation, he does have some respiratory drive, but it is very limited. He is essentially nonresponsive. Blood sugar is checked immediately and it is found to be around 450. IV fluids were immediately started with Bolus therapy commencing. He is also given insulin. Arterial blood gases were obtained and he was noted to have a blood gas below 7 on the pH. He was continued with hyperventilation here. Blood pressure was quite low as well and he was continued on some Dopamine as a vaso active agent. This seemed to gradually improve his situation as his pH and ventilatory status seemed to improve as well. He did seem to become more responsive. Dr. [REDACTED] is the medical back was contacted and he is currently here seeing and evaluating the patient. Dr. [REDACTED] was also contacted at Dr. [REDACTED] request to assist in ventilator management as well. The patient was placed with an NG tube here in the emergency department and he was noted to have NG positive emesis. He will be given Pepcid 20 mg IV for this. He has had an episode of bradycardia initially and he was given Atropine for this and he was continued with hyperventilation and he seemed to respond well with this. Chest pain profile, ethanol level, urinalysis, ABG, EKG, serum osmolarity, Tylenol level, aspirin level, urine tox screen for drugs of abuse, acetone level, portable chest x-ray, and a head CT have all been ordered. The pH has been noted to be improving with follow-up ABGs. The patient is currently in guarded condition.

- DIAGNOSIS:**
1. Hyperglycemia -- DKA.
 2. Respiratory insufficiency.
 3. GI bleed.

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CFSAN ARMS PROJECT 13266
2/5/99 CHU

cc: [REDACTED]

D: 11/07/98 2316 T: 11/07/98 2326

[REDACTED]
Medical Records
[REDACTED]

000002

HISTORY AND PHYSICAL EXAMINATION

NAME: [REDACTED]
ROOM: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]
AGE: 19

ACCOUNT NUMBER: [REDACTED]
DATE: 11/07/98

UNIT #: [REDACTED]

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

CHIEF COMPLAINT: Found unconscious.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old Mexican-American male who is a [REDACTED] student. He was found by his roommate unresponsive in the bathroom this evening. He was brought by [REDACTED] squad to [REDACTED]. According to the roommate and friends, this gentleman has lost about 50 lbs in the last several weeks to months taking a diet pill that was a combination of ephedrine, caffeine, and Ibuprofen. He supposedly has not been taking this medication recently. He had been sleepy over the last couple of days. He took a nap at about 3 o'clock in the afternoon and that is the last roommate saw him until he found him unresponsive. The roommate saw some blood on the couch and on the floor and this was a small amount of blood. He has no prior history of any drug abuse or drug use. He has no prior history of coronary disease. The roommate states that he has not been complaining of headaches, double vision, or blurred vision. One of his friends stated that he had passed out at work a couple of weeks ago, but that is the only other thing that they now there. In the emergency room he was unresponsive and needed to be intubated and ventilated. He had a great deal of some hematemesis in the emergency room. He remained unresponsive and unconscious in the emergency room. The initial blood gases showed a pH of about 6.8. He did have hyperglycemia on his profile with a blood sugar of 440. His sodium was 126, potassium was 4.6, chloride 97, and his CO2 was 8. He had an elevated BUN and creatinine of 27 and 2.2. His screen was negative for Acetaminophen and Salicylate. His clotting studies were normal. His initial hemoglobin was 16.1 and hematocrit 45.9. His white count was elevated at 21,900. His EKG showed a tachycardia. His urine was positive for glucose and ketonic.

PAST MEDICAL HISTORY: From the nurse at the [REDACTED] this gentleman did not have any listed problems on his medical form. The emergency room doctor, Dr. [REDACTED] talked to the parents on the phone and stated there was a family history of diabetes. Again, he was on no current medications that we knew about.

SOCIAL HISTORY: Will be obtained.

PHYSICAL EXAMINATION

GENERAL APPEARANCE: This is an unresponsive Mexican-American male being ventilated.

SKIN: Normal turgor without petechiae or rashes.

HEENT: Head was normocephalic. No evidence of trauma. His eyes were somewhat conjugated up. His pupils were equally round and reactive to light. Nose: Showed no significant lesions. He had an ET tube placed in his mouth.

NECK: His neck had no lumps or masses. There was no thyromegaly.

LUNGS: His lungs were clear to auscultation and percussion. Breath sounds were heard on both sides as he was being ventilated.

CARDIAC EXAM: PMI was not appreciated. There were no heaves or thrills noted. S1 was normal; S2 was physiologically split. He was tachycardic. No gross murmurs, rubs

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HISTORY AND PHYSICAL EXAMINATION

NAME: [REDACTED]
ROOM: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]
AGE: 19

ACCOUNT NUMBER: [REDACTED]
DATE: 11/07/98
UNIT #: [REDACTED]

or gallops.

ABDOMEN: His abdominal exam had multiple striae. There was no organomegaly, no masses, guarding or rebound.

GU AND RECTAL: Deferred. A rectal exam was done by Dr. [REDACTED] which was Hemoccult positive. There was some blood coming out of NG tube and also present in the nares.

EXTREMITIES: No clubbing, cyanosis, or edema.

NEUROLOGIC: Neurologically, he was unresponsive and unconscious. There was no purposeful movements. His eyes were somewhat in a conjugate gaze, upward. Both toe signs were positive, present. He was not hyperreflexic. There was no clonus noted.

IMPRESSION:

1. Unconsciousness, possibly secondary to diabetic ketoacidosis but especially with an elevated sugar and significant acidosis on his blood gas. Other considerations for this event could be an arrhythmia causing a hypoxic encephalopathy, an arrhythmia secondary to the caffeine and ephedrine he had been taking. A third possibility would be a drug overdose. A fourth possibility could be that he had a seizure, bit his tongue and had hypoxic encephalopathy secondary to that.

2. He has some renal failure with elevated BUN and creatinine.

3. He has GI bleeding, etiology undetermined.

PLAN: See orders. Dr. [REDACTED] has been consulted will assist in his care. Dr. [REDACTED] has also been consulted.

His CAT scan was read by Dr. [REDACTED] and had a lot of motion artifact but did not show any gross bleeding and no gross hydrocephalus or midline shift.

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3/5/99 GJH

[REDACTED] M.D.

D: 11/07/98 2340
T: 11/07/98 2343

000004

[REDACTED]

CONSULTATION REPORT

PATIENT NAME: [REDACTED]
CONSULTING PHYSICIAN: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]

ACCT # [REDACTED]
ROOM: [REDACTED]
AGE: 19
UNIT # [REDACTED]

DATE OF CONSULTATION: 11/08/98

CHIEF COMPLAINT: Unresponsiveness.

HISTORY OF PRESENT ILLNESS: This is a 19-year-old young man with no known past medical history who was found at approximately 9:00 p.m. tonight by his college roommate. He apparently was found sitting cross-legged in the corner of a room in an unresponsive state. EMS was called and he was taken to the emergency room. We do not have the EMS sheet available for review at this time but his blood pressure in the emergency room was in the low 70's systolic upon arrival and while in a supine position. His pupils were reactive but his eyes were deviated upwards. The patient was unresponsive. He was given Narcan and a benzodiazepine reversal agent which provided no change in the patient's condition. His initial blood work showed a blood sugar of 444 and a blood gas showed a pH of 6.85. Tox screen as done and was negative on preliminary. His myoglobin was over 5,000. He did not improve or awaken and was intubated.

PAST MEDICAL HISTORY: Unknown at this time but he apparently was taking an over-the-counter diet and energy pill. There is a strong family history of diabetes and his roommates do report that he had been going to the bathroom quite often. There was no history of IV drug abuse or illicit drug use. There is no history of alcohol or cigarette use.

PHYSICAL EXAMINATION: On exam, the patient is lying in bed on a ventilator. He is demonstrating good tidal volume and spontaneous respirations. He demonstrates no response to visual or verbal impulse. His eyes are disconjugate in primary gaze. They are deviated upward and the right eye appears to also demonstrate an exotropia, being deviated laterally to the right. His pupils are 5 down to 3 bilaterally and the cornea appears cloudy. The disks appear flat. Vestibular ocular reflex was impaired. He did have a gag and his heart rate was regular and his blood pressure was now 120 systolic after a bolus of IV fluids. Motor and sensory exam showed no response to painful stimuli in any of his 4 extremities. Deep tendon reflexes were absent and his toes were upgoing on the left and equivocal on the right.

IMPRESSION: This 19-year-old gentleman presents in a comatose state in association with hyperglycemia as well as significant hypotension in a metabolic acidosis. He has an elevated CPK which may be related to his seizure or maybe related to having been found sitting in this position for approximately 6 hours. He was last seen at 3:00 p.m. I am very concerned at this time about a hypoxic central nervous system insult. We cannot rule out a seizure at this time but I do recommend loading him with Dilantin, given the blood in his mouth as well as the high myoglobin. We will have to watch his blood pressure carefully. A repeat CT scan will be arranged. We will follow his blood work as well.

Thank you for this consultation.

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000005

CONSULTATION REPORT

PATIENT NAME: [REDACTED]
CONSULTING PHYSICIAN: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]

ACCT: [REDACTED]
ROOM: [REDACTED]
AGE: 19
UNIT: [REDACTED]

CC: [REDACTED]

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

D: 11/08/98 0035

T: 11/08/98 0042

[REDACTED] M.D.

000006

[REDACTED]

CONSULTATION REPORT

PATIENT NAME: [REDACTED]
CONSULTING PHYSICIAN: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]

ACCT #: [REDACTED]
ROOM: [REDACTED]
AGE: 19
UNIT #: [REDACTED]

DATE OF CONSULTATION: 11/08/98

HISTORY OF PRESENT ILLNESS: This is a 19-year-old Hispanic male admitted now through the emergency department to Dr. [REDACTED] service in an unresponsive state. The history is not entirely clear but apparently some friends saw him lying on the couch in his room at around 3:00 p.m. He was reportedly found at around 9:00 p.m. in his room sitting cross-legged in the corner of the room and unresponsive. EMS was contacted and he was brought in to the emergency department. Apparently there was some blood on the floor near where he was sitting. Upon arrival here, he was attended by Dr. [REDACTED]. Initial blood gases showed severe metabolic acidosis with a pH of 6.85. His PCO2 was low at 16. His sugar was elevated at 444 and serum acetone was positive. He also was found to have some renal insufficiency with a creatinine of 2.2 and a BUN of 27. Acute MI screen showed markedly elevated myoglobin at 5,834 and troponin was normal. Drug screens for salicylate, acetaminophen, and alcohol were all negative. The patient was given IV normal saline wide open because he was hypotensive with a systolic pressure of 76. He was tachycardic in the mid 140's. He was unresponsive to painful stimuli. Eyes were noted to be rolled upward. NG tube was placed into the stomach and significant amount of dark brown Hemoccult positive material has been withdrawn. I was asked to see the patient in consultation to help with the above problems. It is noteworthy that the patient has been on a diet program since about June of this year to lose weight. He has been successful in losing about 40 to 45 pounds of weight. He has been using an over-the-counter health food supplement for the purpose of weight loss and the name of this product is "Hydroxycut". This product contains quantities of ephedrine, caffeine and hydroxycitric acid in addition to some other components. Friends also note that the patient has had excess urination for at least the past month. His parents report that he has had noted some blurred vision. According to all people contacted, he has not been a user of street drugs.

MEDICATIONS: Hydroxycut.

PAST MEDICAL HISTORY: The family denies any significant illnesses other than the usual illnesses of childhood.

PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure 76 systolic, pulse 144.

GENERAL: This is an obese Hispanic male who is unresponsive to painful stimuli at this time.

HEENT: Normocephalic. Pupils are dilated but reactive to light. The eyes are deviated superiorly. Funduscopic examination reveals somewhat cloudy-appearing cornea. The disks are sharp. The tympanic membranes are clear on the left with a slight amount of cerumen on the right. There is an endotracheal tube in the mouth and that was not examined.

NECK: Supple.

LUNGS: The lungs were initially clear in the emergency department. However, after the second unit of normal saline, he does have some faint expiratory wheezing.

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[REDACTED]

CONSULTATION REPORT

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CFSAN ARMS PROJECT 15266
3/5/99 GJH

PATIENT NAME: [REDACTED]
CONSULTING PHYSICIAN: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED]

ACCT #: [REDACTED]
ROOM: [REDACTED]
AGE: 19
UNIT: [REDACTED]

HEART: Regular rhythm with a tachycardia.

ABDOMEN: Soft, bowel sounds hypoactive. No organomegaly or masses palpable.

EXTREMITIES: No cyanosis or edema.

NEUROLOGIC: He is unresponsive to sternal rub. There is a slight Babinski present in the left foot.

LABORATORY: The significant data was noted above. Hemoglobin was normal at 16.1. SGPT and SGTP were very slightly elevated. The urinalysis shows a specific gravity of 1.025. There is some proteinuria. Casts were noted. Tox screen was negative. Electrolytes revealed hyponatremia with a sodium of 126.

IMPRESSION:

- 1. Diabetic ketoacidosis.
- 2. Hyponatremia.
- 3. Renal insufficiency.
- 4. Unconscious state, rule out hypoxic encephalopathy.
- 5. Obesity with recent weight loss.
- 6. Upper gastrointestinal hemorrhage, rule out peptic ulcer disease.
- 7. Ephedrine use--"Hydroxycut".
- 8. Bronchospasm.

RECOMMENDATIONS: I agree with the program you have initiated; that is, generous IV fluids with normal saline. He has just completed his second liter of normal saline and will now receive normal saline with potassium supplement. He should have blood sugars and potassium and sodium checked every 4 hours initially. Due to the onset of some bronchospasm, I am going to add Atrovent by inline aerosols every 4 hours. Certainly the hemoglobin will need to be followed closely and he is typed and crossed for blood if needed. I will be happy to follow this patient along with you medically and manage the ventilator until he is stabilized. As we discussed, neurologic consultation is desirable and Dr. [REDACTED] has been contacted in this regard.

[REDACTED]

D: 11/08/98 0111
[REDACTED]

T: 11/08/98 0116 [REDACTED]

M.D.

[REDACTED]

000008



HISTORY AND PHYSICAL

Patient: [redacted] Reg#: [redacted] Unit#: [redacted]

Patient Status: [redacted] Clinic Code: [redacted]
Room: [redacted] Adm: 11/08/98 Dis: [redacted]

Atd Phys: [redacted]
Dct By: [redacted]
PCP Phys: [redacted]

Document ID: [redacted] Document Type: HP
Date Typed: 11/12/98 By: [redacted]
Date Dct: 11/10/98 1809 PC: [redacted]

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CHIEF COMPLAINT: Coma, elevated blood sugar.
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CFSAN ARMS PROJECT 13266
3/5/99 GJH

HISTORY OF PRESENT ILLNESS:
This is a 19-year-old male who was admitted as a transfer from [redacted]. The patient was directly admitted to the intensive care unit. The patient per [redacted] records was found by his roommate at college unresponsive six hours after having last seeing him. The patient was found in the bathroom on the floor. There was some blood noted, unknown quantity, on the floor of the bathroom and on the couch in the room. The patient had lost 40-50 pounds over the past several months, and was taking a product called Hydroxycut. This product contained, among other ingredients, ephedrine, caffeine, ibuprofen, and hydroxycitrates. The patient, per family, had also had polyuria for several weeks. The patient was treated for less than one day at [redacted] prior to being transferred. Initially at [redacted] the patient had a pH of 6.85 and blood sugar of 440 with ketones. The patient was loaded with Dilantin at [redacted] and intubated and transferred to [redacted].

PAST MEDICAL HISTORY:
None.

PAST SURGICAL HISTORY:
None.

ALLERGIES:
None.

Signature
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HISTORY AND PHYSICAL

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

MEDICATIONS:

None, except the over-the-counter Hydroxycut.

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

SOCIAL HISTORY:

Nonsmoker, non drug abuser, questionable alcohol use.

FAMILY HISTORY:

Diabetes mellitus.

REVIEW OF SYSTEMS:

Unable to be obtained as the patient is intubated, other than what is given in the HPI.

PHYSICAL EXAMINATION:

On presentation to the intensive care unit, blood pressure 138/63, pulse 84, temperature 36.7, oxygen saturation 100%. Patient on a ventilator with tidal volume of 800, assist control 10, respiratory rate of 24.

GENERAL APPEARANCE: The patient is intubated, responds to deep pain with flexion of the upper extremities, otherwise is unresponsive. Eyes are open.

HEENT: Pupils are equal and reactive to light. Tympanic membranes are without bulging or erythema. No JVD or carotid bruit noted. No lymphadenopathy noted.

HEART: Regular rate and rhythm. No S3, No S4, no murmurs.

LUNGS: Clear to auscultation bilaterally without rales, rhonchi, or wheezes.

ABDOMEN: Soft, no bowel sounds noted. No organomegaly noted.

GU: Normal male genitalia without masses.

RECTAL: Normal tone. Heme negative.

EXTREMITIES: There is no edema, clubbing, or cyanosis. Pulses are 2+ in all four extremities distally.

Signature

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[REDACTED]

HISTORY AND PHYSICAL

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

NEUROLOGICAL: Exam limited secondary to patient's altered mental status and decreased level of consciousness. However, reflexes are equal in the upper and lower extremities and toes are upgoing bilaterally and flexion response to painful stimulation of the upper extremities.

On chest x-ray the ET tube is in good position. Lungs are without infiltrates.

LABORATORY DATA:

On presentation to the ICU, pH of 7.31, CO₂ of 19, pO₂ of 114, bicarb of 9. White blood cells 6.6, H&H 14.5 and 42, platelets 117, ketones 1:32, ionized calcium 5.16. Electrolytes: Sodium 137, potassium 2.7, chloride 108, bicarb 13, BUN and creatinine 40 and 2.4, glucose 332, PT is 11.9, INR 1.1, PTT 24.1, amylase is 655, lipase is 5,078, alk phos 116, albumin 2.5, total bilirubin 0.4. CPK of 24,000, myoglobin of 58,000. These labs were from [REDACTED] LVH 4,109. CT scan from [REDACTED] was brought with the patient. It is of poor quality secondary to motion and being a copy. There does not appear to be any brain mass or brain hemorrhage. However, it is of poor quality. CT scan of the abdomen does reveal apparent free air in the mediastinum.

ASSESSMENT:

1. Diabetic ketoacidosis.
2. Altered mental status, coma.
3. Pancreatitis.
4. Hepatitis.
5. Acute renal failure insufficiency.
6. Rhabdomyolysis.
7. Upper GI bleeding.
8. Hypokalemia.
9. Mediastinal free air.

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 CFSAN ARMS PROJECT 13266
 3/5/99 GJH

PLAN:

The patient is admitted to MICU. The patient was placed on an insulin drip and aggressive IV fluid management with bicarbonate. Pulmonary artery catheter will be placed to manage IV fluids. Electrolytes, including phosphorus, calcium, magnesium, potassium will be managed and repleted. Blood glucoses will be checked q1h and insulin will be titrated. Neurology will be consulted, Dr. [REDACTED] The patient will be continued on Dilantin.

Signature

000011



HISTORY AND PHYSICAL

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

Nephrology will be consulted, Dr. [REDACTED] group. The patient is on renal dose dopamine and this patient was discussed with Dr. [REDACTED]

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CFSAN ARMS PROJECT 13266
3/5/99 GJI

Signature

000012

CONSULTATION

Patient: [redacted] Reg#: [redacted] Unit#: [redacted]

Patient Status: [redacted] Clinic Code: [redacted]
Room: [redacted] Adm: 11/08/98 Dis: [redacted]

Atd Phys: [redacted]
Dct By: [redacted]
PCP Phys: [redacted]

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

Date of Consult: 11/14/98
Requesting Dr: Dr. [redacted]
Consulting Dr: Dr. [redacted]

Document ID: [redacted] Document Type: CO
Date Typed: 11/15/98 By: [redacted]
Date Dct: 11/14/98 10:48 PC: [redacted]

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The patient is a 19-year-old Hispanic male who in order to try and lose weight was taking over the counter medications that contained Motrin, caffeine and other compounds. He had lost 40-50 pounds over the last several months but was found in his dorm room by his roommate around 11/7 or 11/8 unconscious, lying on the floor, with evidence of having vomited blood. The patient was taken to [redacted] where he was found to have sever elevated blood sugar, severe acidosis. He was intubated, placed on a ventilator. He was transferred here to the intensive care unit where he was found to have anoxic brain injury with probably an infarct, possibly in the hippocampal area on MRI, severe pancreatitis, renal shutdown and renal failure, now currently requiring dialysis, very high liver functions, extensive muscle breakdowns wit high CPK's. He also initially had evidence of a pneumomediastinum on his x-ray and CT. He had evaluation of the esophagus to try and determine whether he had esophageal rupture during the time of the vomiting, however, there was no signs of any problems there, and the pneumomediastinum resolved spontaneously on its own. The patient has been running high fevers ever since he was brought in. He was initially treated as an outpatient with Timentin. When he was brought in here he was placed on Zosyn and was given doses of Vancomycin but continues to rune fevers. He has not had any documented infection and we were asked to see the patient in consultation. There was no history of any allergies. The rest of the past medical history is really fairly unremarkable.

FAMILY/SOCIAL HISTORY:
Family and social history as per the chart.

REVIEW OF SYSTEMS:
Unobtainable.

PHYSICAL EXAMINATION:
The patient has been running temperatures up to 102 almost daily. His hemodynamics have been fairly stable, however. He is starting to wake up a little bit and yesterday apparently did nod his head and follow commands somewhat, but he continues with a dysconjugate gaze and evidence of CNS damage.

Signature

000013

CONSULTATION

Patient: [REDACTED] Reg#: [REDACTED] Unit#: [REDACTED]

His neck has been supple. There is no evidence of any nasal drainage at all. He is intubated and is suctioning small amounts of light tan secretions. Sputum in the past has not suggested any evidence of infection. He does have infiltrates on his chest x-ray which could be compatible with ARDS. His lungs are fairly clear anteriorly. Cardiovascular exam is unremarkable. His abdomen is soft, does not appear to be tender at this point in time. He is not putting out any stool. He does have stool in the rectal vault. He has NG output which is non-bloody. He has an indwelling Foley and the urine is clear. His extremities show no evidence of cellulitis, skin breakdown or lesions. No embolic lesions.

White count has been fairly normal since the time of admission. He had one out of two blood cultures on the ninth and one out of two blood cultures on the tenth with coag negative Staph. Blood cultures on the 12th were all negative. Again, no other cultures have been positive and no other evidence of infection. His amylase is coming down. His liver functions seem to be improving. CPK levels are starting to come down. He continues to have renal failure and is on dialysis for that.

IMPRESSION:

I suspect that his fevers are related to extensive tissue breakdown with severe pancreatitis, muscle breakdown, hepatitis from anoxic injury and also his fevers may in part be central in origin related to hypoxic encephalopathy and possibly brain stem anoxic injury.

At this point in time I do not see any evidence of ongoing infection and to keep him on broad spectrum antibiotics is only like to select out multiresistant organisms and/or problems with VRE, MRSA or fungal superinfections. Therefore I have gone ahead and DC'd his antibiotics. We will re-culture him off of antibiotics and watch to see how he does.

This situation was discussed with Dr. [REDACTED]. Thank you for allowing us to see this patient in consultation. We will follow along with you.

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

[REDACTED]

Signature

000014

[REDACTED]

CONSULTATION

Patient: [REDACTED] Reg#: [REDACTED] Unit#: [REDACTED]

Patient Status: [REDACTED] Clinic Code:
Room: [REDACTED] Adm: 11/08/98 Dis:

Atd Phys: [REDACTED]
Dct By: [REDACTED]
PCP Phys: [REDACTED]

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CFSAN ARMS PROJECT 13266
3/5/99 GJH

Date of Consult: 11/09/98

Requesting Dr: [REDACTED]
Consulting Dr: [REDACTED]

Document ID: [REDACTED]
Date Typed: 11/10/98
Date Dct: 11/09/98 1131

Document Type: CO
By: [REDACTED]
PC: [REDACTED]

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REASON FOR CONSULTATION:

Rising BUN and creatinine, electrolyte imbalance, dehydration, low phosphorus, low calcium, etc, for further evaluation and management.

I have reviewed the chart and x-rays, examined the patient. For details, please see the excellent notes written by the various physicians involved with this case.

Basically, in short, Mr. [REDACTED] is 19-years-old (college student). He is unconscious at this time, and therefore, most of the information is obtained from the chart, the house doctor, Dr. [REDACTED] and from both parents.

Apparently he was doing reasonably well as per parents all along, except that he was trying to lose weight. His usual weight is 260 pounds and he lost about 40 to 50 pounds of weight in the last three months or so. The patient was taking the Hydroxy-cut which contains Ephedrine, caffeine and ibuprofen and hydroxy citrate.

By his roommate he was found to be unconscious on 11/7/98 in the room and also found some blood in the bathroom and also on his bed. The patient was brought to the [REDACTED] in [REDACTED] where I understand the patient was at about 12 hours. There the patient was found to have pH 7.08, bicarb 8, sodium 126, BUN 27 and creatinine 2.2, amylase of 765, lipase of 478. Serum myoglobin was 5834. For all these problems, and further management, the patient was transferred to [REDACTED] yesterday. The patient's urine output remained low and BUN and creatinine remained high. He also had a problem with electrolyte imbalance with low phosphorus, etc; therefore we have been called in consultation for further evaluation and management.

As dictated above, the patient is unconscious. Therefore, not much history could be obtained. According to both parents, the patient does not have any disease in the past. He is not taking any medication except now for the

Signature

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CONSULTATION

Patient: [REDACTED] Reg#: [REDACTED] Unit#: [REDACTED]

weight. He has been taking this Hydroxy-cut. The parents also deny any history of diabetes, hypertension, or any other illness.

FAMILY HISTORY AND SOCIAL HISTORY:

Does not smoke and does not drink. There is no family history of renal disease except the grandma had one kidney taken out, and other kidney functions pretty good. She also has diabetes. One of his aunts has diabetes.

REVIEW OF SYSTEMS:

Integument: No skin rash.

HEENT: Vision is grossly normal. There is no ear discharge.

Cardiovascular: No history of shortness of breath, PND, orthopnea, or chest pain.

Respiratory: No history of cough.

GI: No history of nausea, vomiting, diarrhea.

GU: No history of dysuria, pyuria, or hematuria.

Neurological: No history of CVA, TIA.

It is also noted that the review of systems is obtained from the family (parents).

PHYSICAL EXAMINATION:

On examination, the patient is unconscious, intubated, on a respirator. There is no peripheral edema present. There is minimal puffiness over the face. Neck veins were difficult to see. Mucous membranes seems to be on the wet side. Chest is clear to auscultation and percussion. Heart tones are normally heard. I could not hear distinct gallop, pericardial rub or hemodynamically significant cardiac murmur. The abdomen is mildly distended, soft and not tender. One can see the multiple striae of the recent weight loss. I could not feel the kidneys on bimanual examination. There is no CVA tenderness present. The rest of the examination as per the other services including Dr. [REDACTED]

PERTINENT LABORATORY DATA:

For details, please see the renal flow sheet. At [REDACTED] on 11/7 and 11/8/98, shows BUN 27 to 41, creatinine was 2.2 to 2.6. pH was 7.08, bicarb 7 to 8, sodium 126 to 133. The serum amylase was 765, lipase was 478, serum myoglobin was 5834.

During the admission over here, yesterday BUN 40 and creatinine 2.4, bicarb 13, pH 7.30. Amylase 655, lipase 5078.

Today BUN 45, creatinine 3.8, sodium 133, potassium 3.1, chloride 109, bicarb 17, Hemoglobin is 10 with a hematocrit of 29. Platelet count 55,000. Phosphorus is less than 0.5, total calcium 7.8, ionized calcium 4.32.

Chest x-ray does not show any evidence of congestive heart failure.

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Signature

000016

[REDACTED]

CONSULTATION

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

IMPRESSION:

1. The patient most likely has acute renal failure, the cause of it is not certain, possibly secondary to:
 - A. Acute pancreatitis.
 - B. Acute myoglobinuria.
 - C. Hypotension.
 - D. Volume depletion with dehydration.
 - E. Rule out obstruction, etc.
2. The patient has dehydration.
3. Electrolyte imbalance with low potassium, low phosphorus, low calcium and also has significant metabolic acidosis which is getting better.
4. History of hypotension.
5. History of possible GI bleed.
6. History of acute pancreatitis.
7. History of diabetes mellitus during this admission.
8. Rule out hepatitis during this admission.
9. Obesity.
10. The rest of the diagnoses as per other physicians.

PLAN & SUGGESTIONS:

1. IV dopamine drip.
2. IV Lasix and Lasix drip.
3. IV Diuril.
4. IV phosphorus replacement.
5. IV calcium replacement.
6. IV potassium replacement.
7. IV 5% dextrose in normal saline at this time.
8. Check the lab reports, especially like calcium, phosphorus, lytes every four hours and other labs less often, like every 12 to 24 hours.
9. Check ultrasound of the kidney examination.
10. Check chest x-ray.
11. Discussed with both parents about the renal status, and the possibility of dialysis and complications like low blood pressure, cardiac arrest, death, infection, bleeding, etc. They understand it. I have discussed with Dr. [REDACTED] the house staff, and also with Dr. [REDACTED]
12. Prognosis is poor.
13. Will watch with you.

Thank you for allowing us to participate in the management of this interesting and complicated patient.

cc: [REDACTED]

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S [REDACTED]

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[REDACTED]

CONSULTATION

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PATIENT NAME: [REDACTED]
REG. NUMBER: [REDACTED]
UNIT NUMBER: [REDACTED]
PATIENT STATUS: [REDACTED]
CLINIC CODE: [REDACTED]
ROOM NUMBER: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED] M.D.
DICTATING PHYSICIAN: [REDACTED]
CONSULTING PHYSICIAN: [REDACTED]
REQUESTING PHYSICIAN: [REDACTED] M.D.
DATE OF ADMISSION: 11/08/98
DATE OF CONSULTATION:
DATE OF DISCHARGE:
FINANCIAL CODE: [REDACTED]
PC PHYSICIAN: [REDACTED]

REASON FOR CONSULT: Coma.

HISTORY OF PRESENT ILLNESS: This 19-year-old Hispanic male, previously healthy, with loss of 40-50 lbs. in the past 3-4 months using hydroxy cut as a diet medicine, stopped using this recently and was seen by friends at 3:00 p.m. on 11/7, lying on the couch and acting normal. At 9:00 p.m. he was found by friends to be unconscious on the floor with a slight amount of blood around the body, with no pill bottles nor suicide evidence noted. He was taken to [REDACTED] at that time. He was intubated and best motor response was flexion/withdrawal. At [REDACTED] they noted no seizure activity and the systolic blood pressure was 76. Laboratory studies showed him to have pH of 6.85, pCO2 of 16, blood sugar 444, bicarb 5, sodium 126, creatinine 2.2., BUN 27, and myoglobin 5834.

On examination they also found him to be tachycardia in the 140s and he had guaiac positive GI aspirate by N/G. Pupils were dilated, but responsive and he had slight left foot Babinski.

PAST MEDICAL HISTORY: None.
PAST SURGICAL HISTORY: None.
ALLERGIES: None.
MEDICATIONS: None, except for the hydroxy cut.
SOCIAL HISTORY: Unknown.

[REDACTED]

CONSULTATION

PATIENT NAME:
REG. NUMBER:
UNIT NUMBER:
PAGE 2



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FAMILY HISTORY: Unknown.

REVIEW OF SYSTEMS: Limited because of the patient's comatose state.

PHYSICAL EXAMINATION: Exam shows him to be a well-developed, well-nourished, Hispanic male who appears to weigh approximately 160-170 lbs. He is slightly obese with oral endotracheal tube in place, N/G tube in place with a Glasgow coma scale of 5, with best motor being decorticate posturing. Cranial nerves are unable to be appreciated except for good corneal reflexes and he does have a slight blink, showing cranial nerves V and VII to be intact. Sensory is unknown. Deep tendon reflexes are 1+ throughout. He does have bilateral equal Babinski. Vital signs show a temperature of 99.4, blood pressure 94/46 by arterial line, tachycardic in the 130s. He is on a ventilator with respiratory rate of 16. Pulse ox is 98%. Skin is warm and dry without lesions or rashes or track marks. The HEENT shows him to be normocephalic, atraumatic. Pupils are 3 mm, equally reactive. The corneas are clouded and covered with mucus. He does have some slow horizontal movement of eyes. Funduscopic is unable to be performed because of the mucus over the corneas. Ears show normal external ears and canals. TMs clear, nonbulging. No hemotympanum. Nose symmetrical with midline septum. Mouth- good dentition. ET tube in place. Neck- No JVD, lymphadenopathy or bruits. Cardiovascular- Regular rate and rhythm- tachycardic without murmurs or gallops. Lungs are clear to auscultation bilaterally. Abdomen soft, nontender, nondistended. Bowel sounds positive. Extremities- Are cool and dry with no trauma noted. Faint pulses radially bilaterally.

LABORATORY EXAMS: Shows him to have abnormal labs which include a potassium 2.9, bicarb of 9, creatinine 2.9, blood sugar 305, white blood cell count 15.2. Serum osmolality 323. Ketones 1:32. Myoglobin 24,000. CPK 16,000. Amylase 765. Lipase 478. ALT-90, AST-246.

Head CTs from [REDACTED] which was done 11/7-11/8, show some evidence of cerebral edema, but otherwise no intracerebral hemorrhage, no hydrocephalus, but very limited reading because of artifact of what appears to be motion. Swan-Ganz catheter, which was just placed previous to my seeing him, showed a wedge pressure of 5.



CONSULTATION

PATIENT NAME:
REG. NUMBER:
UNIT NUMBER:
PAGE 3



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ASSESSMENT AND PLAN:

- 1. This is a 19 year-old Hispanic male in comatose state with DKA, pancreatitis, metabolic acidosis, hepatitis, rhabdomyolysis.

Most likely, this is of metabolic origin, but possible hypoxic encephalopathy. There is possible toxidrome involved, but many of the pieces do not fit together nicely. Because of the bilateral Babinski and decorticate posturing, the prognosis is poor. Therefore, we will get repeat CT of the head.

- 2. Possible seizure disorder.

This certainly would not account for the extent of his rhabdomyolysis. He is on Dilantin. We will continue Dilantin and get an EEG in the morning, a dilantin free and total level in the morning.

- 3. GI bleed.

The patient does have continued good and normal hemoglobin, therefore I doubt this is a significant factor or probably a result of his underlying pathology.

I spoke with Dr. [redacted] and Dr. [redacted]

[redacted]
D:11/08/98
T:11/08/98
[redacted]



[REDACTED]

HISTORY AND PHYSICAL

Patient: [REDACTED] Reg#: [REDACTED] Unit#: [REDACTED]

Patient Status: [REDACTED] Clinic Code:
Room: [REDACTED] Adm: 11/08/98 Dis:

Atd Phys: [REDACTED]
Dct By: [REDACTED]
PCP Phys: [REDACTED]

Document ID: [REDACTED]
Date Typed: 11/12/98
Date Dct: 11/10/98 1809

Document Type: HP
By: [REDACTED]
PC: [REDACTED]

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CHIEF COMPLAINT:

Coma, elevated blood sugar.

HISTORY OF PRESENT ILLNESS:

This is a 19-year-old male who was admitted as a transfer from [REDACTED]. The patient was directly admitted to the intensive care unit. The patient per [REDACTED] records was found by his roommate at college unresponsive six hours after having last seeing him. The patient was found in the bathroom on the floor. There was some blood noted, unknown quantity, on the floor of the bathroom and on the couch in the room. The patient had lost 40-50 pounds over the past several months, and was taking a product called Hydroxycut. This product contained, among other ingredients, ephedrine, caffeine, ibuprofen, and hydroxycitrates. The patient, per family, had also had polyuria for several weeks. The patient was treated for less than one day at [REDACTED] prior to being transferred. Initially at [REDACTED] the patient had a pH of 6.85 and blood sugar of 440 with ketones. The patient was loaded with Dilantin at [REDACTED] and intubated and transferred to [REDACTED].

PAST MEDICAL HISTORY:

None.

PAST SURGICAL HISTORY:

None.

ALLERGIES:

None.

MEDICATIONS:

None, except the over-the-counter Hydroxycut.

SOCIAL HISTORY:

Nonsmoker, non drug abuser, questionable alcohol use.

FAMILY HISTORY:

Diabetes mellitus.

REVIEW OF SYSTEMS:

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[REDACTED]

HISTORY AND PHYSICAL

Patient: [REDACTED] Reg#: [REDACTED] Unit#: [REDACTED]

Unable to be obtained as the patient is intubated, other than what is given in the HPI.

PHYSICAL EXAMINATION:

On presentation to the intensive care unit, blood pressure 138/63, pulse 84, temperature 36.7, oxygen saturation 100%. Patient on a ventilator with tidal volume of 800, assist control 10, respiratory rate of 24.

GENERAL APPEARANCE: The patient is intubated, responds to deep pain with flexion of the upper extremities, otherwise is unresponsive. Eyes are open.

HEENT: Pupils are equal and reactive to light. Tympanic membranes are without bulging or erythema. No JVD or carotid bruit noted. No lymphadenopathy noted.

HEART: Regular rate and rhythm. No S3, No S4, no murmurs.

LUNGS: Clear to auscultation bilaterally without rales, rhonchi, or wheezes.

ABDOMEN: Soft, no bowel sounds noted. No organomegaly noted.

GU: Normal male genitalia without masses.

RECTAL: Normal tone. Heme negative.

EXTREMITIES: There is no edema, clubbing, or cyanosis. Pulses are 2+ in all four extremities distally.

NEUROLOGICAL: Exam limited secondary to patient's altered mental status and decreased level of consciousness. However, reflexes are equal in the upper and lower extremities and toes are upgoing bilaterally and flexion response to painful stimulation of the upper extremities.

On chest x-ray the ET tube is in good position. Lungs are without infiltrates.

LABORATORY DATA:

On presentation to the ICU, pH of 7.31, CO₂ of 19, pO₂ of 114, bicarb of 9. White blood cells 6.6, H&H 14.5 and 42, platelets 117, ketones 1:32, ionized calcium 5.16. Electrolytes: Sodium 137, potassium 2.7, chloride 108, bicarb 13, BUN and creatinine 40 and 2.4, glucose 332, PT is 11.9, INR 1.1, PTT 24.1, amylase is 655, lipase is 5,078, alk phos 116, albumin 2.5, total bilirubin 0.4. CPK of 24,000, myoglobin of 58,000. These labs were from [REDACTED] LVH 4,109. CT scan from [REDACTED] was brought with the patient. It is of poor quality secondary to motion and being a copy. There does not appear to be any brain mass or brain hemorrhage. However, it is of poor quality. CT scan of the abdomen does reveal apparent free air in the mediastinum.

ASSESSMENT:

1. Diabetic ketoacidosis.
2. Altered mental status, coma.

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HISTORY AND PHYSICAL

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

3. Pancreatitis.
4. Hepatitis.
5. Acute renal failure insufficiency.
6. Rhabdomyolysis.
7. Upper GI bleeding.
8. Hypokalemia.
9. Mediastinal free air.

PLAN:

The patient is admitted to MICU. The patient was placed on an insulin drip and aggressive IV fluid management with bicarbonate. Pulmonary artery catheter will be placed to manage IV fluids. Electrolytes, including phosphorus, calcium, magnesium, potassium will be managed and repleted. Blood glucoses will be checked q1h and insulin will be titrated. Neurology will be consulted, Dr. [REDACTED]. The patient will be continued on Dilantin. Nephrology will be consulted, Dr. [REDACTED] group. The patient is on renal dose dopamine and this patient was discussed with Dr. [REDACTED].

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DISCHARGE SUMMARY

Patient: [redacted] Reg#: [redacted] Unit#: [redacted]

Patient Status: [redacted] Clinic Code: [redacted]
Room: [redacted] Adm: 11/08/98 Dis: [redacted]

Atd Phys: [redacted]
Dct By: [redacted]
PCP Phys: [redacted]

Document ID: [redacted] Document Type: DS
Date Typed: 03/28/1999 06:39 EST By: [redacted]
Date Dct: 03/24/1999 11:19 EST PC: [redacted]

=====

ADMITTING DIAGNOSES

- 1. Diabetic ketoacidosis, resolved.
- 2. Insulin-dependent diabetes mellitus.
- 3. Renal failure.
- 4. Anemia.
- 5. Upper gastrointestinal bleed.
- 6. Respiratory failure.
- 7. Pancreatitis.
- 8. Coma.
- 9. Obesity.

INFECTIONS: The patient did have infections here and was treated on multiple antibiotics for these nosocomial infections.

PROCEDURES

- 1. Hemodialysis.
- 2. Arterial catheterization.
- 3. Bronchoscopy.
- 4. Esophagogastroduodenoscopy.

HOSPITAL COURSE: This 19-year-old male who was admitted from [redacted] was found unresponsive after being seen with his friends. The patient was found on the bathroom floor. The patient had lost 40 to 50 pounds over the last several months and was taking a weight thinner, Hydroxycut. The patient was found to be initially unresponsive and found to have a pH of 6.85 and a blood sugar of 440, and he had ketones. At that time he was transferred to [redacted]. Upon arrival at [redacted] he was admitted and intubated for respiratory failure and treated for DKA, plus the patient had multiple complications throughout the hospital stay including renal failure which required hemodialysis. He had upper GI bleeding which required transfusion as well as EGD. He also had pancreatitis which resolved slowly. The patient also had bronchoscopy due to pneumonic processes. The patient's sugars were normalized

Date

Signature

000024

DISCHARGE SUMMARY

Patient: [REDACTED]

Reg#: [REDACTED]

Unit#: [REDACTED]

gradually over time. The patient had multiple consults including neurology, infectious disease, gastroenterology, as well as endocrinology. The patient also had multiple lower extremity Dopplers which were negative. The patient gradually improved, becoming more alert approximately November 30, 1998. The patient also had pulmonary consult which was also the primary service, nephrology consult with Dr. [REDACTED] infectious disease with Dr. [REDACTED] gastroenterology with Dr. [REDACTED], neurology with Dr. [REDACTED] rehab with Dr. [REDACTED] and surgery with Dr. [REDACTED] for the trach placement. The patient had multiple problems throughout the stay and as of November 30, 1998, he had DKA which resolved, diabetes mellitus which was requiring insulin, pancreatitis which was continuing at that point, GI bleeding secondary to esophagitis and gastritis which was improving, anemia secondary to the GI bleeding, rhabdomyolysis which resolved, acute renal failure which resolved, hepatitis which resolved, left hippocampal infarct [REDACTED] with right-sided weakness, and altered mental status, improving. He was ventilator-dependent which had been improving as well as he was having unknown causes of fevers. The patient gradually improved over time and was no longer requiring hemodialysis. The patient was also tracheostomized on December 6, 1998. The patient improved by December 7, 1998, was alert and responding with hand gestures. It was felt at that time that the patient could be transferred. The patient ended up being transferred on December 9, 1998. [REDACTED] works for rehab.

CONDITION ON DISCHARGE: Fair.

DISCHARGE MEDICATIONS

1. Carafate 1 g per G-tube q.8h.
2. Insulin NPH 30 units subcu b.i.d. with sliding scale.
3. Prilosec 20 mg per G-tube b.i.d.
4. Tylenol 650 mg per G-tube q.4h. p.r.n.
5. Nembutal 100 mg q.2h. p.r.n. for a total of two doses.
6. Ativan 1 to 2 mg p.o. q.2-4h. p.r.n.
7. Sliding scale insulin; 100 to 200, no change; 201 to 250, 2 units; 251 to 300, 4 units; 301 to 350, 6 units; 351 to 400, 8 units; 401 to 450, 10 units; for greater than 451 call the hospital.

DISCHARGE INSTRUCTIONS: To do Accu-Cheks q.6h. Tracheostomy care as well as cap tracheostomy with O2 to keep saturations greater than 92%. Check amylase and lipase on December 11, 1998.

cc: [REDACTED] MD

Date-----
Signature

000025



MR#: [REDACTED]
Pt. Name: [REDACTED]
Admitted: 12/09/1998
Discharged: 12/31/1998
Physician: [REDACTED]

DISCHARGE SUMMARY

ADMISSION DIAGNOSES

1. Activities of daily living, mobility and cognitive deficits secondary to diffuse ketoacidotic encephalopathy.
2. Diffuse weakness, right side greater than left side.

CONDITION ON ADMISSION: The patient was admitted in stable condition.

ALLERGIES: No known drug allergies.

DIET: G-tube feeds, Peptamen 70 cc an hour.

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DISCHARGE DIAGNOSES

1. Hypoxic encephalopathy.
2. Rhabdomyolysis.
3. Pancreatitis.
4. Improved activities of daily living, mobility, and cognitive level.

CONSULTATIONS: ENT for tracheostomy management. Physical therapy for gait training, ambulation, transfers, range of motion, and strengthening. Occupational therapy for activities of daily living and mobility. Speech pathology for cognitive and speech evaluation. Therapeutic recreation for reintegration and recreation. Social work services for discharge planning.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old, Hispanic male found unresponsive on November 7, 1998, in his college dormitory sitting on the bathroom floor with a small amount of blood found on the bathroom floor and the couch. The patient was last seen in a normal state six hours previous to discovery by a college roommate. The patient was taken to [REDACTED] treated, and transferred to [REDACTED] on December 8, 1998. The patient was found to have diabetic ketoacidosis with a random blood sugar of 440 and a pH of 6.85. The patient was positive for rhabdomyolysis with an MB level of 5834. The patient was noted to have an upper gastrointestinal bleed, pancreatitis, hepatitis, and acute renal insufficiency as well as hypokalemia. The patient required mechanical ventilation, tracheostomy placement on November 25, 1998. The patient required hemodialysis for a short interval. Percutaneous endoscopic gastrostomy tube was placed on December 8, 1998.

PHYSICAL EXAMINATION: On admission for rehabilitation neurologic improvement was noted to be slow. The patient was oriented to person, currently using nods and hand gestures to communicate at times. The patient followed a few simple commands. Vital Signs: Temperature 100.3, respiratory rate 20, pulse 126, blood pressure 144/78.

LABORATORY DATA: On admission glucose was 147, sodium 134, potassium 3.8, chloride 103, calcium 8.8, creatinine 0.5, total protein 6.6, albumin 3, total bilirubin 0.5, SGOT 21, alkaline phosphatase 154, amylase 116, total amylase 110. White blood cell count 12, hemoglobin 11.7, hematocrit 33.5, platelet count 515. Urinalysis, color was yellow, specific gravity 1.027, pH 5, protein +3, negative for nitrates, trace leukocyte esterase, occasional bacteria. Urine culture revealed no growth.

HOSPITAL COURSE: The patient was continent of bladder on admission and discharge, incontinent of bowel on admission and continent of bowel on discharge.

Attention and concentration were reduced. Orientation was intact. Memory remote was intact. Memory recent was reduced. Memory immediate was reduced. Orientation and sequencing was reduced. Problem solving and abstract reasoning were reduced.

Speech language evaluation on admission revealed functional primary language ability. Speech production and intelligibility was poor secondary to aphonia. Reading comprehension was reduced, and written expression was nonfunctional. Cognitive deficits were apparent in attention, memory, and reasoning. On discharge, speech and voice production at the sentence level was adequate for a quiet environment, sustained phonation has improved however. The patient continues to be reduced from expected levels. The patient does not initiate much speech, however responses to auditory or visual stimuli are appropriate at the word or sentence level. Reading comprehension for multi-paragraph level stimuli 100%, immediate recall 80%. The patient was writing sentences with fair legibility. Reasoning for multi-step tasks 85%. Immediate recall for six-unit stimuli 75%.

Functional mobility on admission, posture PPT, kyphotic, decreased control of neck. Balance sitting static poor, dynamic poor. Standing static poor, dynamic poor. Functional mobility dependent. Endurance poor. Bed mobility maximum assistance rolling left to right. Maximum assistance side-lying to sit. Transfers maximum assistance times two. On discharge posture sits in PPT. Balance sitting dynamic good, static good. Standing balance static good, dynamic fair. Functional mobility, ambulatory with standby assistance and straight cane. Endurance good. Bed mobility independent. Transfers basic standby assistance, advanced contact guard assistance to minimum assistance.

Activities of daily living on admission were eating percutaneous endoscopic gastrostomy tube in place. Grooming maximum assistance. Upper extremity dressing maximum assistance. Lower extremity dressing maximum assistance. On discharge eating was independent with regular diet. Grooming independent after setup. Upper extremity dressing independent after setup. Lower extremity dressing independent after setup.

000027

Skin was intact on admission. Edema +1 on admission of bilateral lower extremities. None on discharge.

Education provided for the patient, mother, sister, and father was self care, dressing, hygiene, transfers from mat, bed, toilet, tub, and soft chair. Education for sensation and perceptual deficits. Cognition education mainly for home safety and problem solving. Patient interview arranged for [REDACTED] within three to five weeks.

DISPOSITION: The patient was discharged to home with family providing transportation.

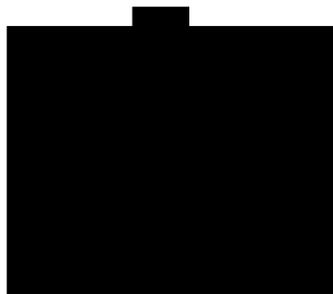
FOLLOW UP INSTRUCTIONS: The patient was to follow up with Dr. [REDACTED] on February 11, 1999; with Dr. [REDACTED] on January 25, 1999. The patient is to have physical therapy, occupational therapy, and speech therapy at [REDACTED]

DISCHARGE EQUIPMENT: The patient was given a straight cane, a bedside three-in-one commode.

DISCHARGE MEDICATIONS: Mirapex 0.25 mg one p.o. t.i.d.

CONDITION ON DISCHARGE: Stable.

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Date Dict: 02/01/1999
Date Trans: 02/02/1999 3:02 [REDACTED]

cc: [REDACTED]

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