

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

ARMS#

13031



5 - SUMMARIES

000001

CONSULT

**** ORIGINAL ****PRINTED: 6/11/98 9:23

BY:

PATIENT: [REDACTED]
MR#/ACT# [REDACTED]
ADM/DSH DATE: 05/28/98 06/02/98
ORDER #: [REDACTED]
DOCTOR: [REDACTED]

NEUROLOGY CONSULTATION REQUESTED BY DR. [REDACTED]
DATE OF CONSULTATION: 5/28/98
CONSULTING PHYSICIAN: DR. [REDACTED]

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08/05/98
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The patient is a 28-year-old female admitted status post a cardiac arrest while playing softball.

The history is from the girlfriend who was an eyewitness. Patient was playing in her second softball game today, probably had not eaten most of the day, had taken her herbalife pill for dieting, had hit a grand slam and was rounding all the bases to home, when, according to a friend, appeared to have difficulty breathing and collapsed with some help to help her down. She did not appear to injure herself when she fell. She was not noted to be incontinent. She apparently was noted not to have a pulse and was become pale and blue. There was no definite seizure activity described but there was some question. CPR was started immediately. Patient was found to be in ventricular fibrillation and required defibrillation three times. She became somewhat agitated and was subsequently sedated in the emergency room with Deprivan and Valium. Patient was intubated, had previously received Lidocaine. There has no history of head trauma or recent illness. CT scan of the head without contrast was negative. Dr. [REDACTED] also viewed this.

The patient had a heart murmur as a child but this was not felt to be significant, according to the mother. There was some questionable history of a DVT at age 16. The patient had not been on birth control pills. There was no history of hypertension, diabetes, previous seizures or loss of consciousness. She has had some history of headache with stress. She had a headache over the weekend while she was in [REDACTED]. There was no associated fever or trauma. When she came home, she apparently was not complaining during the rest of the week. She previously had used Xanax probably several months ago, none recently. No history of known drug abuse or recent smoking. She may have been out last evening and had a few alcoholic drinks but not many, according to the girlfriend, because she was driving.

Mother is alive with a history of hypertension and breast cancer. Father died of lupus. She was two sisters. No neurological history. There is one nephew with seizures. There is no family history of aneurysm.

On exam, her temp was 100.4 rectally, pulse 133, blood pressure 106/60, respirations 28. Patient was intubated.

Mental status: She was sedated, occasionally with spontaneous movement of the extremities would become extremely agitated. No posturing noted currently. Cranial nerves revealed her pupils to be equal and reactive to light. There was no gaze preference. Corneal reflexes were depressed bilaterally. Fundi revealed sharp disc margins without hemorrhages.

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CONSULT

*** ORIGINAL ***PRINTED: 6/11/98 9:23

BY: [REDACTED]

PATIENT: [REDACTED]
MR#/ACT#: [REDACTED]
ADM/DSH DATE: 05/28/98 06/02/98
ORDER #: [REDACTED]
DOCTOR: [REDACTED]

Jugular venous pulsations were seen. Patient was intubated, occasionally would swallow. Motor exam was generally flaccid. Reflexes 2-3+ bilaterally with downgoing toes. There was no clonus. Her neck appeared supple. There was no discharge from her ears or nose.

IMPRESSION: Status post cardiac arrest, questionable etiology, probably arrhythmia, probably some hypoxic encephalopathy, questionable seizure secondary to electrolyte abnormality or cardiac event.

PLAN: Metabolic workup.

Case discussed with PMD and family. Prognosis guarded. LP after informed witnessed consent, EEG.

D: 5/29/98 T: 5/29/98 [REDACTED]

[REDACTED]

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DISCHARGE SUMMARY

*** ORIGINAL *** PRINTED: 6/04/98 16:00
BY: AS/400

PATIENT: [REDACTED]
MR#/ACT#: [REDACTED]
ADM/DSH DATE: 05/28/98 06/02/98
ORDER #: [REDACTED]
DOCTOR: [REDACTED]

DR. [REDACTED]
DATE OF ADMISSION: 5/28/98
DATE OF DISCHARGE: 6/2/98

This is a 28 year old white female, with no significant past medical history, who was admitted with a cardiac arrest secondary to ventricular fibrillation while she was playing softball. She has been taking Herbal Life teas for weight loss for the past couple of weeks prior to admission.

She had CPR in the field. She was brought to the emergency room and intubated prophylactically to protect the airways. Cardiology and neurology consultants were called. She had CT, MRI, spinal tap and all were negative. The patient was transferred to the ICU for monitoring. She was extubated the second day of her admission. She did spike temperatures to as high as 102o with high white count. Chest x-ray was consistent with infiltrates, probable aspiration, post-intubation in nature. She was started on IV antibiotics, to which she did well. She ruled out for MI.

Now she is being transferred to [REDACTED] for EPS studies, as well as cardiac catheterization.

[REDACTED] Med-Scribe
D: 6/2/98 T: 6/3/98 [REDACTED]

[REDACTED]

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CONSULTATION RECORD

REASON FOR CONSULTATION:

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SIGNATURE OF REQUESTING PHYSICIAN

M.D.

DATE

CONSULTATION REPORT:

News (consult dict)

28yo female admitted s/p cardiac arrest while playing softball. Hx from pt friend who was present. Pt played in 2nd softball game; prob. had not eaten all day. Had taken herba-life pill for dieting. Had hit sand storm & was windy base to home when accid to friend appeared to have difficulty breathing & collapsed to help; did not appear to injure self when fell. Noted not to have pulse & becoming pale & blue. No def. seizure activity described. CPR started immediately. Pt in v. fib reg. Defib 3x. Pt came somewhat agitated & sedated to Depivan & valium. Pt intubated & received lidocaine CT head w/o contrast req.

PTX head exam normal recent illness

PTX heart @ as child - not felt to be by accid to mother. Lx DVT age 16 @ SCP

@ HTN @ DM @ seizures @ LOC

Anne OK of HTN & stress. Had HTN over week-end w/ [redacted] @ fever or

fraxime; not complaining during week.

Pres used Xanax post sev. no @ go

No hx known of drug abuse @ recent smoking

S

M.D.

DATE

7/28/98

000005

TATION RECORD

REASON FOR CONSULTATION:

SIGNATURE OF REQUESTING PHYSICIAN M.D.

DATE

CONSULTATION REPORT:

1. Suspected cardiac death / VF arrest.
? Ventricular arrhythmia secondary to VF.
? MI - no acute ECG changes
? Aortic

2. Am. lev.
independent
/ 2D - 62%
Swirl calc / 62%
Will print further w/o if
fr. Genetic Chromosomal Screening.

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SIGNATURE OF CONSULTANT

DATE

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STATION RECORD

REASON FOR CONSULTATION:

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SIGNATURE OF REQUESTING PHYSICIAN

M.D.

DATE

CONSULTATION REPORT:

28/98 28 WF 2 no PMH had v. fib / card arrest
possible seizure activity while running to
home plate during a baseball game.

EKG LVH ST-T's sinus tach

PMH heart murmur - w/o by echo - neg.

DVT

uses diff. diets / diet pills ...

Imps v. fib / card. arrest ? etio
seizure prob 2° to above
hyponatremia, hypokalemia

Plan ICU Admit

Lidocaine if recurrent v. tach ...
cardio / neuro consult

IV saline

strict I/O's

replace KCl

? dilantin

SIGNATURE OF CONSULTANT

M.D.

DATE

000009

SUMMARY SHEET

MEDICAL RECORD #: [REDACTED]
BILLING #: [REDACTED]
ADMIT DATE: 06/02/98
DISCHARGE DATE: 06/05/98
UNIT: ROOM:
SVC: PT STS:

PATIENT NAME: [REDACTED]

AGE: 28

Discharge Summaries must include:

1. Pertinent history and physical findings.
2. Pertinent laboratory, x-ray, and pathological findings.
3. Hospital course (include consultations, complications, procedures performed, operations, and condition on discharge).
4. Discharge recommendations (medications, activity limitations, diet, followup if required, when and by whom).

HISTORY OF PRESENT ILLNESS: Miss [REDACTED] is a 28-year-old female, who was admitted to [REDACTED] post-cardiac arrest. The day of admission to [REDACTED] she had taken Herbalite, which is a supplement, to try to lose weight. All day long, she stated she felt "pepped up" and had palpitations. During a softball game, she had a cardiac arrest with documented ventricular fibrillation. She was successfully resuscitated by the [REDACTED], and taken to [REDACTED] emergency room where she was admitted. Electrocardiogram revealed sinus rhythm with no Q-T abnormalities, and electrolytes were all normal. She had no prior medical history at all; specifically, no history of palpitations, syncope or near syncope. She was transferred to [REDACTED] for a cardiac catheterization.

HOSPITAL COURSE: On June 2, 1998, a complete heart catheterization was performed, which revealed normal left ventricular function, normal coronaries, and normal right heart pressures. Electrophysiology consult was obtained. On June 3, 1998, an electrophysiologic study was performed which revealed no etiology for the ventricular fibrillation arrest. It was determined that, although the electrophysiologic study was negative, an AICD (automatic internal cardioverter-defibrillator) would be indicated due to the patient's documented ventricular fibrillation arrest. The AICD was implanted on June 4, 1998, and the patient tolerated the procedure well. She was discharged to home on June 5, 1998, after being given instructions on her activity, diet, medications, and her AICD. Followup would be with Dr. [REDACTED] group the following week.

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06/05/98
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Dictated By: [REDACTED]

R.N., [REDACTED]

DD: 07/07/98

DT: 07/16/98

[REDACTED]/002

JOB #: [REDACTED]

[REDACTED] M.D.