

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

ARMS#

13110



5 - SUMMARIES

000001

DISCHARGE SUMMARY



DISCHARGE DATE: 7-3-98

LENGTH OF STAY: 1

DISPOSITION: Transferred to [REDACTED]

FINAL DIAGNOSIS:

- 1. Seizure, etiology unclear.
- 2. Altered mental status.
- 3. Respiratory insufficiency despite ventilator treatment.
- 4. Hypotension requiring dopamine drip.

PROCEDURES:

- 1. Intubation and ventilation.
- 2. Lumbar puncture.
- 3. Computerized tomography scan of the head.

**CONFIDENTIAL
INFORMATION**
NOT TO BE FORWARDED WITHOUT
WRITTEN CONSENT OF PATIENT

HOSPITALIZATION SUMMARY: [REDACTED] is a 42 year old divorced white female who was admitted through the Emergency Room with sudden onset of generalized seizure disorder and then combative behavior and apparent confusion. She was seen in the Emergency Room and had been given a total of 10mg of IV Valium without any response. There were no focal neurological findings. Succinylcholine, Valium and Versed all were given without much success. Dr. [REDACTED] anesthesiologist, was able to anesthetize and intubate the patient and she was admitted to the ICU. A lumbar puncture had been done by Dr. [REDACTED] radiologist. The pharmacist, [REDACTED] came in and helped arrange for Cerebyx drip.

Examination at the time of admission showed the patient to be on a ventilator but arousable. There were still no focal neurological findings. Her general physical examination was unremarkable.

LABORATORY DATA: Spinal fluid was clear and colorless with only 1 white cell and 2 red cells. Glucose 78, protein 35. Urine specific gravity 1.030, negative nitrite, 20 white cells, 10 red cells. Her CBC showed WBC of 16.5 with 5 bands and 77 segs. Hemoglobin 12.6, platelets 242. Drug screen was positive for benzodiazepine (given in Emergency Room) plus amphetamines. Protime was 12.5. BMP showed potassium of 3.1, glucose 155, CK up to 347, AST slightly up to 42. CK-MB was 6.49, index was only 1.9 and Troponin T was borderline at 0.18. Initial blood gases on the ventilator showed pH of 7.4, PCO2 30, PO2 52, O2 sat only 87%. Gram stain of the CSF was negative and culture was negative. Chest x-ray was unremarkable except for some prominent central markings. A repeat several hours later showed a pattern consistent with pulmonary edema. Computerized tomography scan of the head on 7-2 was normal.

HOSPITAL COURSE: The patient was admitted to the ICU and was initially maintained on a Versed and Nimbex drip. She was started on some IV Unasyn. Foley catheter had been placed. She was monitored very closely. She was given potassium supplement in the IV. In the early morning hours, she began to develop hypotension and hypoxemia. She was placed on Dopamine to maintain her BP and PEEP was increased to try to maintain the O2 sat at least 90%. Dr. [REDACTED] neurologist [REDACTED] was contacted and arrangements were made to transfer the patient to [REDACTED] for further diagnosis and treatment. At the time of transfer, it was not clear what was causing her initial seizure or her deterioration. Multiple discussions were held with family members.

After evaluation and treatment at [REDACTED] and being maintained on the ventilator for approximately

-- DISCHARGE SUMMARY

Signature _____

000002

DISCHARGE SUMMARY

a week, the patient did eventually make a full recovery. It was determined that she had a severe cardiomyopathy with ejection fraction in the 10-20% range and this was felt to be due to high doses of Ephedrine that were in an herbal diet pill that she had been taking.

dd 7-28-98
dt 7-29-98

-- DISCHARGE SUMMARY

Signature _____

000003

HISTORY AND PHYSICAL EXAMINATION

CHIEF COMPLAINT: This is a 42 year old white female with an episode of loss of consciousness and probable seizure activity this evening.

HPI: The history is sketchy and the patient is unable to talk as she is intubated. The patient works as a dental assistant. She was found unresponsive in a dental chair, not responding to stimuli. She was brought to the E.R. where she was disoriented and combative. She was given a total of 43 mg. of Versed and 10 mg of Valium in the E.R. She was intubated. A head CT was done and was negative for bleed or other abnormality. A toxic screen was done and positive for benzodiazepine, however, this was drawn after she was given Versed. Also positive for amphetamines. In the ICU, the patient is able to answer questions with nodding or shaking her head. She does suggest that she has been using a diet medication.

With a normal head CT, an LP was done. This showed clear fluid, glucose of 78, protein 35. The micro is pending. The WBC is 16.7. CPK is 347. The UA shows 15-25 WBC's, 5-10 RBC's, nitrite negative.

PAST MEDICAL HISTORY: Surgeries - none. Medical - depression. Allergies - no known drug allergies. Medications - OTC diet medication as above.

FAMILY HISTORY: The patient's mother has lymphoma. No other family history is able to be obtained.

SOCIAL HISTORY: The patient works as a dental assistant.

PHYSICAL EXAMINATION

GENERAL: This is an arousible, 42 year old on a ventilator.

VITALS: Temp. 97°. BP 98/60. Pulse 96.

HEENT: Head-atraumatic. Eyes- PERRL, EOMI. Ears - EAC's are clear, TM's clear. Throat - there is an ET tube in place.

LUNGS: Clear to auscultation in all fields.

HEART: Regular rate. Normal S1, S2. No murmurs or gallops appreciated. Carotid upstroke and duration are within normal limits. No JVD is appreciated.

ABDOMEN: Obese, soft. There are active bowel sounds. No guarding or rebound is appreciated. No masses are appreciated.

EXTREMITIES: There is no peripheral edema. No joint swelling or erythema. Strength is 5/5 to grip strength, flexion/extension at the ankles, extensor hallus longus. Reflexes 2+ elbows, knees and ankles bilaterally.

LABORATORY DATA: LP shows colorless fluid, 1 WBC, 2 RBC's, G 78, protein 35. UA shows a specific gravity of 1.030, nitrite negative, 15-25 WBC's, 5-10 RBC's. CBC shows WBC 16.5 with 77 segs, 5 bands, 15 lymphs, 2 mono, 1 eo. Hgb. 12.6, Hct. 36.2. Platelets 242,000. Drug screen is positive for benzodiazepines and amphetamines. Chemistry shows K 3.1, G 155, CK 347. PT and PTT are within normal limits.

ASSESSMENT & PLAN:

1. Episode of LOC, probable seizure. Head CT in the E.R. is negative. She is positive for amphetamines on drug screen. This may be related to her use of an OTC diet medication. LP micro is pending, however, the initial results are benign. A urine culture is pending. Will cover the patient with Cephazolin. She will continue intubation and will monitor overnight.

dd 7-2-98 dt 7-3-98

HISTORY AND PHYSICAL

Signature _____

000004

NAME: [REDACTED]
UNIT #: [REDACTED]
ROOM #: [REDACTED]
ADMITTED: 07/03/98
DISCHARGED: 07/15/98
DOCTOR: [REDACTED] MD

DOB: [REDACTED]
AGE: 42
SEX: F

Dictated by [REDACTED]

CLINICAL RESUME: Patient is a 42-year-old white female who presented to [REDACTED] ER after having a headache, dizziness, lethargy, chest pain and then tonic-clonic seizure. Apparently, the patient had been complaining to the family about some lethargy and headache for three to four days. On the morning of 07/02/98, she went power walking with her sister for about 90 minutes doing 12-minute miles. She then washed the car and went to her job as a dental assistant. She worked all day with no complaints but around 7:30 p.m., she felt increasing headache as well as dizziness with some chest pain. The headache was the greatest complaint, and she felt that it might be a migraine which she has a history of. She lain down and called her sister to bring her contact lenses over. Her blood pressure was taken and was 150/100 at the time. Patient then developed some bizarre behaviors, screaming, kicking and started having seizures. So, 911 was contacted at which time the patient had tonic-clonic seizure. She was given 10 mg of Valium by the paramedics and was taken to [REDACTED] ER. According to the ER note, over the next three or four hours, she was given about 43 mg of Versed, 200 mg of succinylcholine, and additional 10 mg of Valium, 100 mg of Cerebyx to finally calm her down and calm her seizures. CT scan of her head was done which was essentially negative as was her lumbar puncture. Urinary drug screen was taken after Versed showing positive for benzodiazepines and amphetamines. She received an echocardiogram showing severe cardiomyopathy with ejection fraction of less than 15%, and therefore, she was transferred to [REDACTED] for further cardiac management and cardiac catheterization.

CLINICAL COURSE: She was taken to the cardiac cath lab with Dr. [REDACTED] after informed consent given. Catheterization findings revealed a dilated hypokinetic ventricle with reduction in ejection fraction. Her hemodynamics were normal. Her coronary arteries were normal. There was a normal aortic root injection. She was transferred back to the ICU in critical condition on heparin, Dopamine, dobutamine, Versed. Dr. [REDACTED] and Dr. [REDACTED] both were consulted. Patient was sedated and paralyzed to maintain adequate ventilation.

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 2

Blood cultures were obtained. Her chest x-rays were reviewed and showed good position of the T-tube with diffuse bilateral interstitial infiltrates, diffuse and symmetric. It was felt she had multisystem failure, severe hypoxemia and cardiogenic shock. An echocardiogram was performed on 07/06/98 which revealed severe myopathic left ventricle with biventricular dysfunction, mild mitral insufficiency seen and interatrial septal aneurysm with left to right shunting present. There was spontaneous left atrial contrast. An EEG was performed which was remarkable for diffuse theta activity consistent with patient's history of being on Versed. No epileptiform activity was seen. CT scan of the head without contrast was negative. V/Q scan showed low probability for evidence of acute pulmonary emboli but markedly abnormal ventilation study with the appearance of chronic lung disease with retention and peripheral bullae. Cardiac enzymes were obtained which were markedly elevated up to 12,000 with negative MBs. Her AST was up to 150. Albumin was quite low at 2.8 on admission. Her potassium fluctuated and was replaced throughout hospital course. Her kidney function remained stable.

Continued inotropic support and fluids were maintained. She appeared to be neurologically intact, although somewhat sedated in appearance. She started weaning from the ventilator, and on 07/05/98, she had acute sense of dyspnea with desaturations and right parasternal chest pain; therefore, V/Q scan was performed which was unremarkable. She did start to wean off dobutamine and Dopamine as well as heparin. She was started on an ACE inhibitor and digoxin for her poor LV function.

She did develop a fever and, therefore, Dr. [REDACTED] from internal medicine was consulted who recommended urine eosinophils to assure that this was not a drug-related fever as well as checking urine Legionella antigen and urinalysis. She was placed on IV antibiotics. Because of the yeast in the urine, she was started on Diflucan through her NG tube. Viral serologies were also obtained including Coxsackie, Ebstein-Barre and CMV serology. Culture of the line tip was also obtained.

Because of her hypoxemia and respiratory failure with desaturation, weaning from the ventilator was not successful. Prognosis was felt to be guarded because of her severe hypoxemia and respiratory failure. Neurology still continued to follow, and it was felt that there were no neural abnormalities since patient able to write in complete and complex sentences.

[REDACTED]

DISCHARGE SUMMARY

000006

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 3

She slowly continued to improve from a respiratory standpoint with oxygen requirement decreasing and chest x-ray improving. She did have a paroxysmal cough for which was started on propofol which seemed to help. Her propofol was decreased and started to wean her from the ventilator which was successful and complete on 07/11/98. She did have atelectasis on chest x-ray; therefore, a bronchoscopy was performed by Dr. [REDACTED] to rule out plug. She was suctioned clear and extubated.

She continued to be seen by infectious disease. Her blood cultures returned with coag-negative staph sensitive to cefazolin, clindamycin, nafcillin and penicillin. Her temps remained elevated but started to decline while on Unasyn, Cipro and Diflucan as well as Trovan which was ultimately changed to Trovan and fluconazole. HIDA scan and ultrasound of the gallbladder were obtained which revealed dilatation of the common bile duct which may have represented cholecystitis; therefore, HIDA scan was obtained which was negative for gallbladder defect. This was performed because of her persistent right upper quadrant pain. He had favored the pain secondary to passive congestion; therefore, the same antibiotics were continued.

Repeat echocardiogram was performed on 07/13/98 which revealed persistent severe diffuse hypokinesis with markedly depressed ejection fraction; therefore, she was continued on the ACE inhibitor and digoxin. Her blood pressure remained stable, 112 systolic. Pulse was in the 80s. Her rhythm was stable and normal sinus. She symptomatically improved and was switched to p.o. Trovan for her pneumonitis and CHF and Diflucan p.o. was continued for her yeast in her urinary tract. She was diuresed with Lasix as well. She was transferred out of the MICU to [REDACTED] and actually did remarkable. Her O₂ sats were 92-89% ambulatory. Blood pressure remained stable on digoxin and lisinopril. Repeat echocardiogram was performed on 07/14/98 which revealed normal LV function with borderline concentric hypertrophy. Compared to the previous echocardiogram, this represents a dramatic improvement in LV function.

It was felt that her current multisystem failure was most likely due to obesity medications which she was taking, Ma huang and guarang. She was ambulating without complaints and discharged home in stable condition on 07/15/98.

[REDACTED]

DISCHARGE SUMMARY

000007

NAME:

UNIT #:

PAGE: 4

DISCHARGE INSTRUCTIONS:

ACTIVITY: No driving x 1 week. Return to work in two weeks.

DIET: Regular diet.

MEDICATIONS: Triphasil birth control p.o. q.day, digoxin 0.25 mg a day, lisinopril 5 mg b.i.d.

FOLLOW-UP INSTRUCTIONS: Patient will follow up with Dr. [REDACTED] in one week and follow up with Dr. [REDACTED] in two months. Patient is to obtain her temperature b.i.d. and call if greater than 100.6, fever, chills or increasing dyspnea. She was to call any of the M.D.s, Dr. [REDACTED]

PRINCIPAL DIAGNOSIS:

Multisystem failure secondary to obesity drugs (?).

SECONDARY DIAGNOSES:

Sepsis.

Respiratory failure.

Cardiogenic shock.

Congestive heart failure.

Rhabdomyolysis.

Tonic-clonic seizure.

Obesity.

Urinary tract infection.

Pneumonia.

COMPLICATIONS:

As stated in clinical course.

CONSULTATIONS:

[REDACTED] Infectious Disease.

[REDACTED] M.D. - Neurology.

[REDACTED], M.D. - Pulmonary.

PROCEDURES:

Left heart catheterization, 07/03/98.

Bronchial lavage, 07/05/98, Dr. [REDACTED]

Fiberoptic bronchoscopy, 07/05/98, Dr. [REDACTED] and, 07/11/98, with Dr. [REDACTED]

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 5

CONDITION AT DISCHARGE:
Stable and discharged home.

[REDACTED] MD

DD: 08/12/98

DT: 08/14/98 4:57 P

CC: [REDACTED]

DATE SIGNED [REDACTED]

[REDACTED]

NAME: [REDACTED]
UNIT #: [REDACTED]
ROOM #: [REDACTED]
ADMITTED: 07/03/98
DOCTOR: [REDACTED] MD

DOB: [REDACTED]
AGE: 42
SEX: F

Dictated by [REDACTED] MD

HISTORY OF PRESENT ILLNESS: This patient is a 42-year-old white female who presented to the [REDACTED] ER after having headache, dizziness, lethargy, and some chest pain and then a tonic/clonic seizure.

The patient had been complaining to the family about some lethargy and headache for 3-4 days. On the morning of 7/2 she went power walking with her sister for about 90 minutes doing 12 minute miles. She then washed the car and went to her job as a dental assistant. She worked all day with no complaints. At around 7:30 p.m. she felt increasing headache as well as dizziness and some chest pain. The headache was the greatest complaint and she felt that it might be a migraine which she has a history of. She laid down and called her sister to bring her contact lenses over. Blood pressure was taken and was 150/100 at that time. The patient developed some bizarre behavior screaming and kicking and started having seizures. 911 was called and patient was in a tonic clonic seizure by the time the ambulance arrived. She was given 10 mg of Valium by the paramedics and then was taken to [REDACTED] ER.

According to the ER note, over the next 3 or so hours she was given about 43 mg of Versed, 200 mg of succinyl choline, an additional 10 mg of Valium, 100 mg of Cerebyx to finally calm her down and calm her seizures. CT scan of her head was done at [REDACTED] which was essentially negative as was her LP. A urine drug screen that was taken after receiving Versed showed positive for benzodiazepines and amphetamines.

This morning the patient was transferred to [REDACTED] to the NICU where she received an echocardiogram. The echo showed a severe cardiomyopathy with an ejection fraction of less than 15% and the patient was then transferred to the MICU. The patient was then sent to cardiac catheterization and was received again at the MICU post-cath.

Almost all of this history was obtained from the chart, other health care workers, and the patient's family as the patient is sedated and intubated.

PAST MEDICAL HISTORY: Obesity. Surgical - none.

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

000010

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 2

ALLERGIES: No known drug allergies.

MEDICATIONS: Ma Huang and Guarang - both medications for obesity.

SOCIAL HISTORY: The patient is a divorced mother of a 17-year-old boy who lives with his father and two 15-year-old girls who live with her. She is a nonsmoker and nondrinker. Does not take any other drugs. She is currently not dating because her daughters have been having trouble at school and she has decided to spend more time with them. She has had some problems with obesity and has lost 60 pounds over the past two years through an exercise program. She has recently increased her weight by about 15 pounds and has been fairly unhappy with that. She works as a dental assistant and has for the past 9 years with not a day missed of work as she has never been sick.

FAMILY HISTORY: Essentially negative.

REVIEW OF SYSTEMS: Per her family, is essentially negative. She has had some lethargy recently. Has had an increased headache recently. Has recently had the 15-lb weight gain.

PHYSICAL EXAMINATION: Blood pressure 96/63, pulse 120s, respirations 12, temperature 99.9, 98% saturations on vent. Pulmonary capillary wedge pressure 10, cardiac output 4.6, cardiac index 2.3, systemic vascular resistance 1355, central venous pressure 7. Pulmonary pressure is 27/15. Vent settings - FIO2 70%, tidal volume 900, rate 16, PEEP 10, SIMV mode, and pressure support of 0. General - the patient is sedated and intubated. An obese 42-year-old white woman who appears her stated age. SKIN: White with no abnormal pigmentation, bruises, or bleeds. HEENT: Atraumatic and normocephalic. PERRLA. Funduscopic exam revealed no abnormalities. Ears - tympanic membranes with no erythema or exudate. Nose, mouth, and throat - mucosa is pink with no erythema or exudate. Septum is midline. No bleeding is present. NECK: Supple; no adenopathy. No thyromegaly. No carotid bruits auscultated. LUNGS: Clear to auscultation bilaterally. HEART: Tachyarrhythmia. No murmurs, gallops, or rubs were noted by myself although an S3 was noted per Cardiology. Apical impulse was not palpable. ABDOMEN: Rounded, obese abdomen. Soft and nontender; nondistended. Positive bowel sounds and no organomegaly. EXTREMITIES: Lower extremities both cool with positive pulses at dorsalis pedis and posterior tibial. No skin changes or pigment changes. No edema.

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

000011

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 3

Left arm is markedly cooler than right arm, has no palpable pulses, and is cyanotic although everybody agrees it is less cyanotic than earlier. NEURO: The patient is sedated so it is difficult to assess although she moves all four extremities spontaneously. Does cringe and grimace with painful stimuli. Has +2 deep tendon reflexes bilaterally.

LAB: From [REDACTED] - UA showed yellow moderately cloudy urine with 50 mg/dl of ketones, specific gravity of 1.030, pH of 5.0, protein 500 mg/dl, blood of 25 per microliter, WBCs 15-25, RBCs 5-10, bacteria none seen. Urine drug screen - PCP negative, benzodiazepines positive, cocaine negative, amphetamines positive, THC negative, opiates negative, barbiturates negative, tricyclics negative. CK 347, CK/MB 6.49, troponin T 0.181. PT of 12.5; INR 1.1, PTT 22. Hemoglobin 15.5, O2 sats 87.4, oxyhemoglobin 86.8, carboxyhemoglobin 0.1, methemoglobin 0.3, deoxyhemoglobin 12.8, and O2 content 19.0.

LP showed CSF. Gram's stain with no polymorphonuclear leukocytes and no bacteria. CSF was colorless and clear with two RBCs, one WBC, glucose 78, and a protein of 35. Culture was sent.

ABG on a ventilator - tidal volume 900, SIMV rate 16, FIO2 100%. pH 7.399, PCO2 30.5, PO2 52.1, HCO3 actual 18.4, PCO2 19.4, base deficit -5.

Lab 7/3 from [REDACTED] at 1538 hrs - CK 3506, MB 1.9, troponin 1.42, myoglobin 153.8. At 2328 hrs - CK 1546, MB 2.5, troponin 0.81. ABG on 70% FIO2 - pH 7.483, PCO2 24, HCO3 -18, PO2 75, saturation 96%. CBC - WBC 26.7, hemoglobin 15.4, hematocrit 44.4, platelets 285,000, MCV 91, RDW 12.8, PMNs 78%, bands 13%, lymphs 4%, monocytes 3%. Sodium 139, potassium 5.2, chloride 109, bicarb 18, BUN 11, creatinine 1.1, glucose 220. Lactic acid 4.7.

CT scan of the head was negative for blood and edema.

Chest x-ray showed bilateral pulmonary disease more probably either pulmonary hemorrhage or pulmonary edema, less likely pneumonia.

Echocardiogram - decreased left ventricular function. Ejection fraction less than 15%. A questionable aortic dissection.

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

000012

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 4

Ultrasound of both upper extremities showed decreased blood flow bilaterally; no clots.

Cardiac catheterization showed diffuse hypokinetic left ventricle with an ejection fraction around 20%. Coronary arteries okay. Aorta okay with no dissection noted.

ASSESSMENT:

A 42-year-old white female with no past medical history who presents with headache, dizziness, seizures, loss of blood pressure, and cardiomyopathy.

PLAN:

Cardiovascular - the patient is on dopamine 8 mcg/kg/min, dobutamine 5 mcg/kg/min, and still has a low blood pressure. Echo and catheterization show cardiomyopathy with a dilated left ventricle and a low ejection fraction of 15-20%. CK is high as is MB, troponin, and myoglobin. The patient has a negative past medical history, negative family history, and no coronary artery disease by cardiac catheterization. Some possibilities include a toxic or a viral cardiomyopathy, an MI secondary to either toxins or vasospasm. The patient is currently on dopamine and dobutamine drips to keep systolic blood pressure above 90, IV fluids of D5 half normal saline to keep pulmonary capillary wedge pressure above 12, heparin per pharmacokinetics, Versed and vecuronium drips to keep patient sedated.

Neuro - with seizures, headache, and bizarre behavior. Past history of migraines. Negative CT. Negative LP. Metabolic abnormalities ruled out with laboratory studies. There are still the possibilities of anoxic encephalopathy and drug intoxication or drug withdrawal as well as an unusual or atypical migraine pattern. The patient has been taken off anti-seizure medications and will continue on Versed and have an EEG in the morning.

Infectious Disease - with increased white blood count and increased bands with a negative review of systems for any possible source for infection. Afebrile with a temperature of 99.9. LP negative for meningitis. Chest x-ray is doubtful for pneumonia. Because of the high white count and because of the difficulties with intubation at [REDACTED] and the possibilities for aspiration, the patient will be started on Unasyn 3.0 gm IV q.6h. We will continue to run a rule out sepsis protocol and await cultures.

Renal - stable.

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

000013

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 5

Fluids, electrolytes, and nutrition - potassium is high at 5.2 and 20 mEq of KCl in her IV fluids were stopped. The patient is currently NPO and on no nutrition. Will discuss nutritional status with attendings in the morning. Will increase IV fluids to keep pulmonary capillary wedge pressure above 12. Will continue to check lytes and increase IV fluids.

Respiratory - patient is currently on a ventilator on an FIO2 of 55% and is saturating above 95%. Chest x-ray shows bilateral disease although it is unclear whether that is due to hemorrhage, edema, or pneumonia. No past medical history of any respiratory abnormalities. The patient is an exerciser so should have decent respiratory function. The patient is also a nonsmoker. Will continue to keep patient sedated and on ventilator. Will continue to watch ABGs and will try to keep PEEP down so as not to decrease blood return to the heart.

[REDACTED]

DD: 07/04/98
DT: 07/04/98 1:34 P
CC: [REDACTED]

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

000014

NAME: [REDACTED]
UNIT #: [REDACTED]
ROOM #: [REDACTED]
ADMITTED: 07/03/98
DOCTOR: [REDACTED] MD

DOB: [REDACTED]
AGE: 42
SEX: F

HISTORY OF PRESENT ILLNESS: The patient is a 42-year-old woman who was in her usual state of good health until yesterday evening when she was at work. That morning the patient had done a 75 minute "power walk", walking brisk, fast miles and experienced no symptoms. Late in the afternoon the patient complained of chest heaviness and feeling ill. She lay down to rest in one of the dental chairs. The dentist took her blood pressure and found it to be 150/100. He checked on her periodically and at one point found her lying in the chair, combative and flailing, and appearing to have a generalized seizure. The patient was taken to the [REDACTED] via the paramedics and was given Valium and was intubated. She was brought to their intensive care unit. Chest x-ray was consistent with pulmonary edema. She remained paralyzed and on a Versed drip through the night. This morning when she became more hypotensive and required Dopamine for pressure support, a neurology consultation was requested, along with transfer to [REDACTED]

According to information in the chart, the patient has never had seizures before. She is nonsmoker, not known to use recreational drugs. A drug screen was done showing amphetamines and it was subsequently found that she had been taking an over-the-counter herbal diet pill that contained ephedrine.

The patient has had migraine headaches which she treats with aspirin and rest. She has not been taking any sumatriptan or similar medication.

According to the chart the patient had been awake periodically, nodding her head to questions last night. This morning the patient was able to raise an eyebrow in response to a yes-no question appropriately, but then her sedation and paralysis were deepened. A CT scan was done which was unremarkable for bleeding or other injury, and a follow-up CT done upon arrival here showed no evidence of acute process.

Upon arrival here the patient was immediately cared for by Dr. [REDACTED] from critical care. He noted that the patient had an elevated CPK with elevated MB bands. She was thought to be in failure and cardiogenic shock. A white count was noted to be 26.7, hemoglobin 15.4. Electrocardiogram was consistent with an anterior MI. Blood gases were 7.40, 29, and 103 on respiratory rate of 16, 70% oxygen and 10 of PEEP. The patient was also noted to have poor peripheral perfusion. Dopplers showed poor peripheral pulses and poor subclavian on the right.

[REDACTED]

NEUROLOGY EVALUATION

000015

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 2

Transesophageal echo was done which showed possible dissection, but definitely severely impaired left ventricular function.

The patient has otherwise enjoyed good health. Past medical history is as noted above.

NEUROLOGY EXAMINATION: The patient presents as an intubated, mildly overnourished woman who is paralyzed and on a ventilator. During the transesophageal echo she did move from side to side, resisting noxious stimulation. Pupils are equal, briskly reactive, disks could not be seen. No doll's eyes, no corneals. Positive gag when sedation is lifted slightly. Absent deep tendon reflexes, no spontaneous movement, but movement as noted above with noxious stimuli, this was not noted to be posturing. The rest of the examination is per Dr. [REDACTED]. She is noted to have very cold, dusky upper extremities with poor peripheral pulses, absent to palpation.

IMPRESSION:

Cardiac failure of undetermined etiology at this point. Patient's mental status maybe related to significant cardiac event, possibly to a shower of emboli.

The patient is going to be taken to the cardiac catheterization laboratory to determine further what is happening with her heart. Once this is known, further neurologic workup can be done. A CT scan tomorrow to look for cerebral edema maybe reasonable as evolving infarcts may not show in less than 24 hours. EEG might be minimally helpful, but the patient is on Versed. Clearly, once the patient is able to be awakened from the vecuronium, looking to see how she follows commands will be the most helpful.

Thank you for this consultation. I will follow this woman with you while she is hospitalized.

[REDACTED]
DD: 07/03/98
DT: 07/04/98 8:44 A
cc: [REDACTED] MD
[REDACTED] MD



NAME: [REDACTED]
 UNIT #: [REDACTED]
 ROOM #: [REDACTED]
 ADMITTED: 07/03/98
 CONSULTING DOCTOR: [REDACTED]
 REFERRING DOCTOR: [REDACTED]
 DATE OF CONSULT: 07/03/98

DOB: [REDACTED]
 AGE: 42
 SEX: F

PULMONARY MEDICINE CONSULTATION

HISTORY: I was asked by Dr. [REDACTED] to see Ms. [REDACTED] in consultation regarding multiple system failure. She is a 42-year-old woman in previously good health with chronic obesity who apparently has recently been taking some diet pills. She was in her usual state of good health until the day of admission to the [REDACTED]. By report of her sisters and review of outside records, the patient went on a vigorous walk for 70-90 min on the morning of admission. They were walking at approximately a 12 mph pace. During the remainder of the day she was very active and activities included washing her car and doing some housework. She went to work as a dental assistant where she developed some vague symptoms of headache and fatigue as well as some chest tightness. She subsequently became agitated and it was felt she had seizure activity with gross movements and arching of her back. Throughout this time she also had some inappropriate behavior with screaming and agitation. She was taken to the emergency room at [REDACTED] where she was difficult to control in terms of her movement activity and in addition, she was very difficult to intubate despite large doses of sedatives as well as attempts at paralysis. Ultimately she was intubated, however, over the next 8 hrs she had a rather unstable course with recurrent hypoxemia associated with hypotension.

Laboratory values of note at the other hospital included an admission white blood cell count of 16,500, hemoglobin and hematocrit of 12.6 and 36.2. A drug screen was obtained and was positive for benzodiazepines (she had received Valium prior to arrival in the emergency room) and amphetamines. Serum electrolytes were remarkable only for a low potassium. BUN and creatinine were normal. CK was 347 with 6.5 nanograms per ml MB fraction. Coagulation parameters were normal. Her CSF was also normal. There were only 3 cells in her CSF.

During the night she had hypoxemia documented with an arterial blood gas on 100% oxygen with a PO2 of only 52.

Because of continued instability, she was transferred here.



CONSULTATION

000017

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 2

On arrival here it was noted she had a cool, swollen left hand with no palpable radial pulse.

When I saw her initially in the Neuro Intensive Care Unit she was sedated and paralyzed after having received Versed and vecuronium en route. She was unable to give further history.

PAST MEDICAL HISTORY: Is as above. She has not had previous hospitalizations other than childbirth. She takes some diet pills.

REVIEW OF SYSTEMS: Was unobtainable, however, in detail at the outside hospital is unremarkable.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: Remarkable for a recent MI in her mother. Her mother also has lymphoma. No history of asthma or underlying respiratory disease.

SOCIAL HISTORY: She is single with 15-year-old twins and a 17-year-old son. Her family says she recently made a conscious effort to stop dating in order to be more available for her children who apparently are having some difficulty in school. She does not smoke, use alcohol, or recreational drugs.

PHYSICAL EXAMINATION: Her initial examination when I saw her at about 1 o'clock in the afternoon on 7/3 revealed an overweight woman, sedated and paralyzed, who was extremely diaphoretic. Skin was cool and clammy. Her left upper extremity was swollen and blue. Blood pressure ranged between 90 and 110 systolic. Heart rate was 140-150 and regular. Respirations were 16 at a set rate on the ventilator of 60. She was afebrile. HEENT: Revealed the presence of an oral endotracheal and nasogastric tube. Mucous membranes were moist. Pupils were minimally reactive. NECK: Supple without palpable adenopathy, thyromegaly, or jugular venous distention. CHEST: Grossly clear to auscultation and percussion with equal breath sounds bilaterally. CARDIAC; Remarkable for tachycardia and a summation gallop. I did not hear a murmur. ABDOMEN: Soft and quiet without appreciable hepatosplenomegaly or mass. EXTREMITIES: There was no clubbing, cyanosis, or edema. She had dopplerable pulses in her right and left brachials. I could not feel a radial pulse on either side. She had dopplerable dorsalis pedis and posterior tibials bilaterally in the lower extremities. There were no cords.

[REDACTED]

CONSULTATION

000018

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 3

LAB: Pertinent labs at the outside hospital were as described above. Initial labs here included a CK of 3506 with 1.9 MB. Potassium had risen to 5.2. BUN was 11 and creatinine 1.1 and her glucose was elevated at 220. Total CO2 was 18. White blood cell count was increased to 26,700, hemoglobin and hematocrit 15.4 and 44.4. Platelet count was 285. She had 13 bands in her differential cell count. Lactic acid was elevated at 4.9. Urinalysis was pending.

Arterial blood gas on a tidal volume of 900, 10 of PEEP, respiratory rate of 16, assist control mode, revealed a pH of 7.4, PCO2 29, and a PO2 of 103.

Chest x-rays were reviewed and showed good position of her endotracheal tube. Her heart size appeared to be normal. She had diffuse bilateral interstitial infiltrates which on one of her outside films was more prominent in the right upper lung zone, however, on arrival here, was diffuse and symmetric.

Over the course of the day a variety of tests were ordered and coordinated. Because of the cold left upper extremity she had Dopplers which showed diffuse decrease in flow with no appreciable pulses at the left radial. There was decreased flow in subclavians bilaterally.

A CT scan of her head showed no bleeding or edema.

EKG showed poor R-wave progression suggesting an anterior MI of indeterminate age.

Consultation was obtained from Dr. [REDACTED] and Dr. [REDACTED] and she was seen also by Dr. [REDACTED]

An urgent transesophageal echocardiogram was done which showed diffuse hypokinesis. Initially we thought there was suggestion of an aortic dissection, however, this was subsequently felt not to be the case. Her ejection fraction was estimated to be 15 or 20%.

After a lengthy discussion with multiple consultants, it was elected to take her to the cardiac lab to try to determine if she had diffuse coronary artery disease as a cause of an apparently acute severe cardiomyopathy. This was done and apparently revealed

[REDACTED]

CONSULTATION

000019

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 4

low wedge pressure, poor cardiac output, and normal coronary arteries. No intimal flap was seen suggesting an aortic dissection.

IMPRESSION:

This is a critically ill 42-year-old woman with multiple system failure. The etiology of her decompensation is really not clear but a toxic metabolic problem is suggested. The active ingredients of her diet pills include ephedrine and caffeine. It does not appear that she has taken an overdose of these or any other medication at this point.

The etiology of her severe hypoxemic respiratory failure appears to be cardiogenic. I failed to mention above that a patent foramen ovale was noted during her echocardiogram. It is possible that she has a small PFO which was opened up and became clinically more important with respect to hypoxemia when she was placed on positive pressure ventilation.

Other than her elevated white count, there is nothing to suggest ongoing sepsis and her hemodynamic parameters are not consistent with that diagnosis. It is possible given the difficulty of her intubation that she has an aspiration pneumonitis.

Her metabolic and lactic acidosis appear to be on the basis of a low output state. It really is not clear whether she actually had seizure activity initially.

RECOMMENDATIONS:

At this point we are going to continue to sedate her and will paralyze her if necessary in order to maintain adequate ventilation. We have increased her PEEP level to 10 to maintain adequate oxygenation with the hope that we will be able to lower her FIO2.

She will receive intravenous fluids given her low wedge pressure and low blood pressure. Dopamine and dobutamine have been started to optimize her hemodynamics.

She is being pancultured.

If she becomes febrile or leukocytosis worsens, I would probably cover her broadly for an aspiration pneumonia.

[REDACTED]

CONSULTATION

000020

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 5

Lengthy discussions were held with the patient's multiple family members including her two sisters who were present throughout most of the day. More than 1 1/2 hrs was spent at the bedside and in the Neuro Intensive Care Unit as well as the CT scanner managing blood pressure, sedation, and paralytic and attempting to coordinate care of various consultants.

[REDACTED] MD [REDACTED]

DD: 07/03/98

DT: 07/04/98 12:18 P

CC: [REDACTED]

[REDACTED]

CONSULTATION

000021

NAME: [REDACTED]
UNIT #: [REDACTED]
ROOM #: [REDACTED]
ADMITTED: 07/03/98
CONSULTING DOCTOR: [REDACTED] MD
REFERRING DOCTOR: [REDACTED] MD
DATE OF CONSULT: 07/03/98

DOB: [REDACTED]
AGE: 42
SEX: F

CARDIOLOGY CONSULTATION

HISTORY: [REDACTED] is a 42-year-old woman who presents with respiratory distress following collapse while at work yesterday. At that time she was working at her usual job as a dental assistant. She noted the onset of fatigue and weakness along with a headache and light-headedness. She also complained of substernal chest discomfort. She went to lie down in a dental chair and was found to have a blood pressure in excess of 150/110. Ultimately she was found to be unresponsive with posturing similar to a seizure. Paramedics were summoned. She was given benzodiazepines and she was admitted to the hospital at [REDACTED] where ultimately she required intubation and treatment for what was presumed to be a seizure. She had a CAT scan that was negative and an LP that was negative. Because of labile blood pressure she was intermittently given Dopamine. Because of ongoing respiratory distress, labile blood pressure and her neurologic status she was transferred today to [REDACTED]. After initial evaluation by Dr. [REDACTED] who believed the patient could have cardiogenic pulmonary edema, I was summoned to evaluate her.

Upon questioning the patient's sisters, there is no history of myocardial infarction or rheumatic fever. There is no history of prior cardiomyopathy or any cardiac complaints, in fact, they state the patient has been in excellent health and has been exercising vigorously as recently as 24 hours prior to this admission. There is no history of hypertension or diabetes, she has not been a smoker. There is no known hyperlipidemia. There is no family history for premature coronary disease.

Her medications included a dietary supplement called Easy Trim. No known drug allergies.

PAST MEDICAL HISTORY: Unremarkable.

PHYSICAL EXAMINATION: Revealed a young woman in respiratory distress on a ventilator. She moves minimally. Blood pressure is 80/40 with a pulse of 130. HEENT: Unremarkable. NECK: There is no jugular venous distention. The carotid upstrokes are diminished, there are no bruits. LUNGS: Bilateral crackles. HEART: S1 and S2 with a loud gallop. ABDOMEN: Benign.

[REDACTED]

CONSULTATION

000022

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 2

EXTREMITIES: Dusky, pale left arm and hand and poor perfusion in the right arm. There are diminished distal pedal pulses.

Review of her laboratory values reveals initially elevated CPK at [REDACTED] of greater than 300 with positive MB. Her CPK is 3500 today with a troponin of 1.42. Her chemistry profile is remarkable for a sodium of 139, potassium 5.2, chloride 109, CO2 18, BUN 11, creatinine 1.1. Lactic acid level is elevated at 4.7. Chest x-ray reveals normal-sized heart, bilateral interstitial infiltrates.

Electrocardiogram reveals sinus tachycardia with an anterior myocardial infarction pattern that appears to be old.

Urinalysis is remarkable for microscopic hematuria. CBC shows a hemoglobin of 15, hematocrit 44, white count 26. Recent blood gas shows a pH of 7.4, PCO2 29, PO2 103.

There is a concern about embolic phenomenon to her brain and her left arm. Doppler ultrasound of the arms revealed diminished blood flow bilaterally.

Because of her clinical presentation, the patient has had a transesophageal echocardiogram performed emergently by Dr. [REDACTED]. This shows normal sized aortic root. Left ventricular function is significantly impaired and estimated to be 15% or less. She also has spontaneous echo contrast. There is a patent foramen ovale with some left to right shunting.

IMPRESSION:

It is my impression that Ms. [REDACTED] presents with congestive heart failure, possible embolic event to her arms and brain, and there is no obvious explanation for her poor left ventricular function. After discussion with Dr. [REDACTED], Dr. [REDACTED] and Dr. [REDACTED] we have elected that she should go to the cardiac catheterization laboratory to exclude the possibility of acute coronary syndrome, particularly with the rising CPK and electrocardiogram evidence of anterior infarct of age indeterminate. She also has some indications of cardiogenic pulmonary edema and hemodynamic measurements would be valuable to clarify her clinical status. The high risk nature of this procedure has been fully described to the patient's family. They agree that we should proceed.

[REDACTED]

CONSULTATION

000023

NAME: [REDACTED]
UNIT #: [REDACTED]

PAGE: 3

Of note, there has also been consideration of an aortic dissection in this circumstance, the transesophageal echocardiogram was initially suggestive of this, but further review reveals that there is no definitive proof of this. An aortogram will also be done at the time of cardiac catheterization.

[REDACTED] MD
DD: 07/03/98
DT: 07/04/98 12:10 P
CC: [REDACTED]

[REDACTED]

CONSULTATION

000024

NAME: [REDACTED] DOB: [REDACTED]
UNIT #: [REDACTED] AGE: 42
ROOM #: [REDACTED] SEX: F
ADMITTED: 07/03/98
CONSULTING DOCTOR: [REDACTED], MD
REFERRING DOCTOR: [REDACTED] MD
DATE OF CONSULT: 07/08/98

INFECTIOUS DISEASE CONSULTATION

REASON FOR ADMISSION: Antibiotic recommendations and persistent temperatures.

The patient is a 42-year-old female whose [REDACTED] records, records from this hospitalization and all the other various consultants notes have been reviewed.

The patient originally presented to [REDACTED] after headache, dizziness, lethargy, chest pain and probable tonic clonic seizure. She apparently had onset of symptoms approximately 3-4 days prior to this admission. She was brought to the ER by ambulance on 7/2. Apparently she was at her dentist's office where she works as a dental hygienist when these events occurred. The patient was evaluated in the ER and was given Versed, succinylcholine and Cerebyx to calm seizures. CT scan and lumbar puncture were performed which are unremarkable. I attempted to call [REDACTED] today to update culture reports. It seems as though only routine cultures were done and appeared to be negative at this time. I will verify that information tomorrow. Her urine was positive for benzodiazepine and amphetamines after the patient was given Versed. The patient was transferred to [REDACTED] on 7/3 and was evaluated by numerous consultants. She has had neurologic, cardiac, pulmonary evaluations. She has had echocardiograms performed which have indicated ejection fraction of less than 15% and was felt to have significant cardiopulmonary compromise due to unknown reason. The patient on admission on 7/3 was empirically placed on Unasyn because of the elevated white count, difficult intubation and possible aspiration. Of note--the patient had been on Ma Huang and Guarang medications which are over the counter that can be used for obesity. The patient has had persistent temperatures and on 7/7 Cipro was added to her antibiotic regimen. I have been asked to see the patient secondary to persistent temperatures.

Over the course of the period of a few days, her pressors have gradually been weaned. The last time that she was on any pressors was yesterday on July 7, and her blood pressure has been hemodynamically stable. Over the course of time, her FIO2 has come down to 35%. She is producing good urine. Her temperature

[REDACTED]
CONSULTATION

000025

NAME:
UNIT #:

PAGE: 2

max yesterday was 101.8 and has been running temperatures since admission.

SOCIAL AND FAMILY HISTORY: Well outlined in previous consultants notes.

According to nursing staff, there has been minimal suctioning. She has tube feedings going and there has not been any stool since admission. In terms of line status, she has a triple lumen in her right groin which was placed at [REDACTED] and will be removed later on today. She has a right groin A line which was removed today. A left groin Swan came out yesterday and today a new PIC line has been placed.

PHYSICAL EXAMINATION: She opens eyes and responds to commands, nods appropriately to questioning. HEENT exam indicates that her NG tube is bothering her somewhat. There is no JVD. Lung examination--transmitted breath sounds diminished on the left. Heart examination--S1 and S2. Abdomen is soft and mild. Extremity edema.

CULTURES AND LABS: White count was 7.8. A bronchial washing on 7/5 has many PMNs, no bacteria, no growth. Her most recent sputum on 7/7 has some light gram-negative rods. ID and sensitivities are pending. Her urinalysis from 7/6 catheterized has 10 K of yeast. Blood cultures from 7/6 are negative, 7/5 are negative and 7/3 one blood culture positive with two staph coagulase negative sensitive to all antibiotics except penicillin. Other staph coagulase negative is sensitive to all.

Review of x-rays revealed marked improvement. Her current antibiotic regimen does consist of Unasyn and Cipro intravenously.

ASSESSMENT:

This is a patient with a complicated course with cardiopulmonary failure, now with gradual improvement in the sense of decreasing FIO2 as far as the ventilator as well as weaning of pressors. She still has some persistent temperatures and no definitive etiology has been found. Certainly toxin induced cardiomyopathy is part of the differential based on the diet preparations that she had been taking. Other etiologies do include infection and viral certainly is part of the differential diagnosis. In terms of current ID issues, her 7/3 blood culture is probably a

CONSULTATION

000026

NAME:

UNIT #:

PAGE: 3

contaminant. Her 7/7 sputum does have 2 gram-negative rods--ID and sensitivities are pending. Her chest x-ray is clearly improving. She does have a 7/6 urine with some yeast.

My recommendations include check urine eosinophils to assure that this is not drug related fever. For completeness, checking a urine Legionella antigen. Have requested urinalysis. Because of IV access and the fact that she is on sedative and heparin, I will simplify her current regimen so that she would not require another line to be placed. I have recommended switching her to IV Trovan 200 mg IV q.24h. Because of the yeast in the urine, we can start her on some Diflucan through her NG tube. I have recommended for completeness checking some viral serologies including coxsackie serology, Epstein-Barr and CMV serology. Cultures of the line tips will be done.

MD

DD: 07/08/98

DT: 07/08/98 11:05 P

CC:

MD

MD

CONSULTATION

000027