

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

ARMS#

12452



5 - SUMMARIES

000001

[REDACTED]

NAME : [REDACTED] ADMITTED : 06/19/97
AGE : 59 DISCHARGED : 06/30/97
PT.NO. : [REDACTED] PHYSICIAN : [REDACTED] M.D.
UNIT : [REDACTED] CONSULTANT :

ADMITTING DIAGNOSIS:

1. Chest pain.

DISCHARGE DIAGNOSES:

1. Unstable angina.
2. Coronary artery disease.
3. Myocardial infarction.
4. Hypertension.
5. Chronic renal insufficiency.
6. Hypercholesterolemia.

PROCEDURES:

1. Cardiac catheterization.
2. Coronary artery bypass grafting times four with LIMA, LIMA to LAD, saphenous vein graft to D-1, saphenous vein graft to PDA and PLB.

COMPLICATIONS: None.

HISTORY OF PRESENT ILLNESS: The patient is a 59-year-old woman who is a patient of Dr. [REDACTED]. She presented on 06/19/97 with chest pain and ruled in for myocardial infarction. She was admitted for further evaluation.

HOSPITAL COURSE: She underwent cardiac catheterization which revealed very severe three vessel coronary disease, slightly decreased left ventricular ejection fraction, and she was also noted to have renal insufficiency and was consulted by Dr. [REDACTED]. She was referred to me for revascularization. She was taken to the Operating Room on 06/24/97 and underwent coronary artery bypass grafting times four. This went well. She was taken to the Intensive Care Unit, creatinine remained stable at 1.9, and she was transferred to the floor on the first postoperative day. She did require some Dobutrex which was slowly weaned. She was up ambulating without difficulty in the halls and denying shortness of breath or chest pain. She was ultimately weaned from oxygen and having room air saturations of 94%. She remained in normal sinus rhythm throughout the entire stay and was discharged to home in good condition on postoperative day six.

DISCHARGE DISPOSITION: The patient was discharged home. Follow up will be by Dr. [REDACTED] and Dr. [REDACTED] in two to three weeks.

DISCHARGE INSTRUCTIONS: Patient was instructed not to drive a car for two weeks, not to lift anything heavier than 10 lb for two months, to call for any erythema, drainage, or discharge from her wounds or any other problems whatsoever.

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DISCHARGE SUMMARY

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DISCHARGE MEDICATIONS: Capoten 25 mg p.o. t.i.d., Lortab 5s, 1 to 2 tabs p.o. q. 6 hours p.r.n. pain, enteric coated aspirin 1 p.o. q. day, Lipitor 20 mg p.o. q. day, and atenolol 25 mg p.o. q. day.

[REDACTED]
[REDACTED], M.D.

D: 06/30/97
T: 07/06/97
[REDACTED] 17

DISCHARGE SUMMARY

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Name: [REDACTED]
DOB: [REDACTED]
No: [REDACTED]
Unit:

Admitted: 06/19/97
Discharged:
Physician: [REDACTED] M.D.
Consultant:

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: Mrs. [REDACTED] is a 59-year-old white female who presents for further evaluation of intermittent chest discomfort the last couple of days. The patient describes the pain as like a tightness around her chest radiating to the right jaw and up into the right side of her face. It is associated with some right hand numbness. The patient had this lasting 10-15 minutes on a couple of occasions yesterday. It woke her last night from sleep, again lasting only 10 minutes. It has intermittently been occurring today. She states it has never lasted longer than 10-15 minutes. She subsequently decided to come to the emergency room to get evaluated.

On arrival to the emergency room her electrocardiogram showed evidence of a completed anterior myocardial infarction, and her cardiac enzymes were positive with a CK of 517, IL-2X of 18.1, and troponin I of 6.2. In addition to that, her laboratory data showed a cholesterol of 294 and a creatinine of 2.1. The patient has a history of long-standing hypertension treated by Dr. [REDACTED] since 1982.

HABITS: Smoke a pack per day. Does not drink.

ALLERGIES: No known drug allergies.

PAST MEDICAL/SURGICAL HISTORY: The past medical history is remarkable for a right mastectomy. She was born with a partially paralyzed right arm. She has not had any other surgeries. She does have a history of severe hypertension in the past.

REVIEW OF SYSTEMS:

NEUROLOGICAL: No history of stroke or seizure disorder.

PULMONARY: Denies any cough or sputum production, wheezing, or asthma. She denies any chronic lung disease.

GASTROINTESTINAL: She denies any indigestion, heartburn, reflux type symptoms, dark tarry stools, and bloody stools. She has had episodic diarrhea for the last 2-3 weeks apparently being fairly watery. She has attributed this to a viral syndrome. As stated, she denies any dark tarry stools or bloody stools.

GENITOURINARY: She denies any pain, burning, or frequency of urination. She denies any prior kidney problems. She denies any history of kidney stones.

PHYSICAL EXAMINATION:

GENERAL: A well-developed, well-nourished white female currently in no acute distress.

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HISTORY & PHYSICAL

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PHYSICAL EXAMINATION: Continued

HEENT: Pupils are equal and reactive to light. The sclerae are white.

NECK: The JVP is flat. Carotids are without bruits.

CHEST: Clear to auscultation except for the bases where there are a few basilar rhonchi.

HEART: The heart has a regular rate and rhythm with a 2-3/6 systolic murmur heard at the aortic area and radiating toward the carotids. No gallops or rubs are heard.

ABDOMEN: Soft and nontender with normoactive bowel sounds.

EXTREMITIES: The extremities have 2+ pulses with no clubbing, cyanosis, or edema.

IMPRESSION:

1. Anterior myocardial infarction, possibly completed. She is currently pain free, laughing and joking, and therefore will treat medically for now. She will eventually need coronary angiography but will need renal clearance and evaluation of her aortic valve prior to doing the angiogram.
2. Heart murmur consistent with aortic stenosis or possibly aortic sclerosis. I guess this could be an ejection murmur from hypertrophic cardiomyopathy. In any case, will get an echocardiogram to assess this and her left ventricular function.
3. Renal insufficiency.
4. Hypercholesterolemia.
5. Diarrhea, etiology undetermined. Will go ahead and get Hemocult of the stool and stool for ova and parasites.

PLAN: Go ahead and admit to the [REDACTED] and otherwise as above.

[REDACTED]

D: 06/19/97

T: 06/20/97 [REDACTED]

cc: [REDACTED], M.D.

HISTORY & PHYSICAL

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ccu
Name: [REDACTED]
DOB: [REDACTED]
No.: [REDACTED]
Unit:

Admitted: 06/19/97
Discharged:
Physician: [REDACTED] M.D.
Consultant: [REDACTED] M.D.

DATE OF CONSULTATION: June 20, 1997.

HISTORY OF PRESENT ILLNESS: The patient is a 59-year-old patient of Dr. [REDACTED] who is admitted with an acute anteroseptal myocardial infarction with a history of hypertension and renal insufficiency. The patient has a history of hypertension dating back approximately 15 years with a positive family history (mother) with good control by her recollection over the previous 10 years with some variability in her level of blood pressure control in the past five years but with average reasonable control in the 140/70 mmHg range on Captopril 50 mg t.i.d. as monotherapy. Previous serum creatine is not known, but admission serum creatinine was 2.1 mg per dl. No history of proteinuria according to the patient nor gross hematuria. She had, approximately 15 years ago, some imaging study that sounds like a renal flow study which was said not to disclose any abnormalities. She does not know of any 24-hour urine collections, and she denies any renal Doppler studies. She denies frequent urination, nocturia, heavy use of analgesics or diabetes mellitus.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure was 100/70. Pulse 70 and regular. She was afebrile.

GENERAL APPEARANCE: Physical examination reveals a well-developed, somewhat obese white female in no acute distress.

SKIN: Skin revealed some findings of dependent hyperemia of the feet with loss of skin adventitial markings in the lower extremities.

CHEST: Chest was clear to auscultation and percussion.

HEART: Cardiac exam revealed no evidence for jugular venous distention. Carotid upstrokes are bilaterally brisk and equal. There was a 2/3 crescendo/decrecendo murmur heard best along the left sternal border without radiation to the carotids. Point of maximal impulse was not displaced. She was sputum production right mastectomy.

ABDOMEN: Abdomen was soft and nontender without hepatosplenomegaly. No audible systolic bruits.

EXTREMITIES: Examination of arterial pulses reveals markedly diminished pedal pulses with absent popliteal pulses bilaterally.

DIAGNOSTIC STUDIES: Urinalysis not present. EKG reveals probable acute anteroseptal myocardial infarction. CPKs are elevated with positive MB fraction.

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CLINICAL IMPRESSION:

1. Renal insufficiency with inadequate database at present time. It is difficult to discern the underlying etiology for renal insufficiency, but her current blood pressures are borderline low for autoregulation of glomerular filtration rate, particularly in the presence of angiotensin converting enzyme inhibition.

PLAN: Agree with stopping the Capoten while awaiting decisions on heart catheterization. Orders left for IV hydration with D5 one half normal saline at 150 ml per hour to begin eight hours prior to anticipated heart catheterization. Would hope to minimize her IV contrast exposure by limiting the study to coronary arteries if deemed feasible from a clinical perspective. Will schedule for renal Doppler studies. Will send spot urine for sodium, creatinine, and protein to help expand the database. Will contact [REDACTED] in order to establish previous serum creatinines as a measure of rate of progression and/or duration of renal insufficiency. Will follow with you.

Thank you for your kind referral.

[REDACTED] M.D. [REDACTED]

D: 06/20/97

T: 06/21/97 [REDACTED]

CONSULTATION

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Name:
DOB:
No. :
Unit:

Admitted: 06/19/97
Discharged:
Physician: .D.
Consultant: M.D.

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: Mrs. [REDACTED] is a 59-year-old woman who has been a patient of Dr. [REDACTED] for a while with a known history of hypertension, chronic renal insufficiency, and hypercholesterolemia. She presented on the 19th with chest pain and ruled in for myocardial infarction. She underwent cardiac catheterization today which revealed very severe, three-vessel coronary disease, slightly decreased left ventricular ejection fraction and 1 to 2+ mitral regurgitation. She is referred for revascularization.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Chronic renal insufficiency with a creatinine of approximately 2.
3. Hypercholesterolemia.

PAST SURGICAL HISTORY:

1. Right mastectomy.
2. Tubal ligation.
3. Tonsillectomy and adenoidectomy.

MEDICATIONS:

1. Enteric-coated aspirin.
2. Lopressor.
3. Lipitor.

ALLERGIES: None.

SOCIAL HISTORY: Smoking of one pack per day x 43 years. Alcohol: None.

FAMILY HISTORY: Positive for coronary disease.

REVIEW OF SYSTEMS:

NEUROLOGICAL: Denies any transient ischemic attacks or cerebrovascular accidents.

PULMONARY: Denies any cough, sputum production, or hemoptysis.

GASTROINTESTINAL: Denies ulcer disease, hematemesis, melena, or bright red blood per rectum.

ENDOCRINE: She denies diabetes.

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PHYSICAL EXAMINATION:

GENERAL APPEARANCE: In general, this is a slightly overweight female in no apparent distress.

NECK: Full range of motion. Carotid pulses are 3+/4 without bruits.

HEART: Regular rate and rhythm without rubs, murmurs, or gallops.

CHEST: Chest is clear to auscultation.

EXTREMITTIES: Right arm with paralysis secondary to a birth defect. No varicose veins are noted. Pedal pulses are not palpable in either leg. The legs are warm.

DIAGNOSTIC STUDIES: Hemoglobin is 10.9. The BUN and creatinine are 21 and 1.9. Arterial blood gases and bleeding time are pending. Chest x-ray is clear.

ASSESSMENT:

1. This is a 59-year-old woman with unstable angina status post myocardial infarction with very severe three-vessel coronary disease. Agree with need for revascularization. I explained this procedure at great length to the patient and her family. I explained the possible risks and complications up to and including stroke, death, bleeding, nonhealing of her wounds, infection, and renal failure in light of her chronic renal insufficiency. I have recommended bypass and will check creatinine in the morning. If this is elevated, will postpone surgery. Will also discuss this with Dr. [REDACTED].

PLAN: Coronary artery bypass graft in the morning.

[REDACTED]
[REDACTED] M.D.

D: 06/23/97

T: 06/24/97 [REDACTED]

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