

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

ARMS#

13408



5 - SUMMARIES

000001

PATIENT NAME: [REDACTED]

CHIEF COMPLAINT:
Seizure activity.

HISTORY OF PRESENT ILLNESS:

Mr. the patient is a very pleasant 26-year-old white male with no known past medical history who presented to the Emergency Department of [REDACTED] after he had seizure. The patient apparently had a seizure two days prior to presentation to our emergency room and he presented to the emergency department of [REDACTED] where he was found to be hypoglycemic. He was thought to have a seizure secondary to hypoglycemia and was treated accordingly and was released home. The patient however, he had recurrent seizure at home and then he had a seizure in the Emergency Department and was subsequently given Haldol, Ativan and was admitted to the telemetry floor for further management and treatment.

PAST MEDICAL HISTORY:

Noncontributory.

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SJH

PAST SURGICAL HISTORY:

Noncontributory.

SOCIAL HISTORY:

The patient is married and has one child. He works as a manager for [REDACTED]

REVIEW OF SYSTEMS:

HEENT: The patient reports have some mild headaches, but denies having any significant migraine headaches.

CARDIAC: The patient denies having any cardiac history.

PULMONARY: The patient denies having any shortness of breath.

GASTROINTESTINAL: The patient denies having any history of peptic ulcer disease or gastritis, denies having any melena, hematemesis, hematochezia. The patient denies having any abdominal pain.

NEUROLOGICAL: The patient as above had a seizure the first time four days ago but there is no history of cerebrovascular accident, history of chronic seizure or head trauma.

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: The patient is a young-white male in no acute distress and no apparent pain at the time of this evaluation. He is a little sleepy and groggy.

VITAL SIGNS: Stable. The patient is afebrile.

HEENT: Normocephalic and atraumatic.

HEART: Normal S1 and S2. No murmur.

LUNGS: Clear with good air movement bilaterally.

ABDOMEN: Benign. Soft. Positive bowel sounds.

Name: [REDACTED]
Room: [REDACTED]
Sex: [REDACTED]
Mrun: [REDACTED]
Admit: [REDACTED]
Admit: [REDACTED]

PATIENT NAME: [REDACTED]

EXTREMITIES: No edema or cyanosis.

NEUROLOGICAL: The patient is awake, alert and oriented times three at this time. He is a little sleepy and groggy, but neurologic examination is afocal.

LABORATORY DATA:

Sodium is 140, potassium 3.0, chloride 108, bicarbonate 12 and INR gap of 9, glucose 131, BUN 10, creatinine 1.1, osmolarity of 280.

CBC revealed a white blood cell count of 9,800, hematocrit of 44.2, platelet count of 135,000.

The electrocardiogram was negative.

ASSESSMENT:

1. Seizure disorder in this 26-year-old white male with no known past medical history of seizure. I believe this is a combination of factors with ingestion of over the counter extracts, fatigue and the possible low threshold for seizure disorder that would classify the patient to have a seizure. We are going to admit the patient to telemetry and consult with neurology.

IMPRESSION:

1. Seizure disorder, most likely _____.
2. Slight hyperglycemia probably related to seizure disorder.
3. Hyperkalemia.
4. The patient has elevated liver enzymes most likely related to a small degree of rhabdomyolysis. We are going to follow up on that.

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[REDACTED]
HISTORY & PHYSICAL

Name: [REDACTED]
 Room: [REDACTED]
 Sex: [REDACTED]
 Mrun: [REDACTED]
 Admit: [REDACTED]
 Admit: [REDACTED]

HISTORY AND PHYSICAL

Page 3 of 3

PATIENT NAME: [REDACTED]

PLAN OF TREATMENT:

1. Admit to telemetry.
2. Ativan p.r.n.
3. Electroencephalogram.
4. Neuro checks.
5. Consult with neurology.
6. Followup laboratory data in the AM.

[REDACTED] MD

[REDACTED]
d:02/22/99 12:48 P

t:02/23/99 8:57 A

cc: [REDACTED] MD

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4/5/99
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[REDACTED]

HISTORY & PHYSICAL

Name: [REDACTED]
Room: [REDACTED]
Sex: [REDACTED]
Mrun: [REDACTED]
Admit [REDACTED]
Admit [REDACTED]

CHART COPY

000004

PATIENT NAME: [REDACTED]
DATE: 02/22/99
CONSULTANT: [REDACTED] MD
REFERRING PHYSICIAN: [REDACTED] MD

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HISTORY OF PRESENT ILLNESS:

Mr. [REDACTED] is a 26 year-old right handed male who on the 20th evening was at [REDACTED] (where he works as an assistant manager) and was talking to his wife on the telephone. He started talking some nonsensical which didn't make sense, and the next thing she remembers she could not get a response from him. The patient last remembers talking on the telephone and the next thing he remembers was waking up with paramedics around him, and he felt tired and confused. The patient was admitted to [REDACTED] where according to the records he had a generalized tonic/clonic seizure, and he was sent home without any antiseizure medication. He had another generalized tonic/clonic episode for which he was admitted to [REDACTED] and he had another event while in the Emergency Room. After talking to the Emergency Room physician, I recommended that he get Phenytoin equivalent of 1.5 grams loading dose. he had some Ativan last night as well. I looked at his CAT scan films without contrast, and it appears normal. Contrast films and EEG is pending.

The only medication the patient was taking was something called "Ripped Fuel" which is obtained from [REDACTED] and is a non FDA approved medication. Also, it appears the paramedics have given the patient a large dose of Haldol because of his postictal combativeness. There is no family history of mental retardation or seizures, and there is no history of head injury with loss of consciousness nor is there a history of meningitis/encephalitis.

REVIEW OF SYSTEMS:

HEENT: He had throbbing headaches associated with photophobia only recently in the last four days, but does not give an earlier history of migraine headaches. Ears - unremarkable. Eyes: no altered vision or discharge. Throat - no dysphagia or hoarseness, no sore throat.
GENERAL: No fevers, chills, Loss of appetite, weight loss or weight gain.
NEUROLOGICAL: No prior history of loss of consciousness or altered conscious episode with staring into space. Denies diplopia, dysarthria, dysphagia, hemilateral numbness or weakness, dystaxia.
GENITOURINARY: Denies dysuria.
CVS: Denies chest pain or coronary history.

[REDACTED]

CONSULTATION

Name: [REDACTED]
Room: [REDACTED]
Sex: [REDACTED]
Mrun: [REDACTED]
Admit: [REDACTED]
Admit: [REDACTED]

PATIENT NAME: [REDACTED]

Also denies any history suggestive of collagen vascular disease, lymphadenopathy, peptic ulcer disease, renal disease.

PAST MEDICAL HISTORY:
Denies past medical problems.

ALLERGIES:
No known drug allergies.

MEDICATIONS:
Prior to admission: Ripped Fuel (from [REDACTED])

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INVESTIGATIONS/LABS:
CT of the brain as above. CBC revealed WBC 11.4, hemoglobin 14.8, hematocrit 42, platelet count was 254,000.

Liver function tests normal except for AST which is 107. Electrolytes are largely normal.

Toxicology screen from [REDACTED] is negative.

SOCIAL HISTORY:
Nonsmoker, non ETOH abuser, non substance abuser.

FAMILY HISTORY:
No history of mental retardation or seizures. Patient lives with his wife and has a 17-year-old healthy daughter.

PHYSICAL EXAMINATION:
Blood pressure 129/61, pulse rate 90 and regular, respirations 18. Temperature 100°F oral.

This is a broad-framed, tall 26 year-old white male who appears his stated age. He carries on an intelligible conversation and he appears sedated but he is arousable and he speaks intelligibly with fluent language speech function.

Pupils equal and reactive. Extraocular movements are full and intact. Visual fields are grossly full. Facial grimace and sensation is symmetrical. Tongue and uvula is midline. Finger-nose-finger motion is steady bilaterally. There is normal tone in upper and lower extremities, and deep tendon reflexes are symmetrical throughout with equivocal plantar response on the right, and somewhat questionable upgoing on the left. There is no asymmetry to primary sensory perception. He does not extinguish to double simultaneous stimulation. Gait is mildly dystaxic.

[REDACTED]

CONSULTATION

Name: [REDACTED]
Room: [REDACTED]
Sex: [REDACTED]
Mrun: [REDACTED]
Admit: [REDACTED]
Admit Phys: [REDACTED] MD

PATIENT NAME: [REDACTED]

HEENT: reveals it is normocephalic, atraumatic. There is no otorrhea or rhinorrhea. Neck is supple, there is no carotid bruit. Lungs are clear bilaterally. CVS reveals S1, S2, regular rate and rhythm without murmur. Abdomen is soft without organomegaly and it is nontender. Lymphadenopathy is absent. Examination of the skin is unremarkable. Examination of genitalia is unremarkable.

IMPRESSION:

- 1. Complex partial seizure with:
- 2. Generalized tonic/clonic seizure which is new onset.
- 3. Recent history of suggestive of migraine headaches.

DISCUSSION:

I had a very lengthy discussion with the patient and his spouse about common-sense situations to avoid where an altered consciousness episode could potentially hurt himself and/or others such as driving alone, heavy machinery, etc. Also, I have given the patient information about seizures, the differential diagnosis, and the advantages and disadvantages of one antiepileptic versus another and the potential side effects.

Follow-up on CT brain and EEG.

Thank you for asking me to see Mr. [REDACTED]

[REDACTED] MD

d:02/22/99 9:48 A
t:02/23/99 3:50 A

cc: [REDACTED] MD
[REDACTED] MD

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4/5/99
SJH

[REDACTED]

CONSULTATION

Name: [REDACTED]
Room: [REDACTED]
Sex: [REDACTED]
Mrun: [REDACTED]
Admit: [REDACTED]
Admit: [REDACTED]

ATTENDING PHYSICIAN: [REDACTED] M.D.
 CONSULTING PHYSICIAN: [REDACTED] M.D.
 CONSULTING SERVICE: Gastroenterology/Hepatology.
 REASON FOR CONSULTATION: Evaluate ileus.

The patient is a most unfortunately 26 year old white male with a history of refractory seizures who subsequently sustained respiratory failure. The patient is intubated and a non historian at this time. The patient is heavily medicated as well. As per discussion with the patient's wife who is at his bed time, he has no established history of peptic ulcer disease, liver disease or idiopathic inflammatory bowel disease. The patient apparently has not had a bowel movement in approximately two weeks, and has been found to have a rather hypoactive bowel activity. There has been no rectal bleeding, melena or vomiting. Consultation now for evaluation of these problems.

The chart is not immediately available for comprehensive review, and therefore the following information is somewhat limited.

PAST MEDICAL HISTORY: Seizure disorders.

ALLERGIES: No known allergies.

CURRENT MEDICATIONS: To be reviewed.

PAST SURGICAL HISTORY: No intra-abdominal surgery, by patient's wife report.

SOCIAL HISTORY: The patient is a restaurant manager. There was a remote history of cocaine use. No history of alcoholism. The patient is on over the counter vitamins that include Ephedrine.

REVIEW OF SYSTEMS: Unable to list.

PHYSICAL EXAMINATION:

VITAL SIGNS: Reviewed.

GENERAL: Adult male who appears mildly obese, in no acute distress. The patient is medicated.

HEAD, EYES, EARS, NOSE AND THROAT: Head normal. Sclera white. Mouth-mucosal membranes pink. No significant gag reflex is noted.

NECK: Jugular vein is flat. No masses.

LUNGS: Coarse breath sounds, diminished at the bases. No wheezing, rales,

ADM DATE: 02/25/99

DSCH DATE:

PT SEX: M

BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]

PT NO.: [REDACTED]

NAME: [REDACTED]

MR NO.: [REDACTED]

rhonchi.

CHEST: No lymphadenopathy. No spider angiomas.

HEART: Normal.

ABDOMEN: Obese, minimally distended. Bowel activity is hypoactive peristalsis. No ascites or abdominal bruit. No borborygmi. No tympany. Spleen not palpable. Stool is heme negative.

EXTREMITIES: No muscle wasting, no palmar erythema.

LABORATORY DATA: Available laboratory data reviewed.

IMPRESSION:

- 1. Adynamic ileus.
- 2. Possible fecal impaction.
- 3. Gastroesophageal reflux disease, on clinical grounds.
- 4. Nutritional impairment.

PLAN:

- 1. KUB, evaluate for possible air/fluid levels.
- 2. Golytely one-half gallon over three hours in an effort to purge the large bowel.
- 3. Nutritional support.
- 4. Monitor metabolic panel and nutritional panel.

Thank you very much for this consultation. Further recommendations depending on the patient's course. The patient may ultimately require a gastrostomy feeding tube depending on his ultimate response.

cc: [Redacted]

cc: [Redacted] MD
[Redacted] MD

[Redacted] MD

ATTENDING PHYSICIAN: [Redacted] MD
SIGNING PHYSICIAN: [Redacted] MD

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [Redacted]

PT LOC: [Redacted]
PT NO.: [Redacted]
NAME: [Redacted]
MR NO.: [Redacted]

CLINIC NOTE

[REDACTED]

[REDACTED]

D: 03/09/99 T: 03/09/99 11:36 A
JOB #: [REDACTED]
DOC #: [REDACTED]
##

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

CLINIC NOTE

Attachment # 5
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ATTENDING PHYSICIAN: [REDACTED] M.D.
CONSULTING PHYSICIAN: [REDACTED] M.D.
CONSULTING SERVICE: Gastroenterology/Hepatology.
REASON FOR CONSULTATION: Evaluate ileus.

The patient is a most unfortunately 26 year old white male with a history of refractory seizures who subsequently sustained respiratory failure. The patient is intubated and a non historian at this time. The patient is heavily medicated as well. As per discussion with the patient's wife who is at his bed time, he has no established history of peptic ulcer disease, liver disease or idiopathic inflammatory bowel disease. The patient apparently has not had a bowel movement in approximately two weeks, and has been found to have a rather hypoactive bowel activity. There has been no rectal bleeding, melena or vomiting. Consultation now for evaluation of these problems.

The chart is not immediately available for comprehensive review, and therefore the following information is somewhat limited.

PAST MEDICAL HISTORY: Seizure disorders.

ALLERGIES: No known allergies.

CURRENT MEDICATIONS: To be reviewed.

PAST SURGICAL HISTORY: No intra-abdominal surgery, by patient's wife report.

SOCIAL HISTORY: The patient is a restaurant manager. There was a remote history of cocaine use. No history of alcoholism. The patient is on over the counter vitamins that include Ephedrine.

REVIEW OF SYSTEMS: Unable to list.

PHYSICAL EXAMINATION:

VITAL SIGNS: Reviewed.

GENERAL: Adult male who appears mildly obese, in no acute distress. The patient is medicated.

HEAD, EYES, EARS, NOSE AND THROAT: Head normal. Sclera white. Mouth-mucosal membranes pink. No significant gag reflex is noted.

NECK: Jugular vein is flat. No masses.

LUNGS: Coarse breath sounds, diminished at the bases. No wheezing, rales,

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

rhonchi.

CHEST: No lymphadenopathy. No spider angiomata.

HEART: Normal.

ABDOMEN: Obese, minimally distended. Bowel activity is hypoactive peristalsis. No ascites or abdominal bruit. No borborygmi. No tympany. Spleen not palpable. Stool is heme negative.

EXTREMITIES: No muscle wasting, no palmar erythema.

LABORATORY DATA: Available laboratory data reviewed.

IMPRESSION:

- 1. Adynamic ileus.
- 2. Possible fecal impaction.
- 3. Gastroesophageal reflux disease, on clinical grounds.
- 4. Nutritional impairment.

PLAN:

- 1. KUB, evaluate for possible air/fluid levels.
- 2. Golytely one-half gallon over three hours in an effort to purge the large bowel.
- 3. Nutritional support.
- 4. Monitor metabolic panel and nutritional panel.

Thank you very much for this consultation. Further recommendations depending on the patient's course. The patient may ultimately require a gastrostomy feeding tube depending on his ultimate response.

cc: [Redacted]

Attachment # 5
Memorandum-FLA-9339
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cc: [Redacted] MD
[Redacted] MD

[Redacted] MD

ATTENDING PHYSICIAN: [Redacted] MD
SIGNING PHYSICIAN: [Redacted] MD

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [Redacted]

PT LOC: [Redacted]
PT NO.: [Redacted]
NAME: [Redacted]
MR NO.: [Redacted]

000012

CLINIC NOTE

[REDACTED]
D: 03/09/99 T: 03/09/99 11:36 A

JOB #: [REDACTED]

DOC #: [REDACTED]

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Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

ADM DATE: 02/25/99

DSCH DATE:

PT SEX: M

BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]

PT NO.: [REDACTED]

NAME: [REDACTED]

MR NO.: [REDACTED]

000013

CONSULTATION REPORT

REASON FOR CONSULTATION: I was kindly asked by [REDACTED] M.D. to assist in the evaluation of this patient's "hypermetabolic state."

HISTORY OF PRESENT ILLNESS: The patient is a 26-year-old male, who first developed the condition on 02/20/99. The first symptom was incoherence during a telephone conversation with his wife. The patient was brought to [REDACTED] where he was first noted to have generalized tonic-clonic seizure. He was then sent home without any medications and he developed another episode. He was then brought to [REDACTED] at [REDACTED] where another seizure event was observed. He was admitted at that hospital, and initial extensive neurologic evaluation was done. He was evaluated by Dr. [REDACTED] a neurologist, who gave the impression of new onset generalized tonic-clonic seizure. The patient was also given Dilantin 300 mg a day.

In the hospital the patient developed subsequent seizure episodes, which necessitated intubation. A lumbar puncture was also done and subsequent result was negative. Because of the family's request, the patient was transferred to [REDACTED] for further evaluation and management.

I was contacted by [REDACTED] M.D. on 03/06/99, to help in the management of this patient. The specific issue that he wanted me to address was the question of hypermetabolism. This patient apparently has been taking different medications (over the counter supplements), which include Ripped Fuel, Wastraw, Creatine, XTC, and GHB. The patient has had intractable seizures since admission to [REDACTED]. He has been given different antiepilepsy medications, but the seizure episodes persist. The patient also developed fever without any obvious infectious etiology.

I was specifically asked on the different means to diminish a person's metabolism, and I responded by saying that we could do it by inducing hypothyroidism or decreasing a patient's body temperature.

PHYSICAL EXAMINATION:

GENERAL: I came to see the patient early in the morning of 03/07/99, and I saw a patient who was intubated, motionless, unresponsive, with no response to pain.

VITAL SIGNS: Blood pressure 108/70, respirations of 18, pulse rate of 96, temperature of 98.2.

HEENT: Reactive pupils.

NECK: No jugular venous distention. The thyroid is not enlarged, without

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000014

CONSULTATION REPORT

nodules.

LUNGS: The lungs are clear to auscultation. No rales and no wheezes.

CARDIOVASCULAR EXAMINATION: Heart normal in rate. Regular in rhythm.

ABDOMINAL EXAMINATION: Soft, positive bowel sounds.

EXTREMITIES: No edema. Positive pulses.

NEUROLOGICAL EXAMINATION: His neurologic examination is consistent with a comatose state.

LABORATORY DATA: The lab examinations from 03/08/99 show a white blood cell count of 6.2, hemoglobin of 11.7, hematocrit of 35, platelets of 283,000. Sodium 143, potassium 3.7, chloride 103, CO2 of 35, BUN of 10, glucose of 114, creatinine of 0.4. There has been a request for cortisol level and 24-hour urinary catecholamines.

ASSESSMENT:

1. Comatose state.
2. Polysubstance drug abuse.
3. Intractable seizures.

PLAN:

I initially ordered a random plasma catecholamine and a thyroid function panel, which subsequently showed findings consistent with central hypothyroidism. I ordered a TRH stimulation test, which did not significantly increase the TSH levels; the highest TSH was 0.8 to 0.85. I have also requested a repeat thyroid function examination, but the results are still not available. The cortisol level is within normal limits with a value of 8.6 mcg/dl. The T₄ is 3.51, the T₄ total is 3.30. A T₃ resin uptake is 0.94. I also ordered metabolic studies to determine the patient's metabolic rate, and the value is 2160, plus 6%.

We will wait for the results of the repeat thyroid panel to determine whether I should start the patient on a low dose thyroid hormone replacement. The plasma catecholamines are still pending.

Thank you, [REDACTED] M.D., for allowing me to see this patient in consultation.

ADDENDUM: This consultation is being dictated on 03/11/99, four days after the initial encounter with the patient. Some of the information dictated are values from after the initial encounter. The first attempt at dictation on 03/07/99, apparently was not accepted by the recording machine.

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000015

CONSULTATION REPORT

CC: [REDACTED] M.D. [REDACTED] M.D.

CC: [REDACTED]

[REDACTED] MD

ATTENDING PHYSICIAN: [REDACTED]
SIGNING PHYSICIAN: [REDACTED]
DICTATING RESIDENT: [REDACTED]

[REDACTED]
D: 03/11/99 T: 03/16/99 4:44 P
JOB #: [REDACTED]
DOC #: [REDACTED]
##

Attachment # 2
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000016

CONSULTATION REPORT

DATE OF CONSULTATION: 03/14/99

ATTENDING PHYSICIAN: [REDACTED] M.D.

REFERRING PHYSICIAN: [REDACTED] M.D.

REASON FOR CONSULTATION: Abnormal liver enzymes

HISTORY OF PRESENT ILLNESS: The patient is a 26 year-old white male who is admitted for refractory seizures. On 02/19/99, the patient initially had acute confusion while talking on the phone. He developed seizures and hypoglycemia. The patient was brought to the Emergency Room Department at [REDACTED] by the Paramedics. The patient was released from the hospital but had further seizures and was admitted to [REDACTED]. The patient was treated with Dilantin and Ativan. He received Haldol from the Paramedics. The patient was put on Phenobarbital and Ativan and then Neurontin.

The patient was eventually transferred to [REDACTED] on a Versed drip. At [REDACTED] the patient was weaned off the Versed drip and placed on Dilantin and Diprivan as needed. The patient subsequently was given Neurontin. By 02/28/99, the patient was given a Phenobarbital load and a drip for suppression. The patient also was restarted on Versed drip.

The patient had an ileus approximately two weeks ago and he was seen by [REDACTED] M.D. and no stool. He was given Golytely and had a prompt response. The patient was started on Depakote on 03/08/99 and apparently was discontinued on 03/11/99. The patient was also on Tegretol from 03/09/99 until 03/11/99.

During this time, the liver enzymes from 02/20/99 were normal with a normal bilirubin, aspartate transaminase and alkaline phosphatase. On 02/22/99, the total bilirubin as normal at 0.8, aspartate transaminase 109, and albumin 3.9. By 03/01/99 the liver enzymes were normal. Total bilirubin was 3.5, aspartate transaminase 18 and alkaline phosphatase 65. A full liver profile done on 03/03/99 was normal. Total bilirubin was 0.4, aspartate transaminase 31, alanine aminotransferase 36 and alkaline phosphatase 74. By 03/09/99, the patient had a minimally elevated aspartate transaminase with total bilirubin 0.2, aspartate transaminase 49, and alanine aminotransferase 30 and alkaline phosphatase 60. By 03/10/99, he had greater rise in his transaminases, with total bilirubin of 0.2, aspartate transaminase 223, alanine aminotransferase 135, alkaline phosphatase 83. On 03/11/99, his total bilirubin was 0.3, aspartate transaminase 326, and alkaline phosphatase 99. The hepatic profile on 03/13/99 revealed a total bilirubin of 0.7 with a direct bilirubin of 0.4 and aspartate transaminase of 939, alanine aminotransferase 150, and alkaline phosphatase of 294. By today, his total

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000017

CONSULTATION REPORT

bilirubin is 1.1, direct bilirubin 1.1, direct bilirubin 0.7, aspartate transaminase 675, alanine aminotransferase 916 and alkaline phosphatase 257.

The patient, according to the chart, had no history of prior liver disease. His liver enzymes were normal before March 1999. The patient has no history of alcohol intake, as per the chart. The patient did use "ripped fuel" ephedrine supplement that had caffeine and chromium piccholate. He took this as an over the counter supplement shortly before his seizures and it has been speculated as a possible causative factor in his seizure disorder.

The patient has also had some diarrhea over the last several days. This is essentially improved by today. The stool is brown and he has had no blood.

The patient, per prior questioning of the family by previous physicians, has no history of peptic ulcer disease, inflammatory bowel disease, or liver disease.

ALLERGIES: None.

CURRENT MEDICATIONS:

1. Neurontin, 300 mg, every four hours
2. Lovenox, 30 mg, every 12 hours
3. Naprosyn, 500 mg, b.i.d.
4. Colace suspension, b.i.d.
5. Phenobarbital, 180 mg b.i.d.
6. Synthroid, 25 micrograms per day
7. Zosyn, 3.375 mg every six hours
8. Vancomycin, 2 grams intravenously every 12 hours
9. Ativan as needed
10. Tylenol as needed
11. Diprivan drip
12. Dopamine drip
13. Hyperalimentation
14. Accu-Cheks
15. Nystatin 16. As needed Haldol

PAST MEDICAL HISTORY: None

SOCIAL HISTORY:

1. The patient works as a restaurant manager at [REDACTED]
2. He does not have a history of smoking or alcohol abuse.
3. He does have a distant history of cocaine abuse.

FAMILY HISTORY: Unobtainable.

REVIEW OF SYSTEMS: Unobtainable.

ADM DATE: 02/25/99
 DSCH DATE:
 PT SEX: M
 BIRTH DATE: [REDACTED]

PT LOC:
 PT NO.:
 NAME:
 MR NO.:

000018

CONSULTATION REPORT

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature - 100.2. Blood pressure - 116/52. Pulse - 64. He is on a ventilator at a rate of 10.

GENERAL: On physical examination, the patient is a critically ill white male with electroencephalogram leads who is ventilated and critically ill in the Intensive Care Unit.

HEAD, EYES, EARS, NOSE AND THROAT: Eyes - conjunctiva pink, sclerae anicteric. Pupils are equal and reactive to light and accommodation. Throat - intubated. No lip erosions.

LUNGS: Clear to auscultation anteriorly and smooth with mechanical ventilations audible.

NECK: No definite bruits audible over the ventilator.

NODES: Negative supraclavicular, cervical or axillary nodes.

HEART: Regular rate and rhythm with no definite gallop audible.

ABDOMEN: His abdomen is slightly protuberant. There is no definite ascites. The liver span is 12.5 cm to percussion. The spleen is not definitely palpable. The abdomen is soft. There is no involuntary guarding. The spleen is not palpable.

RECTAL: Brown stool per bag.

EXTREMITIES: No edema. No clubbing.

NEUROLOGIC: The patient is in pentobarbital coma. He is flaccid. No response to noxious stimulation. Central nervous system - no spider angiomas.

LABORATORY DATA: Liver enzymes as per history of present illness. His drug screen on 02/29/99 was negative. Today's Phenobarbital level is 19. Sodium 143. Potassium 3.4. Blood urea nitrogen 22. Creatinine 0.6. Amylase 160. Lipase 276. Repeat potassium 3.5. Hemoglobin 12.6. Hematocrit 37.8. White blood count 3.9. Platelets 427,000. From 03/02/99 hepatitis B surface antibody was negative. Hepatitis B core antibody was negative. Hepatitis B surface antigen was negative. Hepatitis C antibody was negative.

IMPRESSION AND RECOMMENDATION:

1. Abnormal liver enzymes. The patient has abnormal liver enzymes which basically started on or about 03/09/99 or at least between 03/03/99 and 03/09/99. This happens to coincide with the introduction of the valproic acid on 03/08/99 with a load. The liver enzymes are actually slightly better with the aspartate transaminase down on 03/14/99 although the alanine

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE:

PT LOC:
PT NO.:
NAME:
MR NO.:

000019

CONSULTATION REPORT

aminotransferase is slightly higher today. He was also on Tegretol from 03/09/99. I suspect that the most likely explanation therefore is that the abnormal liver enzymes are due to Depakote hepatotoxicity. However, other possible causes include other drugs, including Naprosyn. Haldol would be less likely to present with this picture. The patient had a negative viral screen on 03/02/99 and it is possible, but extremely unlikely, that he would have acquired a hepatotropic virus in the intervening ten days. Other possibilities include ischemia, although the patient currently is not hypotensive nor was he hypotensive. Furthermore, the pattern of liver enzyme rise is much slower than is sharp and well defined peak one would suspect from ischemic liver injury. Since the liver enzymes suggest that they are improving, would follow them for now. I would not do further workup unless these numbers do not continue to improve.

2. Diarrhea. The patient has had mild diarrhea. We will check stool studies, particularly fecal leukocytes and C. Difficile toxin since he is on antibiotics. If the C. Difficile is positive, will treat him with Flagyl, otherwise will need to do further workup including flexible sigmoidoscopy.

3. Elevated pancreatic enzymes. The patient has elevated pancreatic enzymes. The patient did have an ileus picture earlier, although this is markedly improved. Will follow the enzymes at this time. The patient is being followed by a duodenal feeding tube which is apparently in the distal portion of the duodenum. Would continue feeding for now unless pancreatic enzymes markedly increase.

4. Fevers. The patient has fevers. All of his cultures have been essentially negative. The patient is on Naprosyn to suppress his fevers. If his liver enzymes do not continue to improve off the valproic acid, I would suggest that the Naprosyn be discontinued and the patient be switched to another antipyretic medication.

5. Seizure disorder. The patient had severe seizure disorder requiring hepatotoxic antiseizure medications. Would expect that the GGT would be elevated with the use of Phenobarbital. Will follow liver enzymes with the interdiction of any further medications.

6. Ileus. The patient had an ileus which seems largely improved. May consider rechecking a KUB.

CC:

CC:

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE:

PT LOC:
PT NO.:
NAME:
MR NO.:

000020

CONSULTATION REPORT

MD

ATTENDING PHYSICIAN
SIGNING PHYSICIAN:
DICTATING RESIDENT:

D: 03/14/99 T: 03/20/99 8:37 A
JOB #:
DOC #:
##

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE:

PT LOC:
PT NO.:
NAME:
MR NO.:

000021

CONSULTATION REPORT

DATE OF CONSULTATION: 03/14/99

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

ATTENDING PHYSICIAN: [REDACTED] M.D.

REFERRING PHYSICIAN: [REDACTED] M.D.

REASON FOR CONSULTATION: Abnormal liver enzymes

HISTORY OF PRESENT ILLNESS: The patient is a 26 year-old white male who is admitted for refractory seizures. On 02/19/99, the patient initially had acute confusion while talking on the phone. He developed seizures and hypoglycemia. The patient was brought to the Emergency Room Department at [REDACTED] by the Paramedics. The patient was released from the hospital but had further seizures and was admitted to [REDACTED]. The patient was treated with Dilantin and Ativan. He received Haldol from the Paramedics. The patient was put on Phenobarbital and Ativan and then Neurontin.

The patient was eventually transferred to [REDACTED] on a Versed drip. At [REDACTED] the patient was weaned off the Versed drip and placed on Dilantin and Diprivan as needed. The patient subsequently was given Neurontin. By 02/28/99, the patient was given a Phenobarbital load and a drip for suppression. The patient also was restarted on Versed drip.

The patient had an ileus approximately two weeks ago and he was seen by [REDACTED] M.D. and no stool. He was given Golytely and had a prompt response. The patient was started on Depakote on 03/08/99 and apparently was discontinued on 03/11/99. The patient was also on Tegretol from 03/09/99 until 03/11/99.

During this time, the liver enzymes from 02/20/99 were normal with a normal bilirubin, aspartate transaminase and alkaline phosphatase. On 02/22/99, the total bilirubin as normal at 0.8, aspartate transaminase 109, and albumin 3.9. By 03/01/99 the liver enzymes were normal. Total bilirubin was 3.5, aspartate transaminase 18 and alkaline phosphatase 65. A full liver profile done on 03/03/99 was normal. Total bilirubin was 0.4, aspartate transaminase 31, alanine aminotransferase 36 and alkaline phosphatase 74. By 03/09/99, the patient had a minimally elevated aspartate transaminase with total bilirubin 0.2, aspartate transaminase 49, and alanine aminotransferase 30 and alkaline phosphatase 60. By 03/10/99, he had greater rise in his transaminases, with total bilirubin of 0.2, aspartate transaminase 223, alanine aminotransferase 135, alkaline phosphatase 83. On 03/11/99, his total bilirubin was 0.3, aspartate transaminase 326, and alkaline phosphatase 99. The hepatic profile on 03/13/99 revealed a total bilirubin of 0.7 with a direct bilirubin of 0.4 and aspartate transaminase of 939, alanine aminotransferase 150, and alkaline phosphatase of 294. By today, his total

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000022

CONSULTATION REPORT

bilirubin is 1.1, direct bilirubin 1.1, direct bilirubin 0.7, aspartate transaminase 675, alanine aminotransferase 916 and alkaline phosphatase 257.

The patient, according to the chart, had no history of prior liver disease. His liver enzymes were normal before March 1999. The patient has no history of alcohol intake, as per the chart. The patient did use "ripped fuel" ephedrine supplement that had caffeine and chromium piccholate. He took this as an over the counter supplement shortly before his seizures and it has been speculated as a possible causative factor in his seizure disorder.

The patient has also had some diarrhea over the last several days. This is essentially improved by today. The stool is brown and he has had no blood.

The patient, per prior questioning of the family by previous physicians, has no history of peptic ulcer disease, inflammatory bowel disease, or liver disease.

ALLERGIES: None.

CURRENT MEDICATIONS:

1. Neurontin, 300 mg, every four hours
2. Lovenox, 30 mg, every 12 hours
3. Naprosyn, 500 mg, b.i.d.
4. Colace suspension, b.i.d.
5. Phenobarbital, 180 mg b.i.d.
6. Synthroid, 25 micrograms per day
7. Zosyn, 3.375 mg every six hours
8. Vancomycin, 2 grams intravenously every 12 hours
9. Ativan as needed
10. Tylenol as needed
11. Diprivan drip
12. Dopamine drip
13. Hyperalimentation
14. Accu-Cheks
15. Nystatin 16. As needed Haldol

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

PAST MEDICAL HISTORY: None

SOCIAL HISTORY:

1. The patient works as a restaurant manager at [REDACTED]
2. He does not have a history of smoking or alcohol abuse.
3. He does have a distant history of cocaine abuse.

FAMILY HISTORY: Unobtainable.

REVIEW OF SYSTEMS: Unobtainable.

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME:
MR NO.: [REDACTED]

000023

CONSULTATION REPORT

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature - 100.2. Blood pressure - 116/52. Pulse - 64. He is on a ventilator at a rate of 10.

GENERAL: On physical examination, the patient is a critically ill white male with electroencephalogram leads who is ventilated and critically ill in the Intensive Care Unit.

HEAD, EYES, EARS, NOSE AND THROAT: Eyes - conjunctiva pink, sclerae anicteric. Pupils are equal and reactive to light and accommodation. Throat - intubated. No lip erosions.

LUNGS: Clear to auscultation anteriorly and smooth with mechanical ventilations audible.

NECK: No definite bruits audible over the ventilator.

NODES: Negative supraclavicular, cervical or axillary nodes.

HEART: Regular rate and rhythm with no definite gallop audible.

ABDOMEN: His abdomen is slightly protuberant. There is no definite ascites. The liver span is 12.5 cm to percussion. The spleen is not definitely palpable. The abdomen is soft. There is no involuntary guarding. The spleen is not palpable.

RECTAL: Brown stool per bag.

EXTREMITIES: No edema. No clubbing.

NEUROLOGIC: The patient is in pentobarbital coma. He is flaccid. No response to noxious stimulation. Central nervous system - no spider angiomas.

LABORATORY DATA: Liver enzymes as per history of present illness. His drug screen on 02/29/99 was negative. Today's Phenobarbital level is 19. Sodium 143. Potassium 3.4. Blood urea nitrogen 22. Creatinine 0.6. Amylase 160. Lipase 276. Repeat potassium 3.5. Hemoglobin 12.6. Hematocrit 37.8. White blood count 3.9. Platelets 427,000. From 03/02/99 hepatitis B surface antibody was negative. Hepatitis B core antibody was negative. Hepatitis B surface antigen was negative. Hepatitis C antibody was negative.

IMPRESSION AND RECOMMENDATION:

1. Abnormal liver enzymes. The patient has abnormal liver enzymes which basically started on or about 03/09/99 or at least between 03/03/99 and 03/09/99. This happens to coincide with the introduction of the valproic acid on 03/08/99 with a load. The liver enzymes are actually slightly better with the aspartate transaminase down on 03/14/99 although the alanine

ADM DATE: 02/25/99
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PT LOC:
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NAME:
MR NO.:

000024

CONSULTATION REPORT

aminotransferase is slightly higher today. He was also on Tegretol from 03/09/99. I suspect that the most likely explanation therefore is that the abnormal liver enzymes are due to Depakote hepatotoxicity. However, other possible causes include other drugs, including Naprosyn. Haldol would be less likely to present with this picture. The patient had a negative viral screen on 03/02/99 and it is possible, but extremely unlikely, that he would have acquired a hepatotropic virus in the intervening ten days. Other possibilities include ischemia, although the patient currently is not hypotensive nor was he hypotensive. Furthermore, the pattern of liver enzyme rise is much slower than is sharp and well defined peak one would suspect from ischemic liver injury. Since the liver enzymes suggest that they are improving, would follow them for now. I would not do further workup unless these numbers do not continue to improve.

2. Diarrhea. The patient has had mild diarrhea. We will check stool studies, particularly fecal leukocytes and C. Difficile toxin since he is on antibiotics. If the C. Difficile is positive, will treat him with Flagyl, otherwise will need to do further workup including flexible sigmoidoscopy.

3. Elevated pancreatic enzymes. The patient has elevated pancreatic enzymes. The patient did have an ileus picture earlier, although this is markedly improved. Will follow the enzymes at this time. The patient is being followed by a duodenal feeding tube which is apparently in the distal portion of the duodenum. Would continue feeding for now unless pancreatic enzymes markedly increase.

4. Fevers. The patient has fevers. All of his cultures have been essentially negative. The patient is on Naprosyn to suppress his fevers. If his liver enzymes do not continue to improve off the valproic acid, I would suggest that the Naprosyn be discontinued and the patient be switched to another antipyretic medication.

5. Seizure disorder. The patient had severe seizure disorder requiring hepatotoxic antiseizure medications. Would expect that the GGT would be elevated with the use of Phenobarbital. Will follow liver enzymes with the interdiction of any further medications.

6. Ileus. The patient had an ileus which seems largely improved. May consider rechecking a KUB.

CC: [Redacted]

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

CC: [Redacted]

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [Redacted]

PT LOC: [Redacted]
PT NO.: [Redacted]
NAME: [Redacted]
MR NO.: [Redacted]

000025

CONSULTATION REPORT

MD

ATTENDING PHYSICIAN
SIGNING PHYSICIAN:
DICTATING RESIDENT:

D: 03/14/99 T: 03/20/99 8:37 A
JOB #:
DOC #:
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Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE:

PT LOC:
PT NO.:
NAME:
MR NO.:

000026

CONSULTATION REPORT

REASON FOR CONSULTATION: Evaluation of intractible seizures.

HISTORY OF PRESENT ILLNESS: Mr. [redacted] is a 26-year-old male, transferred to this hospital from [redacted] because of intractable seizures, started on February 20, 1999, associated with the patient taking Ripped Fuel for energy enhancement and Ma-huang, which contains some ephedrine derivative. The patient presented to the emergency room at [redacted] with his first seizure which occurred in the setting of the patient talking on the phone to his wife, then feeling something coming on wrong, screamed out "Wow!" and then passed out, had a generalized seizure, was seen in the emergency room, had a second seizure in the emergency room, and eventually stabilized. CT scan of the brain seems to have been negative. The patient went home. The next day he, again, had a couple more seizures, and was taken to [redacted] at [redacted] at which time he was admitted and continued to have seizures, in spite of aggressive management.

The patient eventually transferred to this hospital on the 24th, where he was placed in the ICU, placed on Versed, Diprivan. In spite of the Versed and Diprivan, he continued to have partial seizures of the face. He has remained unresponsive since then, and he has not recovered anything. He has shown to have significant cerebral edema. He has had multiple spinal taps done, all of which have been normal. He has had cerebral angiogram, which was normal, and he has been treated with steroids, just in case this is a small vessel vasculitis, which does not seem to have helped very much.

He is now being treated with phenobarbital at high dosages, giving him levels in the 30's, and Neurontin, again, giving him reasonable levels, though still can be pushed even higher, and Depakote I.V. However, since the Depakote I.V. started, the patient has been having difficulty with liver function tests, pancreatitis. He has also been receiving TPN.

The patient is still having daily partial twitches of the face, without recovering full consciousness.

PAST MEDICAL HISTORY: His past medical history is, actually, otherwise, unremarkable. He had been a healthy individual all of his life.

- MEDICATIONS: His medications at this time are - 1. Polysporin.
2. Neurontin 400 mg q.4h.
 3. Lovenox 30 mg subq q.12h.
 4. Colace suppositories b.i.d.
 5. Phenobarbital 180 mg q.8h.
 6. Synthroid 0.025 mg I.V. q.d.
 7. Zosyn 3.375 gm q.6h.
 8. Nimotop 60 mg q.4h.

Attachment # 4
Memorandum-FLA-9339
4/13/99
CFSSAN Project #13408
SJH

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [redacted]

PT LOC: [redacted]
PT NO.: [redacted]
NAME: [redacted]
MR NO.: [redacted]

000027

CONSULTATION REPORT

9. Decadron 4 mg q.6h.
10. Vitamin K 10 mg subq q.a.m.
11. Versed 5 mg p.r.n., receives one or two dosages a day.
12. Ativan 1 mg on a p.r.n. basis, receiving it at least two or three times a day.
13. Tylenol p.r.n.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature of 100 at this time, but has been as high as 101 today. Blood pressure is 130/70, pulse in the 100 to 120 range. Respirations are anywhere from 4 to 11, with assist control of 10. He is on a Versed drip at this time, also.

GENERAL: The patient is unresponsive to sternal rub.

HEENT: Pupils are about 3 mm and sluggishly reactive. Corneal reflexes are negative bilaterally.

NEUROLOGICAL EXAMINATION: The tone is flaccid in all four extremities. Deep tendon reflexes are absent throughout, with unresponsive toes to plantar stimulation. There is no doll's eyes movement at this time, although, again, the patient is on a Versed drip.

NEUROLOGICAL ASSESSMENT:

1. Intractable seizures, most likely toxic, related to the Ripped Fuel and the Ma-huang.
2. Pancreatitis and hepatitis, probably secondary to TPN plus the Depakote.

RECOMMENDATIONS:

1. PEG tube and start using this for nutrition, to stop the TPN.
2. Continue phenobarbital.
3. Continue Neurontin.
4. Consider changing the Depakote for _____, Topamax. Topamax.
5. Consider Ativan 1 mg I.V. q.6h. regularly rather than p.r.n.
6. Continue Decadron.
7. Totally agree with Nimotop use.
8. Agree with excellent attempts made so far to diagnose and treat this unfortunate young man.

Thank you very much, [REDACTED] M.D., for allowing me to participate in the care of your patient.

PRELIMINARY REPORTPRELIMINARY REPORT***PRELIMINARY REPORT***

RESPONSIBLE DR: [REDACTED] M.D.
DICTATING DR: [REDACTED] M.D.

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000028

CONSULTATION REPORT

BLANK IN RECOMMENDATIONS.

YOUR ASSISTANCE IS NEEDED BEFORE THIS REPORT CAN BE COMPLETED. PRINT CORRECTIONS ON THIS REPORT AND TAKE IT TO MEDICAL RECORDS DICTATION SECTION, ROOM [REDACTED]

PRELIMINARY REPORTPRELIMINARY REPORT***PRELIMINARY REPORT***

CC: [REDACTED] M.D.

CC: [REDACTED]

[REDACTED]
[REDACTED] MD

ATTENDING PHYSICIAN: [REDACTED]
SIGNING PHYSICIAN: [REDACTED]
DICTATING RESIDENT: [REDACTED]

[REDACTED]
D: 03/20/99 T: 03/21/99 1:55 P
JOB #: [REDACTED]
DOC #: [REDACTED]
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Attachment # 4
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000029

CONSULTATION REPORT

REASON FOR CONSULTATION: Evaluation of intractible seizures.

HISTORY OF PRESENT ILLNESS: Mr. [redacted] is a 26-year-old male, transferred to this hospital from [redacted] because of intractable seizures, started on February 20, 1999, associated with the patient taking Ripped Fuel for energy enhancement and Ma-huang, which contains some ephedrine derivative. The patient presented to the emergency room at [redacted] with his first seizure which occurred in the setting of the patient talking on the phone to his wife, then feeling something coming on wrong, screamed out "Wow!" and then passed out, had a generalized seizure, was seen in the emergency room, had a second seizure in the emergency room, and eventually stabilized. CT scan of the brain seems to have been negative. The patient went home. The next day he, again, had a couple more seizures, and was taken to [redacted] at [redacted] at which time he was admitted and continued to have seizures, in spite of aggressive management.

The patient eventually transferred to this hospital on the 24th, where he was placed in the ICU, placed on Versed, Diprivan. In spite of the Versed and Diprivan, he continued to have partial seizures of the face. He has remained unresponsive since then, and he has not recovered anything. He has shown to have significant cerebral edema. He has had multiple spinal taps done, all of which have been normal. He has had cerebral angiogram, which was normal, and he has been treated with steroids, just in case this is a small vessel vasculitis, which does not seem to have helped very much.

He is now being treated with phenobarbital at high dosages, giving him levels in the 30's, and Neurontin, again, giving him reasonable levels, though still can be pushed even higher, and Depakote I.V. However, since the Depakote I.V. started, the patient has been having difficulty with liver function tests, pancreatitis. He has also been receiving TPN.

The patient is still having daily partial twitches of the face, without recovering full consciousness.

PAST MEDICAL HISTORY: His past medical history is, actually, otherwise, unremarkable. He had been a healthy individual all of his life.

- MEDICATIONS: His medications at this time are -
1. Polysporin.
 2. Neurontin 400 mg q.4h.
 3. Lovenox 30 mg subq q.12h.
 4. Colace suppositories b.i.d.
 5. Phenobarbital 180 mg q.8h.
 6. Synthroid 0.025 mg I.V. q.d.
 7. Zosyn 3.375 gm q.6h.
 8. Nimotop 60 mg q.4h.

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [redacted]

PT LOC: [redacted]
PT NO.: [redacted]
NAME:
MR NO.: [redacted]

000030

CONSULTATION REPORT

- 9. Decadron 4 mg q.6h.
- 10. Vitamin K 10 mg subq q.a.m.
- 11. Versed 5 mg p.r.n., receives one or two dosages a day.
- 12. Ativan 1 mg on a p.r.n. basis, receiving it at least two or three times a day.
- 13. Tylenol p.r.n.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature of 100 at this time, but has been as high as 101 today. Blood pressure is 130/70, pulse in the 100 to 120 range. Respirations are anywhere from 4 to 11, with assist control of 10. He is on a Versed drip at this time, also.

GENERAL: The patient is unresponsive to sternal rub.

HEENT: Pupils are about 3 mm and sluggishly reactive. Corneal reflexes are negative bilaterally.

NEUROLOGICAL EXAMINATION: The tone is flaccid in all four extremities. Deep tendon reflexes are absent throughout, with unresponsive toes to plantar stimulation. There is no doll's eyes movement at this time, although, again, the patient is on a Versed drip.

NEUROLOGICAL ASSESSMENT:

- 1. Intractable seizures, most likely toxic, related to the Ripped Fuel and the Ma-huang.
- 2. Pancreatitis and hepatitis, probably secondary to TPN plus the Depakote.

RECOMMENDATIONS:

- 1. PEG tube and start using this for nutrition, to stop the TPN.
- 2. Continue phenobarbital.
- 3. Continue Neurontin.
- 4. Consider changing the Depakote for _____, Topamax. Topamax.
- 5. Consider Ativan 1 mg I.V. q.6h. regularly rather than p.r.n.
- 6. Continue Decadron.
- 7. Totally agree with Nimotop use.
- 8. Agree with excellent attempts made so far to diagnose and treat this unfortunate young man.

Thank you very much, [REDACTED] M.D., for allowing me to participate in the care of your patient.

PRELIMINARY REPORTPRELIMINARY REPORT***PRELIMINARY REPORT***

RESPONSIBLE DR: [REDACTED]
DICTATING DR: [REDACTED]

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000031

CONSULTATION REPORT

BLANK IN RECOMMENDATIONS.

YOUR ASSISTANCE IS NEEDED BEFORE THIS REPORT CAN BE COMPLETED. PRINT CORRECTIONS ON THIS REPORT AND TAKE IT TO MEDICAL RECORDS DICTATION SECTION, ROOM [REDACTED] OR FAX TO [REDACTED]

PRELIMINARY REPORTPRELIMINARY REPORT***PRELIMINARY REPORT***

CC: [REDACTED] M.D. [REDACTED] M.D.

CC: [REDACTED] [REDACTED] MD

ATTENDING PHYSICIAN: [REDACTED]
SIGNING PHYSICIAN: [REDACTED]
DICTATING RESIDENT: [REDACTED]

[REDACTED]
D: 03/20/99 T: 03/21/99 1:55 P
JOB #: [REDACTED]
DOC #: [REDACTED]
##

ADM DATE: 02/25/99
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000032

[REDACTED]

CONSULTATION REPORT

DATE OF CONSULTATION: May 26, 1999 (dictated May 27, 1999).

ATTENDING PHYSICIAN: [REDACTED] M.D.

CONSULTING PHYSICIAN: [REDACTED] M.D.

CONSULTING SERVICE: Gastroenterology, hepatology.

REASON FOR CONSULTATION: Gastrointestinal follow-up, removal of gastrostomy feeding tube.

The patient is a 26-year-old white male who is known to me from prior consultation when the patient was originally admitted to the [REDACTED] and then from a consultation completed at the [REDACTED] where the patient was recently discharged. The patient has a history of toxic encephalopathy and intractable seizures and previously required ventilator support. A gastrostomy feeding tube had been placed approximately two to three months ago as the patient demonstrated ongoing long-term need for nutritional support due to issues pertaining to transit dysphagia with high aspiration risk and protein/calorie malnutrition.

The patient, at this time, has demonstrated excellent recovery from his neurologic problems and, specifically, his swallowing mechanism has normalized. The patient has demonstrated a sustained and adequate intake of calories with a safe swallow also being documented. Consultation is now for consideration for removal of the gastrostomy feeding tube.

PAST MEDICAL HISTORY: Seizures, gastroesophageal reflux disease, gastritis, transit dysphagia secondary to recent encephalopathy.

MEDICATIONS: Lamictal 200 milligrams b.i.d., Neurontin 400 milligrams, Phenobarbital, Klonopin.

SOCIAL HISTORY: Married, no history of alcoholism or tobacco abuse. Transfusion history is negative.

SURGICAL HISTORY: Gastrostomy feeding tube, otherwise unknown.

REVIEW OF SYSTEMS: Negative for chest pain, shortness of breath, hemoptysis, rectal bleeding, melena, abdominal pain, vomiting, weight loss, pruritus, clinical jaundice.

PHYSICAL EXAMINATION:

VITAL SIGNS: Vital signs reviewed.

GENERAL: General appearance, adult male who appears well-nourished and developed. The patient is lucid without obvious evidence of encephalopathy. The patient appears to be in good spirits.

ADM DATE: 05/20/1999
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000033

CONSULTATION REPORT

HEENT: Head examination normal. Eye examination, sclerae white, conjunctivae healthy. Mouth examination, membranes pink, no exudate, no pigmentary changes.

NECK: Jugular veins/full range of motion, nontender, no adenopathy, thyroid normal.

LUNGS: Lung examination is clear in all fields, negative for retractions, wheezing or rales.

CHEST: Chest examination, no lymphadenopathy, no spider angiomas.

HEART: Heart examination normal. No S2, murmur or cardiac rub.

ABDOMEN: Abdomen examination, soft, nondistended, nontender, bowels normal, no ascites, no visceromegaly. No masses. A gastrostomy tube is identified and demonstrates good placement.

EXTREMITIES: No edema or phlebitis.

IMPRESSION:

1. History of transit dysphagia with aspiration risk, resolved.
2. History of failure to thrive, resolved.
3. Gastritis, reflux esophagitis.

RECOMMENDATIONS:

1. The patient has made excellent recovery over the past several months and, at this time, demonstrates a safe swallowing mechanism and has also demonstrated excellent oral intake. The patient no longer requires his feeding tube. Plans will be made to proceed with endoscopic removal of the G-tube in the a.m.

Thank you very much for this follow-up consultation.

cc: [REDACTED]

CC: [REDACTED] MD
[REDACTED], MD

[REDACTED] MD

ATTENDING PHYSICIAN: [REDACTED] MD
SIGNING PHYSICIAN: [REDACTED], MD

ADM DATE: 05/20/1999
DSCH DATE:
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000034

CONSULTATION REPORT

[REDACTED]
[REDACTED]
D: 05/27/1999 T: 05/28/1999 1:16 P

JOB #:

DOC #:

##

ADM DATE: 05/20/1999

DSCH DATE:

PT SEX: M

BIRTH DATE:

PT LOC:

PT NO.:

NAME:

MR NO.:

000035

PROBLEM LIST:

1. Status epilepticus, secondary to substance abuse.
2. Toxic encephalopathy secondary to #1.
3. Respiratory failure secondary to #1.
4. Status post PEG placement.
5. Status post tracheostomy/decannulated.
6. Early heterotopic ossification of left hip.

PROCEDURE PERFORMED:

1. Electroencephalogram on 05/21/99, which demonstrated epileptiform activity.
2. CT scan of the brain on 06/03/99 showed no acute findings.
3. Removal of PEG tube on 05/27/99.

CONSULTATIONS:

1. Neurology with [REDACTED] M.D.
2. GI Medicine with [REDACTED] M.D.

HISTORY OF PRESENT ILLNESS:

[REDACTED] is a 26-year-old, left-hand dominant gentleman, who was transferred from [REDACTED] to [REDACTED] with encephalopathy secondary to status epilepticus. Limited records were available at the time of admission. [REDACTED] had status epilepticus secondary to presumed substance abuse, which resulted in toxic encephalopathy. As a result, he required prolonged ventilatory support and was transferred from [REDACTED] to [REDACTED]

Following weaning from the ventilator, he was felt to be a good rehabilitation candidate, and then transferred to the rehabilitation center.

HOSPITAL COURSE:

Upon admission he was awake, alert, slow to respond to questions, although he was able to speak in short sentences. He was oriented only to person and place, not to month, year, or circumstances. He was able to follow some one- and two-step commands after a delay. Cranial nerves II through XII were grossly intact. His trach site was healing with a small eschar in place. A PEG tube was then placed. Upper and lower extremity motor strength was at least 4-/5. Left arm and leg Ashworth's score of 2 to 3.

[REDACTED] was started on an intensive inpatient rehabilitation medicine program, including physical therapy, occupational therapy, nursing, speech, and psychology.

Upon admission [REDACTED] remained on Klonopin 1 mg q.6h.; Neurontin 400 mg q.4h.; and phenobarbital 90 mg q.8h., as well as Lamictal 200 mg b.i.d. All

ADM DATE: 05/20/1999
 DSCH DATE: 06/18/1999
 PT SEX: M
 BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
 PT NO.: [REDACTED]
 NAME: [REDACTED]
 MR NO.: [REDACTED]

000036

DISCHARGE SUMMARY

medications were administered through his PEG tube.

Prior to admission to the rehabilitation center, [REDACTED] underwent an MBS study, which showed no evidence of aspiration, although noted poor mastication of solids with intermittent seizure activity. [REDACTED] diet was advanced such that at the time of discharge he is tolerating a regular diet. His PEG tube was removed on 05/27/99, He is able to take all medications orally.

[REDACTED] was followed throughout his hospitalization by [REDACTED] M.D. An EEG was obtained, which showed ongoing epileptiform activity on 05/21/99. His phenobarbital was increased to 120 mg q.8h. The level on 06/02/99 was noted to be 26.9. Lamictal was discontinued secondary to facial rash.

On 06/03/99, [REDACTED] had a fall from his bed. Due to multiple complaints, including striking his head, a CT scan of the head was obtained, which showed no acute findings. X-rays of the left hip demonstrated calcification around the soft tissues of the pelvis and left femur.

[REDACTED] made slow, steady improvement throughout his rehabilitation/hospitalization. At the time of discharge, Psychology notes, however, that he continues to exhibit very poor insight, and has impaired safety awareness. Occupational Therapy notes that he is supervision for self care. In physical therapy he is able to negotiate stairs with assistance, contact guard, and verbal cues. He is ambulatory for 1000 feet with supervision and no assistive devices, although he requires cues for safety.

[REDACTED] continues to exhibit poor short-term memory. He needs cues and written reminders. [REDACTED] is impaired in all higher cognitive levels skills, including poor processing. Arrangements have been made for outpatient physical therapy, occupational therapy, and speech therapy five times a week for three weeks, then three times a week for one week. [REDACTED] and his family have been advised that he should not drive. He requires 24-hour supervision upon discharge. He should not be left alone with his young daughter. He must wear a helmet when outside the hospital. A recommendation is made for a neuropsychological examination in one month. He and his family are further advised that he should not drink alcohol.

FOLLOW-UP: [REDACTED] has a follow-up appointment with [REDACTED] M.D. in one week. He has a follow-up appointment with his local physician at the next available time. He has a follow-up appointment with myself at [REDACTED] in one month.

DISCHARGE MEDICATIONS:

- 1. Phenobarbital 120 mg p.o. q.8h.

ADM DATE: 05/20/1999
DSCH DATE: 06/18/1999
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000037

DISCHARGE SUMMARY

- 2. Klonopin 1 mg, one tablet p.o. q.6h.
- 3. Neurontin 400 mg, one tablet p.o. q.6h.
- 4. Colace 100 mg, one tablet p.o. b.i.d.
- 5. Synthroid 0.025 mg, one tablet p.o. q.d.

CC: [REDACTED] M.D. [REDACTED] M.D.

CC [REDACTED] MD

[REDACTED] MD

ATTENDING PHYSICIAN: [REDACTED] MD
SIGNING PHYSICIAN: [REDACTED] MD

[REDACTED]
D: 06/17/1999 T: 06/21/1999 4:36 A
JOB #: [REDACTED]
DOC #: [REDACTED]
[REDACTED]

ADM DATE: 05/20/1999
DSCH DATE: 06/18/1999
PT SEX: M
BIRTH DATE: [REDACTED]

PT LOC: [REDACTED]
PT NO.: [REDACTED]
NAME: [REDACTED]
MR NO.: [REDACTED]

000038

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Critical Care [redacted]

Requested by:
(Service or Physician)

D. [redacted]

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

PE Tc=99⁸ $\frac{102}{48}$ ($\frac{95-120}{41-55}$) 85 RR=0/2 94-96%
SpO₂ = 516/3555

GEN: Intubated, ventilated sedated ^{cooking} \oplus blanket

HEENT: Pupils 5-6 mm \oplus minimally reactive
 \ominus corneal reflex, Dolls eye abnormal

PE: CTA cv: RR 3 ml/s

Abd: soft NTND +BS

Ext: 1+ edema RVE & LVE, PC/-

A/E 26 yr WM in pharabarb coma 2^o
to intractible seizures 2^o polysub abuse

① Resp Failure - SIMV+PS \downarrow V_T 900
 \rightarrow Hypoxic - Pulmonary shunt vs PE
 \checkmark CXR, Bronchoscopy AC
ABG in Am

② Intractible Seizures -
Diazepam
Tegretol
Pharabarb } Neurology
Following

③ BP/Augmentation
Dopamine 17 mcg/kg/min
= Replen TLC \oplus PA catheter
 \pm reassess cv status.

④ Full code? Discuss w family

Signature of Consultant:

[redacted]

Service:
Time:

[redacted]

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

000039

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Intuition

Requested by:
(Service or Physician)

[Redacted]

Date of Request:

3-4-99

Time: *2033*

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

S- Est'd Ht > 6'2"

O- Dx: new Onset Intractable Sz. Thought to be 2^o Drug/Toxin Ingestion

Labs: Alb 3.3 ^(3/3) 1.39 / 4.3 | 1.15 / 0.6 < 1.32 ^(3/5)

Support: 30 cchr UltraCal T.F. (fevity equivalent) = 760 Cal / 32 g Protein

GI: Absent b/s, Soft Abd. F.T. in mid duodenum per ³¹radiology report

Anthros: ⁹⁷ 2/20 wt 93.5 kg (↓ from 100 kg recorded at Adm) DBW ~ 86 kg ^{±1}

A-Acceptable to provide enteral support via nas-intestinal fdy tube

despite audible bowel sounds (as discussed w/ R.D.) Agree with feeding choice. Wt documentation inadequate at loss; Adm. wt > stand. for Ht.

Alb reflects mild visceral protein deficits. Est. requirements 2600-2700 ^{Cal} / 90 gms ^{Pro}

Rec. continue feedings along with monitoring of tolerance, progressing to goal of 100-105 cchr if tolerated

P. F/U to monitor fdy toler. adequacy
Signature of Consultant:

Thank You For Referral

Service: *Dutille*
Time: *1130*

Date: *3-5-99*

CONSULTATION REPORT

000041

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Requested by:
(Service or Physician)

Date of Request:

3/2/99

Time: 1430

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Status Epil c phenyton infiltr. @ arm

Unit Clerk telephoned the consultant, his secretary or answering service on:

3/2/99

Time: 1450

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

Pt is a 26 yo w/male c Dx of New Onset Intractable seizures. All 3.3 on 3/3/99. Assessed @ arm slanted infiltration site. Site is red, non-blanchable approx 3cm x 3cm; skin intact, mild induration noted. Necrosis of tissues noted. Appears to be resolving.

Warm compresses ^(aspiration) to area [redacted] minutes 4 x a day to promote circulation

Due to length of time since occurred, assessment of area would be sufficient. Reconsult if needed. [redacted]

Signature of Consultant:

Service:
Time:

1025

Date:

3/4/99

RTI

CONSULTATION REPORT

000042

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Requested by:
(Service or Physician)

Date of Request:

3/2/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

26 yo ♂ tx [redacted] for intract SZ; pre resp failure, intub 2/24

2/21 2 Gen Tx SZ; had Dil + Ativan, Neurontin, Pheny

PT now in pentobarb coma -

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

PMUx

995 100-140 90-100 %10

intubated, pentobarb coma

App 1 status

epileptics

pentobarb com

Q

RRR 3mm = NR

(1) SCITLC (2)

SHUx

CTA (6)

Q/E SCOS stim p/lesions

(2) flu 4 IV

Q

S/NT/AB

Soc

2/22 C/Head (1)

(3) comp text screen

Q Job

2/26 Ux (1)

ESR 10

(4) flu CR

Q 404

2/28 CD4 (208)

RPR NR

restaurant

2/26 HSV IgG (1), VZV (1)

manager

2/20 Crypt (1)

LP 2/28 (1) AFB

remote cocaine

2/26 Bix (1) x2

inval cell, glu CT5, TPSS

Rx

3/2 ABG 79/37/7.46/967. e SIMV/0.3/400/10

"Ripped

3/2 14/107/9 <116

9.0 272

fuel 4

4.1 26/0.9

Service: Time:

(coffee OD?)

2/1 30.6

000043

Signature of Consultant:

Date:

See Progress Notes

CONSULTATION REPORT

REQUEST FOR CONSULTATION

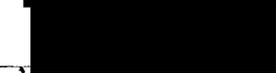
PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)



PAGE: 1 of 3

Requested by:
(Service or Physician)



Date of Request: 3/1/99

Time: 1700

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Drug Induced SEIZURE
Toxic

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26yo M → with a ~ 3yr Hx of Ingesting Ripped FUEL[®] (BY THE M LBS) AS A metabolic enhancer-diet supplement for energy & stimulation. The product contains a combination of MAHUANG (EPHEDRINE ALKALOIDS) ~ 10mg/capsule, along w/ COFFEEINE ~ 100mg/capsule & Chromium Picolinate 100mcg/capsule. His wife claims that he takes a handful at a time, several times per day. Max recommended dose on product is ~ 6 caps/day. While @ work (SAT 2/20) as a pest mgr @ [redacted] he took some of this product & while talking on the phone collapsed & had his first seizure ~ 9:30pm. Taken to [redacted] for Tx & observations & o/c. The next day, he slept most of the day & ~ 5:00pm had another seizure & was brought to [redacted] for EVAL. He is ADMITTED FOR STATUS EPILEPTICUS. Continued to have SEIZURES despite Tx & was transferred to [redacted] (2/25)

Signature of Consultant



Service:
Time: 1000A

Date: 3/2/99

-
-



CONSULTATION REPORT

000044

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Toxicology

Page: 2 of 3

Requested by:
(Service or Physician)

Date of Request: 3/1/99

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

R/O Drug & Toxin Induced Seizure

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

WBS - 141 | 107 | 9 | 116 WBC = 9.0 Hgb = 12.7 Dinit = 30.6 ug/lnd on domg/d
4.1 | 26 | 0.7 RFS = 272K

Pentobarb drip 1.5mg/kg/hr amethyst to

HEAD to 1mg/kg/hr on 60 to 0.5mg/kg/hr overnight

In Pentobarb coma ~ 4-5 sec Rapid Suppression

Phlo 3mm NR, Intubated

Imp: Status Epilepticus most likely due to Chronic Ingestion (overdose) of ~~Amphetamine~~
Ephedrine + Caffeine combination ~ additive β Adrenergic Stimulation.

> 1 gram Caffeine is toxic dose + 5-10 grams potentially lethal

Matt has used "HEROIC ECTASY" used as alternatives to Amphetamines as Adjunct

to Body Building & Dieting / Energy Programs. Ephedrine has a low toxic -

Therapeutic Ratio with toxicity occurring with 2-3x the Therapeutic Dose.

Signature of Consultant

Clinical Toxicology

Service: 1000 Date: 3/2/99 Time: 1000 Dose: 1000-200mg

CONSULTATION REPORT

000045

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Toxicology

PAGE = 3 of 3

Requested by:
(Service or Physician) [REDACTED]

Date of Request: 3/1/99

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

Drug/Toxin Induced SEIZURE

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

The combination of Caffeine & Ephedrine declared IRRADIANT BY FDA + Dangerous - Potential to cause Seizures, strokes (REDACTED). Caffeinism from chronic use leads to HA, Nervousness, Tremor, Anxiety, Muscle Spasm, Palpitations. Seizures esp in ephedrine combination.

Plan: WEAN Pentobarbital Drug + appropriate Seizures

Flu Cyl for pulm. Infection

Consider DIC Phenytoin since less effective for Drug/Toxin Induced Seizures

BARBS, (REDACTED) Better SZ Control.

Verapamil for add'l SZ Protection

NO Anoxic Encephalopathy from Prolonged SZ Activity DIFFERENTIAL DAMAGE

Comprehensive Serum + Urine Drug Screen = Caffeine level

(NL Caffeine levels 1-10mg/L, >50mg/L potentially lethal)

Signature of Consultant: Follow (REDACTED)

Service: ICU/A
Time: (REDACTED) 3/2/99

CONSULTATION REPORT

000046

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Neuro

Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time: 3/1/99

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 y/o ♂, ph/c med. problems, now intractable seizure. First presented 2/19-2/20 to [redacted] EK reports of confusion, "talking nonsense," LOC; HA + photophobia x 4 days. Pt found to be hypoglycemic. Admit to home SAEDs. Presented 2/21/99 to [redacted] EK reports of 6-17/c sz. at home, had another in ER. Treated w Dilantin + Ativan; Haldol from paramed 2° combatives. M.D. Summary of 2/22/99 not to be redacted but arousable + oriented, c intelligible conversation. Dilantin level 11.9. Morning of 2/23/99 R.N. notes repeated seizure at 6 AM pt found unresponsive, wife reported pt. staring blankly at wall while she was speaking. 6:10 AM pt A+Ox1, responsive but confused. Seizure noted at 8 AM, 11 AM, 12:30 AM. Treated w ativan. EEG showed "interictal slow, no PLED or sharp waves." At 4 PM, pt is noted to be unresponsive to vital stimuli, opens eyes to pain. sz again 8 PM. Unfamiliar notes of 2/23/99 (presumably late) reports seizure of 7 min, pt unresponsive to pain. Specific descriptions of seizure activity N/A except as noted.

Signature of Consultant: [redacted]

Service:

Time: SEE ATTACHED

Date:

RECEIVED from 3/1/99

(See attached for original)

For Attending Signature

000047

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) WIND

Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

L.P. @ protein 55 2/25 AST 18 Free Phenytoin 1.62
 glu 95 T.P. 5.3 YSH 1.8
 ABE 36 140/105/8/94
 Nuc 1 3.5/27/1.7 Ca 8.2 mg 1.8 Phos 3.3 -VETA @
 RPR: NR

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 y/o ♂ c phlo medical problems, now c intractable seizures. first presented to
 [redacted] - Admit 2/19-2/20 c report of confusion; found to be hypoglycemic. Sent home w AEDs.
 Presented to [redacted] ER 2/21 c report of OTIC @ home, had another in ER.
 treated c Dilantin + Ativan. Pt also had Haldol (paramedics administered 2° combative per
 M.D. summary of 2/22/99 reported pt to be sedated but arousable, oriented c
 intelligible conversation. Morning of 2/23/99 RN notes document reported sz.
 at 6:00 AM, pt found unresponsive; wife reported that he began staring blankly
 at the wall while she spoke to him. At 6:10 he was A+OK, responsive but
 confused. Sz. noted at 8 AM, 11 AM, 12:30 AM. EEG c "interictal slow, no
 PLED or sharp waves". at 4 PM pt is noted to be unresponsive to verbal
 stimuli; opens eyes to sternal rub. Sz @ 8 PM 4ml note, not mail
 (date 2/23/99) report of sz x 7 min; pt unresponsive to pain.

Signature of Consultant

Service Time:

3/1/99

000048

CONSULTATION REPORT

Received, for clarity see attached

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Neuro

Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

LPC Protein 55 (2/25)
g/dl 75
RBC 36 8 133 40 6/4
WBC 1
Viral @ RPR: NR Cu 8.2 Mg 1.8 Phos 3.3 3.5 37 17
Alb 3.2
AST 18
TP 5.3
140 1705 8 197
Free Phenytoin 1.62
TSH 1.8
W/A @

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time: 3/1/99

52 Continue
REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

2/24/99 pt given phenobarbital 800 mg @ 12:30 P, Ativan 2mg+2mg+4mg @ 1PM-1:15 PM, Ativan drip @ 4-6mg/hr @ 13:45 PM; Newontin 800 mg @ 22:00 (c tid order), Dilantin to 100mg qid, ventilated, pt transferred to [redacted] 2/25/99, put on vered drip, dilantin continued (level was 18.1 @ 2:10 PM). Vered tapered/dec'd 2/26/99; diprison added prn. Dilantin 100mg tid; febrils on 2/26/99 9.7. Nursing notes initial agitation then settled = calm until 2/27/99 @ 4 AM. Seizure ~ 10 sec activity noted @ 11 AM, 12:05 P, 12:20. Pt given 500 mg Dilantin @ 12 P (level 7.1 @ 4 AM). Activity next noted @ 4 PM, 19:40, 22:15, 22:35, 22:50. Ativan given 22:15 (sz @ on own otherwise). sz assoc. c eyes rolling back, jaw, mouth shaking, jaw trembling, facial twitching. Newontin added 300mg qd; Dilantin 200mg bid. Plus load (see Rpt) 500mg @ 2:15 A 2/28/99 Dilantin 8.2 @ 14:15, 13.7 @ 23:07 & 15.6 @ 5 AM 2/28/99. ASSEC, @ EEG, but temp, Service: activity reported (with review)

Signature of Consultant: [redacted]

Time: [redacted] Date: [redacted]

000049

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Neuro

Requested by:
(Service or Physician)

Date of Request:

Time:

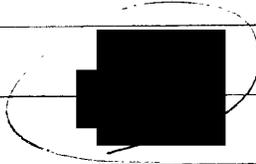
Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:



Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation) (13. activities, ^{provisional} continued)

Phenobarb load & drip added ~ 12P 2/28, Vered drip pertated 15:00.
Ceprosan O/Cd 2/28/99 14:30, pt developed tremors of trunk & rhythmic
movement of legs for ~ 30 sec, followed by chin tremors & eye rolling back.
Pt continued to have events as described
2/28/99 22:00 Pentobarb hung (bdus @ 2050 of 5mg/kg). Vered & Phenobarb
O/Cd. Pt on burst suppression

PE: Comatose

PMH: Denies all

Med's: Pentobarb

PERAL, & corneals
p response to pain

FH: No 52

Peppil

DIRS
Toes mite

Quartan

Acyclovir

SH: Body building - "Ripped Fuel"
Married, daughter. OTOB, ETOH, IVDA

Quarant - cettine
(Muthuang - ephedra)

Signature of Consultant

Service:
Time:

(Signature)

000050

CONSULTATION REPORT

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Neuro

Requested by:
(Service or Physician)

Date of Request:

Time:

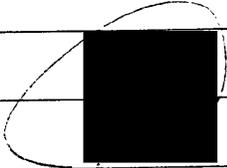
Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:



Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

*Assessment: 26 y/o w/no medical history presents
to ER w/acute seizure, progressed to status over
the next week. Now in peds but come*

*Plan - Extract pentobarbital to burst suppression 5/10
sec. for 12-24 hrs then wean pentobarbital
- Dilantin load 10mg/kg @ 500 mg qd
MRI of brain*

Doc / metabolic / poison work up

Signature of Consultant:

Service:
Time:

Date:

000051

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to: (Service or Physician) Pulmonary Dr. [redacted] [redacted]

Requested by: (Service or Physician) Dr. [redacted]

Date of Request: 2/25/99 Time: _____

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: state "vent management"
264.0 W3 Admitted to intensive
care unit where problems include:
[redacted] [redacted]

Unit Clerk telephoned the consultant, his secretary or (ans) [redacted] service on: 2/25/99 Time: 0630

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

- (1) Sz. Discharge
- (2) Reg. discharge (informed 2/24/99)
- (3) ↑ serum potassium level
- (4) pre-mission man - "Ripped Fuel" ~ [redacted]

- (1) Adjust ventilation (↓ V_T / ↓ P_{CO₂})
- (2) maintain inborned (3) WU for oximetry if possible
- (3) RT 46° & PRU
- (4) send when prophylaxis
- (5) RT prophylaxis
- (6) initiate Tube Feeds in 1-2 days if pt is no longer inborned.

Signature of Consultant: [redacted] Service: _____ Time: _____ Date: 2/25/99

[redacted] Thank you,
will Follow
up on.

CONSULTATION REPORT

000052

CHIEF COMPLAINT

PRESENT ILLNESS

PAST HISTORY

FAMILY HISTORY

SOCIAL HISTORY

PHYSICAL EXAM

pt is transferred from [redacted]
for obstructive Pulmonary

26 y.o. → with recent COTC seizure
started when pt was seen in [redacted]

20 on 2/20/89. following acute
confusion while on the phone at work
a questioned hypoglycemia, serum was

reported. pt. had recent serum following
discharge from [redacted] & was then
admitted to [redacted] & had recent serum

requiring intubation for air way protection
He was treated with Phenytoin. the intravenous
drip.

quest ϕ .

Sitt ϕ .

no H/O smoking
or STD's abuse
Restaurant manager.

needs ϕ .
"Ripell. Fuel"

2/24



REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Speech Pathology

Requested by:
(Service or Physician)

[Redacted]

Date of Request:

4/3/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

26 y/o M transferred from [Redacted]
for retractable seizures. Dx intractable seizures
encephalopathy

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

① - Pt. seen bedside on vent & trach

② - Examination Findings

Communication / Cognition - opens eyes when
name called. Demonstrates facial expression
of pain. NR to 1-step commands
NR to simple yes-no questions. Verbally
level of alertness / awareness reduced &
pt not maintaining arousal (ie eyes open)
for 1 time intervals

③ - Severe - profound cognitive / communication
impairment. Swallowing not assessed
so the pt's current respiratory / cognitive
status

Signature of Consultant:

[Redacted] will continue to follow
[Redacted] provide

Service:

Time:

Date:

4/5/99

as instructed.
CONSULTATION REPORT

000054

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)



Requested by:
(Service or Physician)

Date of Request:

3/29/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Transfer to



Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 yr old male transferred from [redacted] for intractable seizure. (intractable). currently

plmth
none

having fever, being optimized on antiepileptic medⁿ. has touch on vent.

medⁿ
noted.

140/60 / Tman - 102. F 100.7

cess on one the counter medⁿ.

not following commands. Having left facial twitchy

Social
married
hus & wife.

R/S - B/A/E ↓ at bars

ces - scler present

abd - soft, nondistended. Labs noted
↑ WBC; ↑ LFT.

26 yr old male. \bar{c} intractable seizure - patient not appropriate for
sepsis / encephalopathic / on vent. would benefit from sw
consult for placement

Signature of Consultant:

Service:
Time:

Date:

3/30/99

3/30/99

CONSULTATION REPORT

000055

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Dn [redacted]

Requested by:
(Service or Physician) Dr [redacted]

Date of Request: 3/17/99

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: For Tracheostomy.

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 yo M \bar{c} anoxic encephalopathy as result of status epilepticus following polysubstance abuse now \bar{c} respiratory failure. Currently intubated, on vent 50%/SIMV 10/400/5. Consulted for tracheostomy placement.

PMH - \bar{x} PSH - \bar{x} NKDA Current Rx - Neurontin, Lovenox, Colace, Phenobarbital, Synthroid, Zosyn, Ativan prn, Nimetop

PE - Comatose, occas. blinks eyes,
No response to commands

Lab 3/18: $\frac{135}{3.8} / \frac{11}{30} / \frac{144}{0.3}$ $\frac{17}{37} / \frac{12}{48}$

OTT in place, Dobhoff \bar{c} nostril. Both mesial maxillary incisors projecting anteriorly and mobile (reportedly 2° to status epil./oral intubation/dilantin effect)

Neck - \bar{x} scars, nl landmarks.

- A) Resp. Failure, Anoxic encephalopathy (Intubated 7/26 @ [redacted] then transferred to [redacted])
P) Agree \bar{c} indic. for tracheostomy. Will scheduled as soon as OR can accommodate.

Signature of Consultant: Thak 424

Service:
Time: 3/18/99, 8³⁰

Date:

CONSULTATION REPORT

WHITE Card Copy

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000056

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Please
Recall
M
3-15-99
Pm

Consultation to:
(Service or Physician)

Ophthalmology - PS

IS ON CALL

Requested by:
(Service or Physician)

Dr.

Date of Request:

3-14-99

Time:

1650

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

evaluate both eyes for

conjunctival infection

3/15/99

0930

3-15-99

0620

telephoned the consultant, his secretary or answering service on:

3-14-99

Time: 1755

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 year old Grcs / persistent / occluded / with red eyes.
to discharge.

VA / OH / CF could not be opened

B/F lids - cone

cy - mild conjunctiv

con - conjunctiv B01

AC 0/2

Diets 0.05

(1) Dry Eyes / Exposed
PS

localize of white cornea

2-3° oc

Topo Eye, but abs

PS

Signature of Consul

Service:

Time:

2:00p

Date:

3-15-99

CONSULTATION REPORT

000057

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Critical Care ([redacted])

Requested by:
(Service or Physician) Dr [redacted]

Date of Request: 3/9/99 Time: 06:50

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: To follow up patient & to manage care and BP

[redacted] phoned (the consultant, his secretary or answering service on: 07/16/99) Time: 0710

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

HPI: 26 yo WM in pharmer's army 25 to intractable GTC seizures. Pt is 4/6 "kippel evul" metabolic supplements (caffeine, ephedra), "Winstrol" (anabolic steroids), creatine, Ecstasy? GHB? First presented to [redacted] w/ confusion @ work. Discharged & was then admitted to [redacted] w/ intractable seizures.

Tried phenobarb + Ativan → hospitalized for gastric protection MRI (head) 3/5 - all gross/infratentorial, paranasals. V/Q scan 3/4 - low probability EEG → seizure activity as soon as phenobarb

PH: ϕ Phenobarb 300 mg qd 30
SH: ϕ Dupemine 13.2 mg qd/12
MEDS: Loxmax 30mg qd q12

ANCEF 1 gram q8h (3/4/99) Nystatin swish
Depakote 250 IV q6h Thiamine, Colch
Tegretol 400mg IV / 200mg IV q12 q1h Haldol }
Nurammon 300mg IV q4 Ativan } PAN
(14hr)

ANYS 3/8 6.2 } 11.7 } 283
35.1
143/103/10 } 114
3.7/35/0.4

TSH = 0.127 ↓ Free Phenytoin = 3.49

Signature of Consultant: [redacted]

Service: [redacted]
Time: [redacted]

CONSULTATION REPORT

000058

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dn

Requested by:
(Service or Physician)

Dn

Date of Request:

3-8-99

Time:

?

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

3-8-99

Time: *1815*

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

*See
Progress Notes*

Signature of Consultant:

Service:
Time:

Date:

CONSULTATION REPORT

WHITE Chart Copy CANARY Consultant Copy PINK Requesting Physician Copy

000059

CONSULTATION

REQUEST FOR CONSULTATION

hypotensive

PLEASE PRESS HARD WHEN WRITING

Consultation to: (Service or Physician) Pharmacotherapy [redacted]

Requested by: (Service or Physician) Dr. [redacted]

Date of Request: 3/7/99 Time: 1445

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

NKA Consult Ripell Fuel

PMH SHO

[redacted] Unit Clerk telephoned the consultant, his secretary or answering service on: 3/7/99 Time: 1455

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

This is a 26 y/o male wt 100kg Ht & recurrent seizures started when pt was seen in [redacted]

then admitted to [redacted]. Pt c a 3 yr hx of ingesting Ripell Fuel as a metabolic enhanced diet supplement

fuel energy stimulant. A combination of Ephedrine 10mg/capsule along w caffeine 100mg ^{per} capsule + Chrom piccolate 100mg

Pt started on Pentobarbital qtt to max 3.5mg/kg hr & dilate soon thereafter. Pt started on Pentobarbital qtt to max 3.5mg/kg hr & dilate soon thereafter. Pt started on Pentobarbital qtt to max 3.5mg/kg hr & dilate soon thereafter.

300mg ^{per} 4hrs. Pt. pentobarbital levels have been ^{continued seizure activity} subtherapeutic. Would recommend ↑ pentobarbital bolus 10mg ^{per} kg to maximum 25mg/kg. ↓ dilate + inhalers @ 3° as needed. ↑ drip to max 8-10mg/kg hr

Monitor ^{blood} pressure. Would agree ~~to~~ ^{to} early head avert as less effective for drug induced seizure. Another alternative: propofol

Study at 10mg/kg/min. WEL FU. Signature of Consultant: [redacted] Service: Time: 18:15-2000 Date: 3/7/99

CONSULTATION REPORT

000060

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dr. [REDACTED]

Requested by:
(Service or Physician)

Dr. [REDACTED]

Date of Request:

5-25-99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

16 Tube Removal patient known to

you

Unit Clerk telephoned the consultant, his secretary or answering service on

5-25-99

Time: 2030

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

[Lined area for consultant report]

Signature of Consultant:

Time:

[REDACTED]

[REDACTED]

CONSULTATION REPORT

000061



NAME _____ AGE _____

ADDRESS _____ DATE 3/24/99

Rx

Mr. [redacted] is severely
brain damaged from status
Epilepticus result of ingestion
of Malavang. Ripped prel (watered
out's') now he is mentally
incompetent and suspect he will
be permanently impaired

Label

Refill _____ times

[Redacted Signature]

(Signature)

In order for the brand name product to be dispensed, the prescriber must write 'Medically Necessary' below the signature.

[Redacted]

Attachment # 7
Memo FLA-9339
CFSAN Project #13408
4/5/99
SJH

000062



DOCTOR _____ IS REQUESTED TO EXAMINE THIS PATIENT WITH

REFERENCE TO: Seizures



ATTENDING PHYSICIAN

- _____ CONSULTATION ONLY
- _____ CONSULTATION AND ASSIST IN MANAGEMENT
- _____ CONSULTATION AND MANAGEMENT OF SPECIFIC PROBLEM

CONSULTANT NOTIFIED:
DATE: 2-4 TIME: 2225 PERSON NOTIFIED: _____ BY: _____

FINDINGS/RECOMMENDATIONS: _____

Records from _____
referred. pt examined and heard long discussion
in details in pt and spouse. 52 presentation,
no driving, PE, medication side effects est. discussed.
Consult dictated ✓

A) No focal exam.
- Idiopathic CP 52 E 20 BTC 52
- Migraine H/A.
CT films seen and looked at _____

P) F/U Contrast CT Brain and EEG.
DPH 300 of QHS.

Attachment # 3
 Memo FLA-9339
 CFSAN Project #13408
 4/5/99
 SJH

Thank you



CONSULTING

2/22/99 9:45 AM
 DATE TIME

CONSULTATION



000063



DOCTOR [REDACTED] IS REQUESTED TO EXAMINE THIS PATIENT WITH

REFERENCE TO: R/O encephalitis

[REDACTED] ATTENDING PHYSICIAN

- CONSULTATION ONLY
- CONSULTATION AND ASSIST IN MANAGEMENT
- CONSULTATION AND MANAGEMENT OF SPECIFIC PROBLEM

CONSULTANT NOTIFIED:
DATE: 2/24/99 TIME: 12:05 PERSON NOTIFIED: _____ BY: [REDACTED]

FINDINGS/RECOMMENDATIONS:

Thanks very much for this consult.

Dr. [REDACTED] Chart reviewed. Pt examined.

Impression: New onset seizures -> etiology? no hx febrile illness PTA.
Hypoglycemia?
S/P CSF sent Brain - contrast -> neg
= LP -> WNL.
PE unremarkable!!
lab uncl.
CR2 ⊖

Best infectious etiology w/ will R/O. *

- Recommend:
1. Agree to present management
 2. MRI Brain
 3. Insulin Reptide c/N
 4. ESR, ANA, Lyme's serology, HIV, * PPD
 5. No anti-microbials at present

will John
John!

Attachment # 3
Memo FLA-9339
CFSAN Project #13408
4/5/99
SJH

CONSULTING PHY [REDACTED] DATE 2/24/99 TIME 1PM

000064

CONSULTATION

DOCTOR _____ IS REQUESTED TO EXAMINE THIS PATIENT WITH

REFERENCE TO: _____

_____ ATTENDING PHYSICIAN

- _____ CONSULTATION ONLY
- _____ CONSULTATION AND ASSIST IN MANAGEMENT
- _____ CONSULTATION AND MANAGEMENT OF SPECIFIC PROBLEM

CONSULTANT NOTIFIED:
DATE: _____ TIME: _____ PERSON NOTIFIED: _____ BY: _____

FINDINGS/RECOMMENDATIONS: _____

• Asked to exclusively intubate this 26 yo male w/
uncontrolled seizure R/O encephalitis, migraine
headache.
F.F. 102kg = 96 97
with plan to pain administration
w/ fentanyl
C/C: obscur B.S.
Ameny - clon 2
ASA 2 E1
Plan: intubate w/ sig ETT & paralytic for
rotation & pandylicis

Attachment # 3
Memo FLA-9339
CFSAN Project #13408
4/5/99
SJH

CONSULTIN _____ AN

2/24/99
DATE _____ TIME _____

CONSULTATION

000066

CHIEF COMPLAINT

pt transferred from [redacted]
for refractory seizures

PRESENT ILLNESS
(onset and course)

26 y.o. → with recurrent GTC seizures
started when pt was seen in [redacted]

PAST HISTORY:
(past diseases,
operations, accidents,
etc)

SOE on 2/20/89. following acute
confusion while on the phone at work
a questioned hypoglycemia, seizure was

FAMILY HISTORY:
(health, previous
diseases, causes
of death)

reported. pt. had recurrent seizure following
discharge from [redacted] & was then

SOCIAL HISTORY:
(education, diet,
alcohol, etc)

admitted to [redacted] & had recurrent seizure

REVIEW OF
SYSTEMS:

required intubation for air way protection
He was treated with Phenytoin the admission
drug.

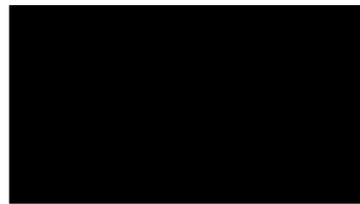
Cons ✓

Sitt ✓

no H/O smoking
or EDVA abuse
Restaurant manager

Needs ✓
"Ripell. Fuel"

2/24



0067

Sedation Intubated
-afebrile vs

chest CTA
Cor norm

PER LA @ mytogram

the cones

(-) Facial Asymmetry

moves bolt spontaneously.

(-) Seizure

(-) Tremor

Diz - symptoms for B.T.
with + for skull

old records reviewed.

Attachment #5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Dyspnea

(1) Intractable Seizures
(2) Encephalopathy

Plan - ECG monitoring
- Tape neck dips
- Dilantin/phenytoin as needed

DATE: 2/24/99

SIGNATURE: [Redacted], M.D.

SIGNATURE: [Redacted], M.D.

Skull, scalp, hair, skin, eyes, ears, nose, mouth (lips, teeth, gums, breath),
throat, heart (B.P.), vessels, lungs, abdomen (liver, spleen, kidneys, scars),
genitalia, vaginal, rectal, lymph nodes, extremities, reflexes,
IMPRESSION

[Redacted]

PHYSICAL EXAMINATION

[Redacted Signature Area]
000068
ical Examination

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to: (Service or Physician) Toxicology / Poison Center

Page: 1 of 3

Requested by: (Service or Physician) [REDACTED]

Date of Request: 3/1/99

Time: 1700

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

Drug/Included SEIZURE
Toxicol

Attachment # 1
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26yo D → With A ~ 3yr Hx of Ingesting Ripped FUEL[®] (BY TRIM LRS) AS A metabolic enhancer-diet supplement for energy stimulation. The product contains a combination of MAHUANG (EPHEDRINE ALKALOIDS) ~ 10mg/capsule, along w/ CAFFEINE ~ 100mg/capsule & Chromium Picolinate 100mcg/capsule. His wife claims that he takes a handful at a time, several times per day. Max recommended dose on product is 6 caps/day. While @ work (SAT 270) as a REST mgr @ [REDACTED] he took some of this product & while talking on the phone collapsed & had his first seizure ~ 9:30pm. Taken to [REDACTED] for Tx + observation & o/c. The next day, he slept most of the day & ~ 5:00pm had another seizure & was brought to [REDACTED] was admitted for STATUS EPILEPTICUS. Continued to have seizures despite Tx & was transferred to [REDACTED] (2/25).

Signature of Consultant

Service: [REDACTED]
Time: 1000A

Date: 3/2/99

CONSULTATION REPORT

000069

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to: (Service or Physician) Toxicology

Page: 2 of 3

Requested by: (Service or Physician) [Redacted]

Date of Request: 3/1/99

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

Rto Drugs & Toxin Induced Seizure

Attachment # 1
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

LBS = 141 | 107 | 9 | 116 WBC = 9.0 Hgb = 12.7 Dnat = 30.6 ug/L on 20mg/d
4.1 | 26 | 0.7 | PLT = 272K 20mg 400mg/d IV

Levamisole drip 1.5mg/kg/hr currently to Phenothiazine 300mg NG qd

WBAW to 1mg/kg/hr on 60 to 0.5mg/kg/hr overnight Titrate 300mg IV qd

In ketorolac coma ~ 4-5 sec Period Suppression

Depth 3mm NR, Intubated

Imp: Status Epilepticus most likely due to chronic ingestion (or abuse) of ~~amphetamine~~

ephedrine & caffeine combination = additive β adrenergic stimulation.

1 gram caffeine is toxic dose & 5-10 grams potentially lethal

Mephedrone is "KICK" used as alternatives to amphetamines AS Agent

to body building & dieting / Energy products. Ephedrine has a low toxic -

Therapeutic ratio with toxicity occurs with 2-3x the therapeutic dose.
Signature of Consultant [Redacted] Clinical Toxicology [Redacted] Service: [Redacted] Time: 3/2/99 1000 Date: 3/1/99 200mg

CONSULTATION REPORT

000070

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) TOXICOLOGY

Page: 3 of 3

Requested by:
(Service or Physician) [REDACTED]

Date of Request: 3/1/99

Time:

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

Drug/Toxic Induced SEIZURE

Attachment # 1
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

The combination of Caffeine & Ephedrine declared DANGEROUS BY FDA +
DANGEROUS - POTENTIAL TO CAUSE SEIZURES, STROKES ([REDACTED]) Caffeinism From
Chronic use leads to HA, Nervousness, Tremor, Anxiety, Muscle Spasm, Palpitation
SEIZURES esp in ephedrine combination.

Plan: WEAN Pentobarbital Drug + Administer SEIZURES

FIN CYCL FOR pulm. Infection

Consider DIC Phenytoin since less effective for Drug/Toxic Induced SEIZURES

RAMS, Reqd's Better SZ Control.

Recommend for Add'l SZ Protection

Also Avoid Oropharyngeal Form Packages SZ Activity DIFFERENTIAL DAMAGE

Comprehensive Serum + Urine Drug Screen = Caffeine level

(NL Caffeine levels 1-10 mg/L, >80 mg/L Potentially lethal)

Follow up ANALYSIS

Signature of Consultant

3/2/99

000071

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

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CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dr. [Redacted]

Attachment # 2
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Dr. [Redacted]

Date of Request:

3-6-99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

re: pt E hypermetabolism

M.D.
Unit Clerk telephoned the consultant, his secretary or answering service on:

3/6

Time: 2:00

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

My impression

patient SE, fever & cough.

1. Refractory Seizures

It pertinent for intake A thyroid & calcium.

2. ? Hypermetabolic Spike

3. Resp Failure (Meth. renal)

P> induce mild hypothermia

Unfortunate 26 y/o

• Check thyroid status

male initially presenting

• Check plasma catecholols

0 seizures (2/20/99). I

• Fleet enema now (? is there a depot of tablets in his GI tract?)

was asked to see this

• Metabolic Study

PO for ? hypermetabolic

state - unable to keep

Thanks. Will follow.

000072

a toxic dilantin level.

Signature of Consultant:

Service:

Time:

Date:

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Critical Care (1/2)

Attachment # 3
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Dr [Redacted]

Date of Request:

3/19/99

Time:

0650

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

*To follow up patient & to manage
care and BP*

Client telephoned ([Redacted]) his secretary or answering service on:

*3/19/99
0740*

Time: *0710*

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

*HPI: 26 yo W/M in pharmer's coming 2° to intractable GTC seizures. Pt is 4/5 "kippal fuel" metabolic
Supplements (caffeine, ephedra), "Winstrol" (anabolic steroids), creatine, Ecstasy? GHB? First presented
to [Redacted] w/ confusion @ work. Discharged & was then admitted to [Redacted] w/ intractable seizures.
Txd w/ phenobarb + Ativan → Intubated for airway protection MRI (head) 3/5 - no gross infarct
, parasinusitis. V/Q scan 3/4 - low probability EEG → seizure activity as seen as phenobarb d*

<i>PMH: φ</i>	<i>Phenobarb 9/1 30</i>	<i>CAMS 3/8 6.2</i>	<i>11.7</i>	<i>283</i>
<i>SH φ</i>	<i>Dupemone 13.2 mg/15/10</i>		<i>35.1</i>	
<i>MEDS</i>	<i>Loxapex 30mg sc q12</i>		<i>143/103/10</i>	<i>114</i>
			<i>3.7/35/0.4</i>	

Ancef 1 gram q8 (3/4/99)
Dopamine 250 IV q6
Tegretol 400mg IV / 200mg IV q12 q12
Nuromin 300mg IV q4
Nystatin swish
Thiamine, Colch
Haldol
Ativan (4/10/99)

*AKG (7.53) (60) / 36 / 31 / 93% / 4:
SIMV + PS R=12 TV 950 PEEP 5 PS*

TSH = 0.127 ↓ Free Phenytoin = 3.49

Signature of Consultant:

[Redacted Signature]

Service:
Time:

[Redacted Service/Time]

000073

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Critical Care [redacted]

Attachment # 3
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Dr. [redacted]

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

PE T=99.8 102/48 (95-120/41-55) 85 RR=12 94-96%
SpO2 = 51/35.5

4/13 - 26 yr W/M in phorbic coma 2°
to intractible seizures 2° polysub abuse

GEN: Intubated, ventilated sedated (4) blanket
COXIN

(1) Resp Failure - SIMV+PS ↓ Vt 900
→ Hypoxic - Pulmonary shunt vs PE
✓ CXR, Bronchoscopy, ABG in room

HEENT: Pupils 5-6 mm (3) minimally reactive
(2) corneal reflex, Dolls eye abnormal

(2) Intractible Seizures -
Diazepam, Tazystal, Phorbic } Neurology
Following

PH: CTR cv: RR 3 ml/s
Abd: soft NTND ↓ BS
Ext: 1+ edema RUE/LUE, p/c

(3) BP/Auxiliary
Dopamine 13 mcg/kg/min
= Repten TLE - PA catheter
& reassess cv status.

(4) Full code? Discuss w family

Signature of Consultant:

[redacted]

Service:
Time:

[redacted]

CONSULTATION REPORT

000074

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to: (Service or Physician) Pulmonary Dr. [Redacted]

Requested by: (Service or Physician) Dr. [Redacted]

Date of Request: 2/25/99 Time: _____

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: state "vent management"
26 y. O.H.O. Admitted to intensive
care whose problems include:

Unit Clerk telephoned the consultant, his secretary [Redacted] on: 2/25/99 Time: 0630

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

- ① Sz. Discharge
- ② Reg. Machine (inboard 2/21/99)
- ③ ↑ serum potassium level
- ④ pre-memorial man - "Ripped Fuel" ~ [Redacted]

- ① Adjust ventilation (↓ V_T / ↓ P_{CO2})
- ② maintain inboard ⑦ WU for volume if program
- ③ RT 9 L° & 8 W
- ④ send when prophylaxis
- ⑤ RT prophylaxis
- ⑥ increase Tube Feeds to 1-2 amp if RT in no remain inboard.

Signature of Consultant: [Redacted] Service: [Redacted] Time: [Redacted] Date: 2/25/99

[Redacted] Thank you!
will

Follow
on.

CONSULTATION REPORT

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

000075

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Neuro

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time: *3/1/99*

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

6 y/o ♂, ph/c med problems, now c intractable seizure. First presented 2/19-2/20 to [redacted] c reports of confusion, "talking nonsense," LOC; HA + photophobia x 4 days. Pt found to be hypoglycemic. Admit -> home 5 AEDs. Presented 2/21/99 to [redacted] ER c report of 16/17/c q. at home, had another in ER. Treated c Dilantin + Ativan; Haldol from presumed 2° convulsion. M.D. summary of 2/22/99 not pt to be sedated but arousable + oriented, c intelligible m.v. Dilantin level 11.9. Morning of 2/23/99 R.N. notes repeated seizure at 4A pt found unresponsive, wife reported pt. staring blankly at wall while she was speaking. 10AM pt A+Ox1, responsive but confused. Seizure noted at 8AM, vom 12:30AM. Treated ativan. EEG showed "interictal slow, no PLED or sharp waves." At 4PM, pt is noted to be unresponsive to verbal stimuli, opens eyes to pain. 8PM. Untimed note of 12/23/99 (presumably late) reports seizure of 7min, pt unresponsive to pain. Specific descriptions of seizure activity N/A except as noted.

Signature of Consultant:

[Redacted Signature]

Service:

Time: *SEE ATTACHED*

Date:

For Attending Signature
000076

[Redacted]
 [Redacted] *RECOPIED from 3/1/99*
(See attached for original)

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) Neuro

Requested by:
(Service or Physician)

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

LP @ protein 55 2/25 Alb 3.2 Free Phenytoin 1.62
g/u 75 AST 18 T.P. 5.3
ABG 36 8/133/316 140/105/8/94 YSH 1.8
Nuc 1 RRR: NR Ca 8.2 mg 1.8 Phos 3.3 WJA @
Vit d @

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 y/o ♂ c 6/10 medical problems, now c intractable seizures, first presented to ER - Admit 2/19-2/20 c report of confusion; found to be hypoglycemic. Sent home w AEDs. Presented to ER 2/21 c report of c/f/c @ home, had another m ER, needed c Dilantin + Ativan. Pt also had had had paramedics administered 2° combative qd. Summary of 2/22/99 reported pt to be sedated but arousable, oriented c intelligible conversation. Morning of 2/23/99 RN notes document reported sz at 6 AM, pt found unresponsive, wife reported that he began staring blankly at the wall while she spoke to him. At 6:10 he was A+Ox1, responsive but confused. Sz noted at 8 AM, 11 AM, 12:30 AM. EEG c "interictal slow, mo PLED or sharp waves": at 4 PM pt is noted to be unresponsive to verbal stimuli, opens eyes to sternal rub. Sz @ 8 PM. Amd note, untimed 'late 2/23/99' report of sz x 7 min; pt unresponsive to pain.

Signature of Consultant

Service Time:

000077

3/1/99

Recognized, for clarity see attached

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Neuro

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

LR protein SS @ 125
glu 75

HbC 36 8 133 314
WBC 1 40

Yield @ RPR: NR Ca 8.2 Mg 1.8 Phos 3.3

Alb 3.2
AST 18
TP 5.3

140 1705 8 194
3.5 27 17

Free Phenytoin 1.62
TSH 1.8

W/A @

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time: 3/1/99

52 Continue
REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

2/24/99 pt given Phenytoin 800mg @ 12:30 P, Ativan 2mg+2mg+4mg @ 1PM-1:15 PM, Ativan drip @ 4-6mg/hr @ 13:45 PM; Dilantin 800mg @ 22:00 (c tid order), Dilantin to 100mg qd ventilated, pt transferred to [redacted] 2/25/99, put on Vered drip, dilantin continued. Vered was 18.1 @ 2:10 PM. Vered tapered/dcd 2/26/99; diprison added. Dilantin 100mg tid; febrile on 2/26/99 9.7. Nursing notes initial agitation then settled calm until 2/27/99 @ 4 AM. seizure ~ 10 sec activity noted @ 11 AM, 12:05 P, 12:30. Pt given 500mg Dilantin @ 12 P (level 7.1). Activity next noted @ 4 PM, 19:40, 22:15, 22:35, 22:50. Ativan given 22:15 (sz dcd on own otherwise). sz assoc. c eye rolling back, jaw, mouth sticking, jaw trembling, facial twitching. Dilantin added 300mg qd; dilant 7 200mg bid. plus load (see list) 500mg @ 2:15 A 2/28/99 Dilantin 8.2 @ 14:15, 13.7 @ 23:07 & 15.6 @ 5 AM 2/28/99. Assoc. EEG, but temped, Service: activity reported [redacted] reviewed [redacted]

Signature of Consultant

Time:

Date:

[redacted signature] 3/1/99

000078

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Neuro

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Date of Request:

Time:

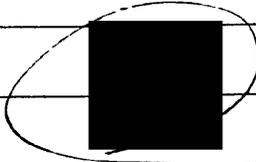
Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:



Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

(13. activity, preatwan continued)

*Pentobarb load & drip added ~ 12P 2/28, Keenid drip restarted 15:00.
Diprivan 2/28/99 14:30, pt developed humming of trunk & rhythmic
movement of legs for ~ 30 sec, followed by chin tremors & eye rolling back.
Pt continued to have events as described
2/28/99 22:00 Pentobarb hung (bolus @ 2050 of 5mg/kg). Keenid & Pentobarb
Oxal. Pt on burst suppression*

PE: Comatose

PMH: Denies all

*Med's: Pentobarb
Pepeid
Diltiazem
Risperidone*

*PERAL, @corneals
@response to pain
@DTRs
Toes mute*

FH: No S2

000079

*SH: Body building -> "Ripped Juel" (Makluang - ephedra)
Married, daughter, @TOB, ETOH, IVDA*

Service:
Time:

Signature of Consultant:

-
-

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to: _____
(Service or Physician)

Neuro

Attachment # *5*
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

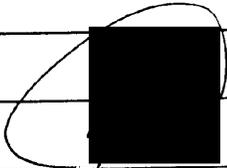
Requested by: _____
(Service or Physician)

Date of Request: _____

Time: _____

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: _____



Unit Clerk telephoned the consultant, his secretary or answering service on: _____

Time: _____

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

*Assessment: 26 y/o w/mo medical history presents
to toxic/chronic seizure, progressed to status over
the most week. Now in post-ictal phase*

*Plan: - Discontinue pentobarbital to burst suppression 5/10
See. for 12-24h then wean pentobarbital
- Dilantin level 10mg/kg @ 500 mg qd
MRT of brain*

Tox / Metabolic / Poison Workup

MD 3/1/99

Signature of Consultant: _____

Service: _____
Time: _____

Date: **000080**

CONSULTATION REPORT

WHITE: Chart Copy

CANARY: Consultant Copy

PINK: Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

1D

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

[Redacted]

Date of Request:

3/2/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

26 yo ♂ tx [Redacted] for intract SZ; pt resp for line intub 2/24
2/21 2 Gen SZ; txd c Dil + Ativan, neurontin, Pheny
Pt now in pentobarb coma.

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

PMUx 995 100-140 90-100 %10
 Q intubated, pentobarb coma
 SLP 3mm = NR
 RRR (L) SCITLC (2)
 CTA (3)
 Q eye SCOS skin lesions
 S/NT/↓BS (2) flu 4 IV
 SAC 2/22 C head (3) comp tox screen
 Q job 2/26 Uix (4) flu CKR
 Q job 2/28 ED (208) RPR NR
 restaurant manager
 remote cocaine (1) 2/26 HSV IgG (+), VZV (+)
 RX start 2/20 crypto (LP 2/28 (3) AFB,
 "Ripped fuel" 4/1 pepcid 1 nucl cell, quicTS, TPSS
 (caffine OD?) 2/26 Bick (x) 2
 phedrine 3/2 ABG 79/37/7.46/96% e SIMV/0.3/900/10
 3/2 141/107/9 <116 90 272
 4.1 26/0.7
 2/1 30.6

000081

Signature of Consultant:

Service:
Time:

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSSAN Project #13408
SJH

Consultation to:
(Service or Physician)



Requested by:
(Service or Physician)

Date of Request:

3/2/99

Time:

1430

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Status Epil c phenytoin infiltr. @ arm

Unit Clerk telephoned the consultant, his secretary or answering service on:

3/2/99

Time: 1450

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

Pt is a 26 yo w/male c Dx of New Onset Intractable seizures. All 3,3 on 3/3/99. Assessed @ arm delatid infiltration site. Site is redden, non-blanchable approx 3cm x 3cm; skin intact, mild induration noted. Necrosis of tissue noted. Appears to be resolving.

Warm compresses ^{correction} to area 20 minutes 4 x a day to promote circulation

000082

Due to length of time since occurred, assessment of area would be sufficient. Reconsult if needed.

Signature of Consultant:

Service:

Time:

1025

Date:

3/4/99

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

nutrition

Requested by:
(Service or Physician)

A [redacted]

Date of Request:

3-4-99 Time: *2033*

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

Attachment # *5*
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Unit Clerk telephoned the consultant, his secretary or answering service on: Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

S- Est'd Ht > 6'2"

O- Dx: new Onset Intractable Sz. Thought to be 2^o Drug/Toxin Ingestion

Labs: Alb 3.3 (3/3) 1.39 / 4.3 | 1.15 / 10.6 < 1.32 (3/5)

Support: 30 cchr UltraCal T.F. (liquid equivalent) = 760 Cal / 32 gm Protein

GI: Absent b/s, Soft Abd. F.T. in mid duodenum per ³¹radiology report

Anthros: ⁹⁷26 wt 93.5kg (↓ from 100kg recorded at Adm) DBW ~ 86kg ¹

A- Acceptable to provide enteral support via nas-intestinal fdy tube despite audible bowel sounds (as discussed w/ R.D.) Agree with feeding choice. Wt documentation indicate wt loss; Adm. wt > stand. for Ht.

Alb. reflects mild visceral protein deficits. Est. requirements 2600-2700 ^{Cal} / 90gm ^{Pro}

Rec. continue feedings along with monitoring of tolerance, progressing to goal of 100-105 cchr if tolerated

000083

P- FIU to monitor fdy toler/adequacy
Signature of Consultant:

Service: *Dutelle*
Time: *1130* Date: *3-5-99*

Thank You for Referral
 [redacted]

[redacted]

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

hypotensive

Consultation to: (Service or Physician) Pharmacotherapy [redacted]

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by: (Service or Physician) Dr. [redacted]

Date of Request: 3/7/99 Time: 1445

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired:

NKA Consult Ripell Fuel

PMH Ø

SJH

[redacted] telephoned the consultant, his secretary or answering service on: 3/7/99 Time: 1455

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

This is a 26 ylb male wt 100kg Ht & recurrent seizures started when pt was seen in [redacted] then admitted to [redacted]. Pt c a 3yr hx of ingesting Ripell Fuel as a metabolic enhancer diet supplement & fuel energy stimulant. A combination of Ephedrine - 10mg/capsule along w caffeine 100mg ^{per} capsule + chronic bicarbonate. Pt started on Pentobarbital qd to max 3.5mg/kg & dilute 500mg IV q mendax 300mg ^{per} q 4hrs. Pt pentobarbital levels have been ^{& continued seizure activity} subtherapeutic. Would recommend ↑ pentobarbital bolus 10mg ^{per} maximum 25mg/kg ↓ ~~bolus~~ + rebolus @ 30' as needed. ↑ drip to max 8-10mg/kg/hr. Monitor ^{blood} pressure. Would agree ~~to~~ ^{to} ~~toxicology~~ ^{toxicology} level dilution is less effective for drug induced seizure. Another alternative is propofol steady at 10mg/kg/min. Will FU.

Signature of Consultant: [redacted]

Service: [redacted] Time: 18:15-20:00 Date: 3/7/99

CONSULTATION REPORT

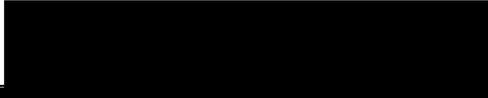
000084

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dr



Attachment # *5*
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

Dr



Date of Request:

3-8-99

Time:

?

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Unit Clerk telephoned the consultant, his secretary or answering service on:

3-8-99

Time: *1815*

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

See Progress Notes

000085

Signature of Consultant:



Service:

Time:

Date:



CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Please Rec'd
AM
3-15-99
Dr.
PM

Consultation to:
(Service or Physician)

Ophthalmology - PO

Requested by:
(Service or Physician)

Dr.

Date of Request:

3-14-99

Time:

1650

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

evaluate both eyes for

Conjunctival infection

3/15/99 0930

3-15-99. 0620

Consultant, his secretary or answering service on:

3-14-99

Time: 1755

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 year old Girl / Persistent / Discharge / with Red Eyes.

Discharge

VA/OM/CF could not be opened

B/E lids - none

conj - mild conjunctiv

cor - few spm BOT

AC 0/2

Discharge 0/5 P

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

(1) Dry Eyes / Exposed

loculation of vitreous

Q2-3^o OC

Tappe Eye det. obs

Plus

Signature of Consultant

Service:

Time:

2:00P

Date:

3-15-99

CONSULTATION REPORT

WHITE: Chart Copy

CANARY: Consultant Copy

PINK: Requesting Physician Copy

000086

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

[Redacted]

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

[Redacted]

Date of Request:

3/29/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Transfer to [Redacted]

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 yr old male transferred from [Redacted]

pl/mlh

for intractable seizure (intractable) currently

none

having fevers, being optimized on

medⁿ

antibiotic medⁿ has trouble on vent

noted

140/60 / Temp - 102. F 100.7

was on over the counter medⁿ

not following commands
having left facial twitching

Social

R/S - BARE ↓ at bars

married
hus & wife

ces - sck present

Ahd - sept, non-tender distal lots noted
18 wt ↑WBC; ↑LFT

26 yr old male. e intractable seizure - patient not appropriate for
at this time.

Sepsis / encephalopathic / on vent would benefit from SW

consult for ECF placement

Signature of Consultant:

[Redacted Signature]

3/30/99

Service:
Time:

[Redacted Service/Time]

Date:

3/30/99

CONSULTATION REPORT

000087

WHITE Chart Copy

CANARY Consultant Copy

PINK: Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dn

Requested by:
(Service or Physician)

Rn

Date of Request:

3/17/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

For Tracheostomy

Attachment # *5*

Memorandum-FLA-9339

4/13/99

CFSAN Project #13408

SJH

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 yo M is anoxic encephalopathy as result of status epilepticus following polysubstance abuse now is respiratory failure. Currently intubated, on vent 50%/SIMV 10/900/5. Consulted for tracheostomy placement.

PMH - \emptyset PSH - \emptyset NKDA Current Rx - Neurontin, Lovenox, Colace, Phenobarbital, Synthroid, Zosyn, Ativan prn, Nimetop

PE - Comatose, occas. blinks eyes, No response to commands

Lab 3/18: $\frac{135}{3.8}$ / $\frac{99}{50}$ / $\frac{11}{0.3}$ < 144 17 / $\frac{12}{37}$ / $\frac{48}{}$

OTT in place, Dobhoff \odot nostril. Both mesial maxillary incisors projecting anteriorly and mobile (reportedly 2° to status epil./oral intubation/dilantin effect)

Neck - \emptyset scars, no landmarks.

A) Resp. Failure, Anoxic encephalopathy (Intubated 2/26 @ [redacted] then transferred to [redacted])

P) Agree is indic. for tracheostomy. Will scheduled as soon as OR can accommodate.

Signature of Consultant:

Thank you

Service:

Time:

3/18/99, 8:30

Date:

000088

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Speech Pathology

Attachment # 5
Memorandum-FLA-9339
4/13/99
CFSAN Project #13408
SJH

Requested by:
(Service or Physician)

[Redacted]

Date of Request:

4/3/99

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

26 y/o M transferred from [Redacted]
for retractable seizures. Dx intractable seizures
encephalopathy.

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

② Pt seen bedside on vent c track

① Examination Findings

Communication / Cognition - opening eyes when
name called. Demonstrates facial expression
of pain. NR to 1-step commands
NR to simple yes-no questions. Verbally
level of alertness / arousal reduced c
pr not maintaining arousal (ie eyes opening)
for 1 time intervals

① Severe - profound Cognitive / Communication
impairment. Swallowing not assessed
Status pt's current Respiratory / Cognitive

Signature of Consultant:

Will continue to follow
provide
as indicated.

Service:
Time:

Date:

4/5/99

CONSULTATION REPORT

000089

Sedation Intubated
afebrile VSS

chest CTA
Cor arm

PER LA Oryzogram

the cones

(-) Facial Asymmetry

moves bolt spontaneously.

(-) Seizure

(-) Tremor

Diz symmetric for RT.
with in to for skull

old records reviewed.

Dryogram

- (1) Intractable Seizures
- (2) Encephalopathy

Plan

- EEG monitoring
- Tapir mixed drip
- Dilantin/phenytoin as needed

SIGNATURE: _____, M.D.

DATE: 2/24/88

SIGNATURE: _____, M.D.

Skull, scalp, hair, skin, eyes, ears, nose, mouth (lips, teeth, gums, breath), throat, heart (B.P.), vessels, lungs, abdomen (liver, spleen, kidneys, scars), genitalia, vaginal, rectal, lymph nodes, extremities, reflexes.
IMPRESSION

[Redacted]

PHYSICAL EXAMINATION

000090

Physical Examination

DATE
5/20/99

26yo LHD gentleman transferred from [redacted] to [redacted] by status epilepticus and encephalopathy. Limited records available for review which include [redacted] and labs/meds.

Mr. [redacted] initially presented to [redacted] it was felt to have had a hypoglycemic episode & observation. He was then admitted to [redacted] → transferred to [redacted] recurrent seizures. When at [redacted] is unclear; however, records reflect he was followed by ID and treated to a course of abx. He ultimately underwent PEG placement & trach and was transferred to [redacted] on mech. ventilation. He was also on TPN upon arrival to [redacted] 20 lbs.

He has since been weaned from the vent & was decannulated 1 wk ago. He underwent an MBS 5/11 which showed no evidence of aspiration.

Signature [redacted], M.D.

ADMISSION CERTIFICATION: This is to certify that inpatient hospital services are needed.

000091

Date 5/20 Physician Signature [redacted], M.D.

ADMISSION
PROGRESS NOTES

PATIENT ADDRESSOGRAPH

[redacted]
 [redacted]

[redacted]

DATE
5/20

I think of the barium but a poor
most active of solids & ex activity
He is currently eating well per
family of only receiving meds via PEG.
He has been followed by Dr. [redacted]
~ once / wk while at [redacted]
last ss per family toxic/chronic ~
2 wks ago Earlier today he
he had an episode of mouth
twitching & staring spells
Also hx of fall on @ side ~ few days
ago no x rays obtained
per family 40 @ hip per
Allergic PRNIX meds

psb
Ø

psb
Ø

Solid

worried
I did it yr old

works as [redacted] manager

⊖ ETOH
⊖ TOB

Benzof 25mg Q6 hr
Syllkaid 0.25mg qd
Colace 100 bid
VIT E 400mg bid
VIT C 500mg bid
Lamictal 200mg bid
Kloroxin 400mg q4h
Neraxin 400mg q4h
Ø barb 90mg q8h

Signature _____ M.D.

ADMISSION CERTIFICATION: This is to certify that inpatient hospital services are needed.

Date 5/20

Physician Signature _____

000092

M.D.

PATIENT ADDRESSOGRAPH

ADMISSION
PROGRESS NOTES

[redacted]

DATE
5/20

PE 115/69 97 114

as he does slow to respond
speaks in short sentences
oriented to self & place
not worth/yes circumstances
Follow 1 step commands & 2 step

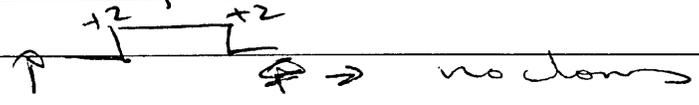
delay
Cox II - III grossly intact
Trunk site escher (-) drainage with
chest clear

Distal exam
abd (+) bs PEG site & nasogastric

soft NTND
cches soft (-) cords/wattle
(-) per tibs or able edem

(L) UE & (L) leg ↑ tone Ashworth 2-3
waves all ext. at least 4/5

(L)
+3/+21



(L) big discomfort in low
back cords tight at 5° DVT
sitting/standing

ADMISSION CERTIFICATION: This is to certify that inpatient hospital services are needed.

Date 5/20

Physician Signature

[Redacted Signature] , M.D.
000093

ADMISSION
PROGRESS NOTES

PATIENT ADDRESSOGRAPH

[Redacted]

[Redacted]

DATE 5/18 8.7 } 14.0 PCT = 398 5/19 AST = 31
 5/20 40.6 }
 ALP 4121 iron = 30
 TIBC = 187
 ALK phos 175
 ✓ barb 23.5

1. ever had another 2° status epilepticus
 continue current sq meds
 consult Dr. [redacted] to
 continue to follow
 ✓ barb level
2. X-ray @ hip q/o fx before
 mobilization
3. low dose for DVT prophylaxis
4. PEG site cdx
 review old records & will
 remove PEG = ✓ cd count

[redacted]

addendum erythematous red below trunk
 site no papules / pustules
 no new meds per family at least
 over 7 months

5/24 intractable seizure 2° substance abuse [redacted]
 toxic encephalopathy
 resp failure [redacted] M.D.

DVT
 ADMISION CERTIFICATION: This is to certify that inpatient hospital services are needed.
 lives also?
 Date 5/20 Physician Signature [redacted] M.D. 000094

ADMISSION
 PROGRESS NOTES

[redacted]

[redacted]

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician) PR

Requested by:
(Service or Physician) PR

Date of Request: 5/20/99

Time: 1815

Check Appropriate Box: Consultation Only Consult and Follow Accept for Transfer

Diagnosis and Information Desired: Please see pt known to you.

Having episodes of staring & mouth twitches
reported by family & seen by nursing.

Unit Clerk telephoned the consultant.

Service on: 5/20/99

Time: 2015

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

26 y.o. ♂ → H/O Toxic Encephalopathy & intractable Seizures
following substance abuse, ketyl fuel & others (Pt. was admitted
to [redacted] → Intractable Seizures → resp. failure, liver failure
& DVT. → had some neurologic recovery → Transferred to
[redacted] for further long term treatment.

Pt. continues to improve & however, He reportedly has 10-15 hrs
[redacted] brief breathless 10-15 sec. Partial Seizures
Meds: Lamictal 200 bid / Neurontin 400 qd / Phobal
70-90 & Klonopin 1 mg qd / but is still having breathless
seizures.

o/c: Awake, alert follow all commands. Poor, STM
- dyslexia, apraxia, dis-co-ordinated.

000095

Signature

Consultant:

UJ 4/5 / UJ 4/5

Service:
Time:

Date:

Dir o/p. → diffuse muscle atrophy
T6-L1

See page
(2)

CONSULTATION REPORT

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)



Requested by:
(Service or Physician)

Date of Request:

Time:

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

(page 2)

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

Injury

- (1) injury toxic Encephalopathy
- (2) Complex partial Seizures
- (3) mild dementia
- (4) ↑ LFTS injury
- (5) mild Anemia

Recommendations:

- (1) Cobin Cont rx
↑ Lanital to 200 mg bid / 25 mg bid
phenobar 90 mg qd
Klonopin 1 mg qd
Mevastatin 400 mg qd

000096

5/21
Signature of Consultant:

[Handwritten signature]
is reviewed
Brief. ⊙ / the
section
will follow



5/21/49

CONSULTATION REPORT

WHITE Chart Copy

CANARY Consultant Copy

PINK Requesting Physician Copy

CONSULTATION

REQUEST FOR CONSULTATION

PLEASE PRESS HARD WHEN WRITING

Consultation to:
(Service or Physician)

Dietitian

Requested by:
(Service or Physician)

Dr. [REDACTED]

Date of Request:

May 20, 99

Time: 11:33

Check Appropriate Box:

Consultation Only

Consult and Follow

Accept for Transfer

Diagnosis and Information Desired:

Nutrition Consult

re difficulty swallowing (+ADB)

Unit Clerk telephoned the consultant, his secretary or answering service on:

Time:

REPORT OF CONSULTANT (Please sign your name, date and time to each consultation)

S: Pt's wife states pt not having any difficulty swallowing currently. Eating well.

Holds food & continues chewing during seizures / no choking episodes. States only meals given via PEG tube. Had MBS c. [REDACTED] - nothing found. Currently 6'1", ~185#.

O: Dx: encephalopathy, seizure d/o. Nutrition Support: Mechanical soft double portions.

Anthrop: Ht: 6'1" wt ~185# DBW: 184# +10%. Labs: (5/21) $\frac{140}{4.1} = 1.8$ (H/H 13.5/41) $\frac{82}{1.5} = 3.8$ Alb 3.8

Po intake: ~100%. (Recently on TPN upon arrival to [REDACTED] 2° ileus)

A: Pt currently 100% DBW, eating well, no current difficulty swallowing per wife, but to be followed by [REDACTED] Alb c 3.8 indicating mild visceral protein depletion and H/H.

Est needs for wt maintenance = 2565 Kcals, 84g pro. Calorie count ordered

per physician to monitor po intake (possible removal of PEG). Pt's diet providing adequate kcal/pro to meet est needs \approx >75% intake on most meals.

P: 1) Calorie count initiated

Signature of Consultant:

Service: Dietetic
Time: 1140

Date: May 21, 99

2) Recommend continue current nutrition mgmt.

3) Monitor Albumin, wt, H/H

CONSULTATION REPORT

WHIT

ANARY Consultant Copy

PINK Requesting Physician Copy

000097

CONSULTATION