Cards 4 PGY-1 Admit Note

Date of Admission:
Admitting Physician:

SOURCE: LMR, patient

CC: chest pain

HPI:
68M w/ h/o CAD s/p stent to RCA 8/08 p/w worsening CP to ED. Patient had stent to RCA 1 year PTA for 80% lesion. On repeat cath 15 days afterwards for chest pain, found to have patent RCA stent and 50% proximal LAD lesion. Pt now p/w 2 months of intermittent yet daily L-sided CP, lasts 3-5min, sharp, no radiation. CP has been occurring more frequently in last week (3-4x/d) and is requiring increasing amounts of SL NTG to achieve relief. At 4AM on DOA, pt had more intense CP that was only minimally improved with 3 SL NTG. A/w SOB/diaphoresis, no n/v, not a/w exertion. He called his PCP and was advised to come into ED.

In ED: VS 98.2 56 214/102 20 100%RA. CE neg x1. CXR negative. Pt was admitted for further work-up. Upon assessment in ED, pt was asymptomatic from elevated BP. Hydral 10mg IV x1 brought sBP down from 210 to 179 in ~30 min. However, BP started to rise again. Amlodipine 5mg was added to his anti-hypertensive regimen, which controlled his BP on the floor initially to 140s sBP.

On the floor, pt had another episode of CP while walking from the bathroom. The CP resolved w/ 2 SL NTG. EKG done during CP showed new biphasic Tw in I, aVL (priors showed inverted Tw), pseudonormalization of Tw in V5-V6 (priors showed TwI). Vitmain K 2.5mg PO x1 was given to reverse coumadin and pt was started on heparin gtt (no bolus). Pt apparently has h/o GIB; guaiac obtained before starting heparin gtt was negative for occult blood.

ROS: Positive for subjective fever, no chills. Negative for SOB not a/w CP, n/v/d/abd pain, dysuria.

PMH:
Htn, h/o AFib (started on coumadin 2 years ago), DMII, morbid obesity, OSA on CPAP, atypical CP, asthma, s/p appy, DJD b/l knees

MEDICATIONS
Home:
1. COUMADIN (WARFARIN SODIUM) 5 MG PO QPM (started for AFib 12/06)
2. ALLOPURINOL 50 MG PO DAILY
3. ENTERIC COATED ASA 325 MG PO DAILY
4. PLAVIX (CLOPIDOGREL) 75 MG PO DAILY
5. COLCHICINE 0.6 MG PO BID
6. PEPCID (FAMOTIDINE) 20 MG PO BID
7. GLYBURIDE 1.25 MG PO BID
8. IMDUR ER (ISOSORBIDE MONONITRATE (SR)) 30 MG PO DAILY
9. METOPROLOL SUCCINATE EXTENDED RELEASE 50 MG PO DAILY
10. ZOCOR (SIMVASTATIN) 80 MG PO BEDTIME
11. TAMSULOSIN 0.4 MG PO DAILY

ALLERGIES: PCN, ERYTHROMYCINS

FHx : Brother: s/p CABG, Mother: DM

SHx: Lives with wife, former driver/salesman. No tob/EtOH/IVDU.

PE

Vital Signs: 98.2 56 214/102 20 100%RA
General: NAD
Skin: no rashes noted
HEENT: OP clear
Neck/Thyroid: no JVD
Pulm: CTAB
CV: RRR, 2/6 SEM at RUSB
Abd: +BS, s/nt, very obese abdomen
Extremities: WWP, no edema b/l
Neuro: A+Ox3

LABS (DATE OF ADMISSION)
NA 143, K 3.9 (#) [1], CL 112 (*), CO2 23, BUN 21, CRE 1.00, EGFR 74 [2], GLU 126 (*)
NA 141, K 5.1 (*#), CL 109 (*), CO2 23, BUN 16, CRE 0.81, EGFR 95 [1], GLU 110
ANION 8
ANION 9
CA 10.0, MG 2.2, TBILI 0.4, TP 6.6, ALB 3.8, GLOB 2.8
[1] MG 2.1
CA 9.4
ALT/SGPT 29 (#), AST/SGOT 24, ALKP 70, TBILI 0.4
CK-MB 1.8, TROP-I 0.04 [1]
[1] CK 113, CK-MB 2.0, TROP-I <0.04 (LESS THAN ASSAY RANGE) [2]
CK 146, CK-MB 1.9, TROP-I <0.04 (LESS THAN ASSAY RANGE) [1]
WBC 7.94, RBC 4.42 (*), HGB 13.6, HCT 39.3 (*), MCV 88.8, MCH 30.7, MCHC 34.5, PLT 156
WBC 6.91, RBC 4.51, HGB 14.0, HCT 39.8 (*), MCV 88.3, MCH 31.1, MCHC 35.2, PLT 135 (*)
RDW 13.8
RDW 13.6
%POLY-A 66.5, %LYMPH-A 24.6, %MONO-A 5.7, %EOS-A 2.9, %BASO-A 0.2
%POLY-A 64.6, %LYMPH-A 26.2, %MONO-A 6.6, %EOS-A 2.2, %BASO-A 0.3
PT 24.8 (*), PT-INR 2.2 (*), PTT 42.2 (*)
PT 24.3 (*), PT-INR 2.1 (*), PTT 38.1 (*)

STUDIES (DATE OF AMDISSION)
CXR: no acute abnormality
EKG A set: NSR at 55, old TwI I, aVL, V5-6
EKG B set: new biophasic Tw I-aVL, new pseudonormalization of Tw V5-6

ASSESSMENT:
68M w/ h/o CAD s/p stent to RCA 8/08 p/w worsening CP, found to have dynamic EKG changes in setting of CP on the floor, concerning for ACS.

PLAN:

Cv-I: History of CAD with PCI 1 year PTA, DES placed in RCA. Had follow-up cath on 15 days later following more CP, showing patent arteries but 50% proximal LAD lesion. Patient now with increasing CP with exertion relieved by NTG. Biomarkers negative x 2 but with e/o EKG changes. Will place on maximal medical therapy for ACS.
[ ] continue ROMI
[ ] hep gtt, plavix, asa, bblocker, lipitor, nitros prn
[ ] reversing coumadin prior to cath in AM with vitamin K po x1

Cv-P: Last ECHO 1 year ago, Ef 65-70%.
[ ] htn at home on nitrates, bblocker
[ ] started ca-channel blocker (amlodipine), given increased BP in house (SBP at 200)
[ ] If htn refractory, can titrate Ca-channel blocker up , consider clonidine
[ ] ECHO prior to discharge

Cv-R: NSR, cont. tele

Endocrine/DM: glyburide at home
[ ] sliding scale here
[ ] re-chceck a1c

HEME: Anitcoagulated secondary to history of AFib
[ ] hold prior to cath

Pulm: CPAP overnight for OSA

CODE full

Admission Orders

John Doe's Admit Medication Orders
Allopurinol 50mg po qd
EC Aspirin 325 mg po qd
Clopidogrel 75mg po qd
Colchicine 0.6mg po BID
Famotidine 20mg po BID
Isordil 10mg PO TID
Metoprolol 12.5mg po Q6H
Atorvastatin 80m po qd
Tamsulosin 0.4mg po qd
Amlodipine 5mg po qd
Insulin Aspart Sliding Scale sc qac
Heparin 1,200 units/hr

Discharge Summary, Including Discharge Orders

Admission Date: XXX
Discharge Date: XXX

****** FINAL DISCHARGE ORDERS ******
M68
Service: CAR

DISCHARGE PATIENT ON: AT 05:00 PM
CONTINGENT UPON HO evaluation
WILL D/C ORDER BE USED AS THE D/C SUMMARY: YES
Attending: XXX, M.D.
CODE STATUS:
Full code
DISPOSITION: Home

MEDICATIONS PRIOR TO ADMISSION:
1. WARFARIN SODIUM 5 MG PO QPM
2. ALLOPURINOL 50 MG PO QD
3. ASPIRIN ENTERIC COATED 325 MG PO QD
4. CLOPIDOGREL 75 MG PO QD
5. COLCHICINE 0.6 MG PO BID
6. FAMOTIDINE 20 MG PO BID
7. GLYBURIDE 1.25 MG PO BID
8. ISOSORBIDE MONONITRATE (SR) 30 MG PO QD
9. METOPROLOL SUCCINATE EXTENDED RELEASE 50 MG PO QD
10. SIMVASTATIN 80 MG PO QHS
11. TAMSULOSIN 0.4 MG PO QD

MEDICATIONS ON DISCHARGE:
1. COUMADIN (WARFARIN SODIUM) 5 MG PO QPM
2. ALLOPURINOL 50 MG PO DAILY
3. AMLODIPINE 10 MG PO DAILY
4. ASPIRIN ENTERIC COATED 81 MG PO DAILY
5. CLOPIDOGREL 75 MG PO DAILY
6. COLCHICINE 0.6 MG PO DAILY
7. FAMOTIDINE 20 MG PO BID
8. GLYBURIDE 1.25 MG PO DAILY
9. IMDUR ER (ISOSORBIDE MONONITRATE (SR)) 30 MG PO DAILY
10. TOPROL XL (METOPROLOL SUCCINATE EXTENDED RELEASE) 50 MG PO DAILY
11. SIMVASTATIN 80 MG PO BEDTIME
12. TAMSULOSIN 0.4 MG PO DAILY

WARFARIN
Indication for anticoagulation: atrial fibrilliation
Anticipated length of anticoagulation: Lifetime
INR Target Range: 2-3
Last 3 INR Results:
02/25/09: 1.3*
02/24/09: 1.6*
02/24/09: 1.8*
INR should next be drawn on:
INR will be followed by: Dr. XX

DIET: House / Low chol/low sat. fat

ACTIVITY: Resume regular exercise

FOLLOW UP APPOINTMENT(S):
1. XXX,M.D. , Primary Care
   Addr: 133 BROOKLINE AVE. BOSTON,MA
   Scheduled date and time: 10:00 AM
   Reasons for Seeing/Tasks to be Accomplished at Visit:
   F/U hospitalization, hypertension, INR check
2. XXX,M.D. , Cardiology
   Addr: 133 BROOKLINE AVENUE BOSTON,MA
   Scheduled date and time: 09:30 AM
   Reasons for Seeing/Tasks to be Accomplished at Visit:
   f/u hospitalization

ALLERGY: Penicillins, Erythromycins
ADMIT DIAGNOSIS:
CHEST PAIN
PRINCIPAL DISCHARGE DIAGNOSIS (Responsible After Study for Causing Admission)
HYPERTENSION
OTHER DIAGNOSIS (Conditions, Infections, Complications, affecting Treatment/Stay)
htn (hypertension) DMII, morbid obesity (obesity), OSA on CPAP (sleep apnea), atypical CP (atypical chest pain), asthma (asthma), s/p appy (S/P appendectomy), DJD b/l knees (OA of knees)
OPERATIONS AND PROCEDURES:
none
OTHER TREATMENTS/PROCEDURES (NOT IN O.R.)
none

BRIEF RESUME OF HOSPITAL COURSE:
CC: Chest pain
******
HPI: 68M w/ h/o CAD s/p stent to RCA 1 year PTA p/w worsening CP to ED. Patient

had stent to RCA for 80% lesion. On repeat cath 2 weeks later for chest pain, found to have patent RCA stent and 50% proximal LAD lesion. Pt now p/w 2 months of intermittent yet daily L-sided CP, lasts 3-5min, sharp, no radiation. CP has been occurring more frequently in last week (3-4x/d) and is requiring increasing amounts of SL NTG to achieve relief. At 4AM on DOA, pt had more intense CP that was only minimally improved with 3 SL NTG. A/w SOB/diaphoresis, no n/v, not a/w exertion. He called his PCP and was advised to come into ED.

In ED: VS 98.2 56 214/102 20 100%RA. CE neg x1. CXR negative. Pt was admitted for further work-up. Upon assessment in ED, pt was asymptomatic from elevated BP. Hydral 10mg IV x1 brought sBP down from 210 to 179 in ~30 min. However, BP started to rise again. Amlodipine 5mg was added to his anti-hypertensive regimen.
Assessment: 68 yo M w/morbid obesity, HTN, CAD s.p. RCA stent on 8/08, who p/w CP x 2-3 weeks with exertion. Pain generally relieved with NTG. Today pain was persistent so presented to ED.
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Hospital Course by problem:
1) Cv-I: history of CAD with PCI 1 year ago, DES placed in RCA. Had follow-up cath on 2 weeks later following more CP. Patient p/w with increasing CP with exertion relieved by NTG. Biomarkers negative x 3. No evidence of ecg changes. On the floor, pt had another episode of CP while walking from the bathroom. The CP resolved w/ 2 SL NTG. EKG done during CP showed new biphasic Tw in I, aVL (priors showed inverted Tw), with question of pseudonormalization of Tw in V5-V6 (priors showed TwI). Vitamin K 2.5mg PO x1 was given to reverse coumadin and pt was started on heparin gtt (no bolus). Pt apparently has h/o GIB; guaiac obtained before starting heparin gtt was negative for occult blood. The patients third set of enzymes remained negative and his C-set EKG had returned to baseline. Decision was made to obtain a stress/PET which showed a likely small sized perfusion defect. Given the patient's frequent presentations for pain and the atypical nature as well as the normal ecg's and negative troponins, the decision was made to continue medical therapy at this time. Futhermore, it was felt that the patient was likely symptomatic from his uncontrolled HTN and his chest pain was secondary to demand. As a result, the patient's medication regimen was optimized and he was started on amlodipine with good effect. At the time of discharge, the patient was pain free both at rest and with exertion, furthermore, the patient's blood pressure was well controlled with the addition of amlodipine.

Type 2 Diabetes: The patient's home medication regimen was held and the patient was started on a insulin sliding scale while in house. He had good glycemic control and will be discharged home back on his home regimen.

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Discharge Physical Exam:
Afebrile. BP 130/80's.
Gen: NAD
Pulm: CTAB. No crackles, rhonci.
Cor: Regular. Distant heart sounds however, no murmurs, rubs or gallops.
Abd: Obese. soft,nt,nd, +BS.
Ext: Warm. No edema. No clubbing.
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Consulting Services: None
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Relevant PMHx: OSA, HTN, cad s/p stent as above, NIDDM, Asthma, s/p appy, morbid obesity
ADDITIONAL COMMENTS: You were admitted secondary to chest pain. This chest pain was likely secondary to your high blood pressure. Please make sure to take your medications as prescribed. Please make sure to follow-up with your PCP next week and with your cardiologist in 2-4 weeks. Please make sure to call with any new chest pain, shortness of breath or with any other symptoms that are new or concerning.

DISCHARGE CONDITION: Stable

TO DO/PLAN:
1) Please follow-up on the patient's hypertension (patient was started on amlodipine while in house)
2) Please follow-up on the patient's chest pain and consider further evaluation if chest pain returns
3) Please follow-up the patient's INR (coumadin was briefly held)
Thank you.
No dictated summary
ENTERED BY: XXX

****** END OF DISCHARGE ORDERS ******