Humana Hospital—Northside

PT. NAME: SCHIAVO, Theresa MR#: 24123

ATTENDING PHYSICIAN: Samir Shah, M.D.

ADMISSION DATE: 02/25/90 DISCHARGE DATE: 05/09/90

CONSULTANTS: Nagella Ravindra, M.D.
Hadi Hakki, M.D.
Garcia DeSousa, M.D.
M. Suksanong, M.D.
R. S. Pascual, M.D.
Casey Gaines, M.D.
Meenakshi Jain, M.D.
Pothen Jacob, M.D.

ADMITTING DIAGNOSIS: Cardiopulmonary arrest.

FINAL DIAGNOSES: Cardiac arrest.
Anoxic brain damage.
Severe hypopotassemia.
Respiratory failure.
Seizure disorder secondary to hypoxic encephalopathy.
Pneumonia, secondary to Staphylococcus aureus.
Right knee fusion.

PRINCIPAL PROCEDURES PERFORMED: Permanent tracheostomy, insertion of endotracheal tube, mechanical ventilation, gastroscopy, bronchoscopy through tracheostomy.

BRIEF HISTORY: This is a 26 year old white female not known to me prior to admission who was brought to the emergency room and admitted to the Intensive Care Unit after stabilization in the emergency room.

She was apparently in good health and was found by her husband on the morning of admission on the floor with difficulty breathing and gasping for air. She was unresponsive. The paramedics were called and it took several minutes for resuscitation She needed to be defibrillated several times at home and was also severely hypotensive.

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She responded in the emergency room to some extent with Dopamine.

Examination showed decerebration and focal seizure activity.

Her only significant recent history was she was being treated by her gynecologist for a vaginal infection with local cream. Her allergies were treated in the past with Benadryl.

Further history revealed that she apparently has been trying to keep her weight down with dieting by herself, drinking liquids most of the time during the day and drinking about 10-15 glasses of iced tea. In the past, she lost about 65 pounds a few years ago.

There is no history suggestive of drug abuse, alcohol abuse, et cetera.

No other significant history was noted.

The rest of the history is as mentioned in the history of the present illness.

PHYSICAL EXAMINATION: At the time of admission, revealed an unresponsive decerebrating young white female on a ventilator. VITAL SIGNS: Blood pressure 90 systolic on Dopamine drip. Respirations on the ventilator 12 per minute, without any assistance by herself. Heart rate was 130 with tachycardia with occasional PVC's. HEENT: Pupils were unreactive. NECK: Somewhat stiff. All other muscles of the body were also stiff. LUNGS: Occasional rhonchi. HEART: S1 and S2 regular, no murmurs. ABDOMEN: Soft, non-distended. Active bowel sounds present. EXTREMITIES: No edema, good

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perioneral pulses were noted. NEUROLOGICAL: The patient was completely unresponsive with decerebrating and in generalized tonic clonic seizure activity.

LABORATORY DATA: Initial laboratory data revealed CBC with WBC of 26.3 and a left shift. Sodium was 138, potassium 2.0, chloride 97, bicarb 15, glucose 373, BUN 2 and creatinine 1.1. Pregnancy test was negative. Urine drug screen was negative. Blood for alcohol was also negative. Initial arterial blood gases showed PH 7.25, PCO2 34, PO2 477 on 100 percent ambu bag. Chest x-ray was negative. EKG showed sinus tachycardia and non-specific ST-T changes. CAT scan of the brain that was done was negative for any acute event.

Initial EEG revealed abnormal electroencephalogram indicative of generalized suppression and slowing of the activity uniformly noted without any significant hemispheric electrolization consistent with diffuse encephalopathy.

Serial EKG's in the first few days did not show any evidence of myocardial infarction.

Her white blood cell count did increase to 34,000 but later on decreased and became normal over the next several days. PT and PTT were within normal range on initial admission. Platelet count was also normal. Total eosinophilic count was 106, within normal range. Urinalysis initially which was a catheterized specimen showed WBC 5-7, RBC too numerous to count. Urine cultures were negative. ESR was 20.

After potassium supplement, her potassium did increase, but stayed on a lower range and became normal the next day.

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The rest of the chemistries revealed LDH 376, SGOT 95, calcium 7.4, inorganic phosphorus 7.1, uric acid 8.6, albumin 2.0 and total protein 4.1, suggestive of some malnutrition. Total CPK did go up to 4,000, but isoenzymes were less than 2 percent. Serial CPK and other enzymes did not reveal evidence of myocardial infarction. Compliment studies were within normal range.

Dilantin level was checked frequently to be kept in therapeutic range.

Various cultures, including blood and sputum were negative initially, but later on the sputum culture was positive for Staphylococcus aureus sensitive to Amoxicillin and the patient was treated appropriately for that. Sputum was negative for fungus, et cetera. Later on, the sputum on 3/22/90 was positive for Enterobacter aurogenes, which was also treated appropriately. Alkaline phosphatase isoenzymes were obtained as it remained high and was suggestive of probable liver origin.

Other special studies included hepatitis which was negative. Also, thyroid function tests were negative. Some other special studies for renin, allisone and urine metanephrines all were within normal range.

HOSPITAL COURSE: The patient was admitted to the hospital with the above-mentioned problems and work-up was done as mentioned above. After stabilization, she was admitted to the Intensive Care Unit. Various consultations weere obtained which included neurology, neurosurgery, cardiology, pulmonary, infectious disease and a GYN consultation. The patient did require a gastrointestinal consultation later on

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during her hospital course. The patient was also seen by Dr. Barras for rehabilitation on 4/04/90. She was initially seen on 5/06/90 by orthopedic surgeon, Dr. Hamilton.

Various possibilities were considered for the patient's event. She was started on IV antibiotic, Rocephin. As her blood sugar was up initially, accu-checks were obtained and covered with Humulin if needed. She was given a loading dose of Dilantin and then regular Dilantin three times a day was administered. The dose was adjusted according to the levels.

Veniltator was managed by Dr. Pascual.

A cardiology consultation with Dr. Kohl was obtained and a Swan-Ganz catheterization was performed. Pressure was supported with Dopamine and fluid was adjusted with Swan-Ganz catheter.

The patient remained significantly unstable in the first few days and did not respond to any kind of stimulation. Later on, as it became difficult to control her seizures with Dilantin alone, Phenobarb was added.

An infectious disease consultation with Dr. Suksanong was obtained and antibiotics were adjusted per her recommendation. IV fluids were adjusted.

Also, a GYN consultation with Dr. Meena Jain was obtained and she recommended vaginal douche with Betadine and to start the patietn on Flagyl 500mg IV piggyback q 6 hours.

The family was contacted every day for her course and plan. She was started on NG tube feeding and Dopamine was being

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tapered off slowly, which she tolerated well.

EEG's and CAT scans were repeated several times to see development of any new CNS pathology. She also required blood transfusions.

NG tube feeding was gradually increased. She developed diarrhea and some other problems related to that.

Dr. Hakki was asked to put a tracheostomy as clinically she needed ventilator support for a longer time. She was later on started on hyperal as she was getting problems with NG tube feedings.

A consultation of a gastroenterologist was also obtained. Dr. Jacob saw the patient and work-up was ordered per his recommendation for diarrhea, et cetera. A percutaneous endoscopic gastrostomy was done with a plan to put the tube into the jejunum, but this was a difficult technique and could not be done and the tube was left in the gastric lumen.

Meanwhile, the patient was continued on hyperal and labs were monitored closely. Maximum hyperal was given while she was off the tube feeding. NG tube feedings were adjusted as tolerated slowly and hyperal was decreased accordingly. Finally, hyperal could be discontinued.

Physical therapy and occupational therapy were also initiated. Tube feeding was maintained and sputum continued to show Enterobacter. The Cipro was continued and Cefazox was discontinued on 3/24/90.

Ventilator support was decreased slowly and as the patient

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was able to manage by herself to keep the blood gases stable, the ventilator was discontinued.

There was a problem with NG tube feeding on 3/30/90, but later on the tube was changed and feeding was resumed.

The patient was put on pressure support alone when the ventilator was discontinued, which she tolerated well.

Later, the patient developed persistent sinus tachycardia and the cardiologists were reconsulted and work-up was done and we started her on Lopressor, which did improve the tachycardia to some degree, but she persisted with significant sinus tachycardia for which no obvious reason was noted and was most likely secondary to central origin.

Dr. Barras from Bayfront Rehab Center was consulted and after his evaluation he recommended intensive rehabilitation and to put the patient in a long-term rehab center such as Mediplex or Hardy Memorial, which I and Dr. DeSousa agreed with. We felt that as the patient had shown some improvement during her hospitalization, though she was not following commands, in her physical and mental status some improvement was noted.

Her insurance company did not approve rehabilitation after she was evaluated by two other facilities.

After she was stable, she was transferred to the Progressive Care Unit. More intensive physical therapy and other supportive care was continued. The patient gained weight and her NG tube feedings were adjusted after her caloric requirements had been calculated.

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The only other problem she developed after she was transferred to the Progressive Care Unit was right knee fusion for which an orthopedic consultation was obtained and the patient was treated conservatively with medication and local care.

After consultation with Dr. Newhart on the phone about her placement, they approved a skilled nursing care facility with physical therapy though intensive rehabilitation care was not approved.

She was advised to be followed by Dr. Barras for continued rehabilitation at the nursing home and is also to be followed by me per the family's request, though she was being transferred to a distant place from here in the South part of St. Petersburg.

The patient was on 30 percent trach collar. NG tube feeding was 65cc per hour with Gevity and she was continued on her same medications she was on here.

The situation was discussed with the family several times and would give follow-up care in the nursing home.

The patient stayed in the hospital for a very long period of time with several complications, but she improved slowly and gradually and was in stable condition at the time of transfer to the nursing home.

Due to her very long stay, all the events that happened in

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the hospital cannot be included in this discharge sumrary and for more detailed information the chart should be referred to.

SAMIR SHAH, M.D.

SS/STI-028
D 06/13/90
T 06/13/90

CC: Dr. Shah

DISCHARGE SUMMARY

REPORT

Humana

DIAGNOSTIC IMAGING

AU-9058 7/89

☐ CT ☐ NUC. MED. ☐ ULTRA ☐ X-RAY ☐ MRI

83813

05/05/90 1:1[illegible] ORDLR 1: 218-31 00050240-2 2/28/90

TODAY ~~CHAIR~~ PORT

SCHIAVO, THERESA
000000024123 DOB:12/03/63
26 F SHAH,SAMIR MD

CARDIOPULMONARY ARREST
ft in lbs ozs Alt qty :

83813

426-30980 PORTABLE KNEE-FLEXT Item:30980 Qty : 1

SC
BP 10 AM

From :ER1 BY :MLR/N

RIGHT KNEE:

AP AND LATERAL VIEWS:

The bones comprising the right knee are intact with no fracture, dislocation or other focal bony abnormality.

IMPRESSION: NO BONY ABNORMALITY.

P3.

DD: 5-06-90
DT: 5-06-90

NA/emc

NANCY ABRAHAMSEN, MD
HUMANA HOSPITAL - NORTHSIDE

DATE _____ BY _____ RADIOLOGIST/M.D.

CHART

Humana

000000592401 SCHIAVO THERESA
Female, 26

DRG

120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES
HCFA wt 2.7059 A/LOS 17.6 S/LOS 10.8 Outlier 39

Principal Diagnosis

V 4275 CARDIAC ARREST

Secondary Diagnoses

4821 ANOXIC BRAIN DAMAGE
2768 HYPOPOTASSEMIA
51881 RESPIRATORY FAILURE
7803 CONVULSIONS
4824 PNEUMONIA DUE TO STAPHYLOCOCCUS
71906 EFFUSION OF JOINT, LOWER LEG
0408 BACTERIAL DISEASE
0411 STAPHYLOCOCCUS INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE &/OR OF UNSPECIFIED SITE

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Principal Procedure

3123 PERMANENT TRACHEOSTOMY

Other Procedures

9604 INSERTION OF ENDOTRACHEAL TUBE
9390 OTHER MECHANICAL VENTILATION
4319 GASTROSTOMY
3321 BRONCHOSCOPY THROUGH ARTIFICIAL STOMA

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

Physician's Signature

5/14/90
Date