MASSACHUSETTS GENERAL HOSPITAL

Admission Note for Bigelow Team C

Name: **********
MRN: 4300338
Attending: **********, MD
PCP: **********, MD
Date of Admission: July 14, 2005

Source: Records and CCU pass off.

CC/ID: Psoas Abscess

HPI:
67 yo who originally presented to an outside hospital with 1 month of leg pain and fevers. CT scan showed a large psoas abscess for which he was transferred to MGH on July 2, 2005. He was initially stable, but subsequently developed atrial fibrillation and rapid ventricular response. Although the originating site of his abscess is unknown, it is thought to have developed from diverticultis, as GNR were drained from within by IR. He has had 4 psoas drains in total, from which Ecoli, VRE, Candida, and Proteus have grown at different times. Over the course of these positive drainage cultures, he has been on Linezolid, Flagyl, Cefipime, and Fluconazaole. He currently has one drain for his psoas abscess.In addition to his psoas abscess he has had several complications problem including the above mentioned atrial fibrillation, acute on chronic renal failure, C. Diff. Colitis, ventilator associated PNA with effusions, cholecystitis an upper GI bleed, and the presence of free air in his abdomen.

His course by problem, in brief, includes:

Afib: Resultant rapid ventricular response to 130s. Responsive to Amiodarone and Digoxin. Sinus rhythm at this time.

Acute on chronic Renal Failure: Originally thought to be secondary to extensive NSAID use for pain control. Resulted in CVVH for several weeks. Currently anuric and had femoral line taken out yesterday. Awaiting tunneled IJ cathether from IR for hemodialysis.

Vent associated/ Aspiration PNA: Intubated 3 times. A week and half ago, received a tracheostomy and a G to J tube to protect airway and decrease aspiration respectively. Has had associated massive bilateral pleural effustion. requiring bilateral chest tubes. R sided tube drains well, while the L pleural side has some loculations. The L side tube has required reposition for IR.

C. Diff colitis: Had several poistive C. Diff toxin screens. Received Vancomycin and has subsequently tested negative for toxin.

Cholecystitis - Shown by CT to have inflamed gallbladder. Mr. Greenwood currently has a percutaneous cholycystotomy tube with plans by IR to remove shortly, perhaps by 8/15.

Free Air: Noted on imaging a few weeks ago, requiring and exploratory LAP. There was no bowel perforation noted, with the air coming from one of the various tube sites.

Upper GI Bleed - Mr. Greenwood has had persistent guaiac positive stool. An EGD has been scheduled by GI. The procedure is being postponed secondary to the need to insufflate a recently incised abdomen. He is being treated prophylactically with Nexium until his procedure.

He is sent to the floor for continued recuperation. He has had a double lumen PICC, placed prior to departure for the floor for IV accesss. He has been afebrile, and currently denies any pain or discomfort on presentation to the floor.

PMHx
Emphysema
Hernia repair
Chronic low back pain
Non malignant colonic polypectomy
Current problem list noted above

Allergies:
NKDA.

Medications:
Vancomycin 125 mg Q6 PO
Digoxin 0.0625 Every 3rd Day
Amiodarone 200 QD
Linezolid 600 QD
Cefepime 1 gm QD
Flagyl 500 TID
Fluconazole 400 QD IV
Nephrocaps 1 tab QD
Neutraphos 1.25 grams tid x 1 day
Lexapro 10 mg po qd
Nexium 40 po qd
T4 75 mcg qd
Zydis 5mg SL QD
Ambien 5mg NGT QD PRN
Dulcolax 10mg PR QD PRN
Tylenol 650 mg PO Q4 HR PRN
Zofran 2mg IV Q8HR PRN

SHx / FHx:
Retired coast guard employee, married. 3 children.
1-2 PPD for 30 years
No ETOH use.
No IVDA per report.

PE:
Temp: 97.7 BP:108/59 HR: 68 RR: 20 O2: 98% on 405 HTM
General: Elderly, malnourished male. Mult tubes, Ill appearing with temporal wasting.
HEENT: Normocephalic, Slightly icteric. PERRL, EOMI. No lympadenopathy, JVD 6cm , tracheostomy in place.
Poor dentition.
Lungs: Bilateral chest tubes in place. Left PICC under bandage. Rhonchi present bilaterally with occasional wheezes.
Heart: Regularly irregular. No murmurs appreciated.
Abd: BS-. J-G tube present. Cholycystecotmy tube, R subcostal to drainage. Healing incision midline of abdomen. Non-tender to palpation. Non-distended. No aortic or renal bruits.
Gen: Foley in place. Testes descended, no masses.
Ext 3/5 strength throughout bilaterally, 2+ pulses bilaterally throughout. 1+ edema bilaterally
Neuro: Alert, Responsive. Non-verbal 2/2 tracheostomy tube. Cranial nerves II-XII intact. Sensation to light touch intact throughout. Reflexes 1+ throughout.

Labs and Studies:

Test Description	Result	Flags	Ref. Range	Units
Plasma Sodium	140		(135-145)	mmol/L
Plasma Potassium	3.7		(3.4-4.8)	mmol/L
Plasma Chloride	106		(100-108)	mmol/L
Plasma Carbon Dioxide	28.9		(23.0-31.9)	mmol/L
Plasma Urea Nitrogen	40	H	(8-25)	mg/dl
Plasma Creatinine	2.1	H	(0.6-1.5)	mg/dl
Plasma Glucose	134	H	(70-110)	mg/dl
Vancomycin,Unspecified	22.3			mcg/ml
FIO2/Flow				FIO2/L
.50 TRACH MASK				
Temp	37.1			deg C
Unspecified pH	7.44		(7.32-7.45)	
Unspecified PCO2	44		(35-50)	mm/Hg
Unspecified PO2	97	H	(40-90)	mm/Hg
Potassium	3.5		(3.5-5.0)	mmol/L
Glucose	128	H	(70-110)	mg/dL

Test Description	Result	Flags	Ref. Range	Units
WBC	11.7	H	(4.5-11.0)	th/cmm
HCT	29.3	L	(41.0-53.0)	%
HGB	9.9	L	(13.5-17.5)	gm/dl
RBC	3.29	L	(4.50-5.90)	mil/cmm
PLT	112	L	(150-350)	th/cumm
MCV	89		(80-100)	fl
MCH	29.9		(26.0-34.0)	pg/rbc
MCHC	33.6		(31.0-37.0)	g/dl
RDW	17.5	H	(11.5-14.5)	%
PT	13.2		(11.3-13.3)	sec
PT-INR	1.1			
APTT	29.8		(22.1-35.1)	sec
DIFFERENTIAL REQUEST	RECEIVED			
Diff Method	Auto			
Poly	88	H	(40-70)	%
Lymphs	10	L	(22-44)	%
Monos	2	L	(4-11)	%
EOS	0		(0-8)	%
Basos	0		(0-3)	%
Absolute Neuts	10.26	H	(1.8-7.7)	th/cmm
Absolute Lymphs	1.19		(1.0-4.8)	th/cmm
Absolute Monos	0.18	L	(0.2-0.4)	th/cmm
Absolute EOS	0.01	L	(0.1-0.3)	th/cmm
Absolute Basos	0.02		(0.0-0.3)	th/cmm
Aniso	1+		(NORMAL)	
Hypo	None		(NORMAL)	
Macrocytes	None			
Microcytes	None			

Micro
Negative for VRE, C.Diff Toxin as of 8/13/05

Radiology:
CXR -IMPRESSION: Heart and Mediastinum are stable. Lines, Tubes and Catheters: Tracheostomy remain present. PICC line central venous catheter tip is in the left brachiocephalic vein. Bilateral chest tubes remain present. No pneumothorax is seen. Lungs show patchy parenchymal opacities in the lungs concerning for bowel pneumonia. There is fluid loculated in the left major fissure there is stable.

EKG:
72 BPM. Irregular sinus rhythm. Normal axis. Normal intervals. Slight depression in II, III, F. No ST elevations. Diffusely, flattened T waves in II, III, and F, V2, V5, V6. Decrease in depression from 8/03/05 EKG. Resolution of TWI in anterior leads since 8/3/05.

Impression :
This is a 67 y/o man initially presenting with psoas abscess and complications including Afib, ARF, recurrent ventilator and aspiration PNA and pleural effusions requiring intubation, chest tubes and

tracheostomy, plus GIB. He presents to the floor for continued treatment including antibiotics and continued dialysis.

Plan:
Psoas Abscess:
-To require prolonged drainage
-Continue linezolid/cefepime/flagyl/fluconazole for infection
-Contact IR, Surgery, and ID regarding antibiotic duration, drain changes, and imaging needs.
-F/U on possible continued source of drainage, e.g. fistula to psoas?

Atrial fibrillation:
-Currently in sinus rhythm
-Stable on 200mg Amiodarone QD and 0.0625 Dig Q3Days
-EKG changes not signicantly changed from prior EKGs.

ARF/CRI:
-Currently anuric/oliguric, and undergoing HD.
-Scheduled for tunnel cath access in AM
-NPO post MN for procedure
-HD scheduled for Tuesday

Recurrent Pneumonias:
-Continue course of antibacterial regimen
-O2 Support as needed

Bilateral Pleural Effusions:
-Continue with drainage via left and right chest tube
-Continue to assess placement of L sided tube to drain loculations

Respiratory Failure:
-Maintain tracheosotmy, to prevent aspiration.
-02 supplmenation as needed.

Cholecystic Collection
-Cholecystotomy tube in place
-F/U on timing for removal with IR

UGIB/Guaic positive stools
-Cont to hold heparin and ASA
-F/U with GI for timing on EGD after surgical healing from ex lap

FEN
-Continue gastrojejunostomy tube feeds to minimize aspirations.
-Continue rate of Nepro @ 45 cc/hr.

Prophy:
-Nexium,
-Pneumoboots (avoid heparin, ASA as heme prophylaxis)given guaic positive stools as
-Vancomycin for 2 weeks after other antibiotic regimen for C. Diff prophy
-Left PICC line in place for access

Code status : Full code

**********, MD, PhD
Pager # 23669
PGY-1