Nicholas Burney ER H&P #2

Full Name: D.P.
Age: 58
Sex: M
Marital Status: Married
Race/Nationality: Russian
Address: Queens, New York
Date of Birth: 2/16/1962
Date and Time: 6/30/2021, 9:45AM
Location: NYP-Q
Source of Information: Son
Reliability: Unreliable (Unresponsive)
Mode of Transport: Ambulance

Chief Complaint: "Unresponsive x 1 hour".

History of Present Illness

D.P. is a 58 y/o male with PMH of DMII and HTN (uncompliant with medication) brought in by EMS unresponsive after patient collapsed 1 hour ago at 8:00 AM during a religious service and had one episode of vomiting. Information was obtained from his son. Patient had "not been feeling well" for several days, he then saw his PCP last week and received acupuncture therapy yesterday. Stroke team was activated at 9:05, and the patient was intubated at the scene. The patient arrived with fixed gaze and decerebrate posturing noted. He was administered Versed and Etomidate prior to intubation.

Past Medical History

DMII
HTN
Noncompliant with medications

Past Surgical History

Unable to be elicited.

Medications

Unable to be elicited, none on record.

Allergies

Unable to be elicited

Family History

Son – Alive and in good health

Wife – Alive and in good health

Social History

No history on file for tobacco, drug, or alcohol use.

Review of Systems

Unable to obtain – Patient is intubated.

Vital Signs

Height: 5’ 6”
Weight: 176 lb
BMI: 28.7
BP: 157/78
Pulse: 125
RR: 25
T: 37.4 degrees Celsius
O2 Sat: 100% on BVM

Physical Exam

General: Intubated, sedated, on bag ventilation.
Head: Normocephalic, right frontal external ventricular drain placed.
Eyes: Fixed gaze, pupils nonreactive, L pupil is greater in size than right pupil
Neck: Trachea is midline
ENT: Vomit present around the mouth, intubation tube prevents visualization of the oropharynx.
Pulmonary: Tachypnic, overbreathing ventilator. Breath sounds are equal bilaterally with no wheezing or rales.
Cardiac: Tachycardic, S1 S2 distinct, Regular rhythm, no JVD. Peripheral pulses 2+
Abdomen: Soft, nontender, non-distended.
GU: Foley catheter placed
MSK: Decerebrate posturing on admission and in response to sternal rub.
Neurological: RASS -5, obtunded pupils non reactive to light bilaterally.
Skin: Scattered ecchymoses in various stages of healing over the thorax, legs and arms.

Labs

CBC:
WBC – 117.89
RBC – 3.82
Hb- 11.7
Hematocrit- 36.2
CMP:
Na – 138

K – 3.5
Cl – 102
CO2 – 21
BUN – 25
Creatinine – 0.99
Glucose – 327
Coagulation Tests:
PT- 16.6
INR – 1.44
Peripheral Blood Smear:
Anisocytosis- Slight
Poikolocytosis – Moderate
Burr cells – Many
Ovalocytes - Few

EKG:

Sinus Tachycardia

Imaging

CT Cervical Spine – Endotracheal tube visualized, thyroid nodules with an exophytic nodule along the inferior pole

CT Head – Left basal ganglia intraparenchymal hemorrhage, intraventricular hemorrhage and moderate hydrocephalus

Assessment and Plan

58 year old male with intraventricular hemorrhage and newly diagnosed acute myelocytic leukemia.

Disposition: Admission

1. Neuro: Monitor for changes in neurological function, HOB >30 degrees, monitor ICP, patient is not a candidate for TPA and ICP will rise once EVD clots off.
2. Pulmonary: Avoid hypercapnia, protect airway.
3. CV: A line, keep SBP 155-170, low dose nicardipine drip as needed.
4. GI: Keep NPO.
5. Renal: s/p Foley catheter placement, monitor I&Os.
6. ID: WBCs >100k predominately blast cells from AML.
7. Heme/onc: Consult explains peripheral smear shows newly diagnosed acute severe AML, overall grave prognosis and high risk of DIC.
   Prophylaxis: Venodynes for DVT.
8. Consult palliative care, inform next of kin.